

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
LAKE CHARLES DIVISION

THE STATE OF LOUISIANA, by and through its
Attorney General, Liz Murrill;

THE STATE OF ARKANSAS, by and through its
Attorney General, Tim Griffin; and

THE STATE OF ALABAMA, by and through its
Attorney General, Steve Marshall;

PLAINTIFFS,

v.

BRANDON NOUHAVANDI;

JESSICA NOUHAVANDI;

JBN OPERATIONS LLC;

CAMBRIDGE REPRODUCTIVE HEALTH
CONSULTANTS (D/B/A THE MASSACHUSETTS
MEDICATION ABORTION ACCESS PROJECT);

ANGEL FOSTER;

SUSAN YANOW;

MAUREEN PAUL;

REMY COEYTAUX;

MARGARET SIMEONE;

A SAFE CHOICE INC.;

A SAFE CHOICE NETWORK INC.;

REMY COEYTAUX, MD, PC (D/B/A CHOIX
REPRODUCTIVEHEALTH);

Civ. No.:

Judge:

Mag. Judge:

OPTIO WOMEN'S HEALTH, INC.;

ABUZZ, LLC;

MANISHA KUMAR;

ISHANI VILLAGE LLC;

CHRISTIE PITNEY;

CHRISTIE PITNEY NURSING AND
REPRODUCTIVE HEALTH INC. (D/B/A
FORWARD MIDWIFERY, NURSING, AND
REPRODUCTIVE HEALTH);

FORWARD MIDWIFERY PLLC;

ROBIN TUCKER;

R. TUCKER LIMITED (A/K/A R. TUCKER
CHARTERED, A/K/A METRO AREA ADVANCED
PRACTICE HEALTHCARE);

METRO AREA MODERN REPRODUCTIVE CARE,
LLC (D/B/A ROXY CLINIC);

CHARLENE EISENBERG REPRODUCTIVE
HEALTH COLLABORATIVE, INC. (A/K/A CE
REPRO, A/K/A CE REPRO FUND);

PEA CONN LLC (D/B/A SOUTHERN WOVEN);

SOUTHERN WOVEN HEALTH PLLC (A/K/A
WOVEN HEALTH PARTNERS);

ONE PLUS FOUR LLC (D/B/A WE TAKE CARE
OF US);

ROBIN HEWLETT;

CSA ASC LLC (D/B/A WE TAKE CARE OF US);

TIMOTHY PAIK-NICELY; AND

WITH OPEN ARMS CENTER FOR REPRODUCTIVE CHOICES, INC. (D/B/A CHOICES RISING), DEFENDANTS.

COMPLAINT

(NOTICE: Graphic images appear on pages 81–83.)

1. In our constitutional system, the sovereign, co-equal states are endowed with the power and responsibility to regulate within their borders for the health and safety of their citizens.

2. This case involves a sweeping, coordinated scheme to violate such laws through individuals and organizations who do not reside in the forum states and swear to never set foot in those states. They instead advertise illegal services online in the forum states, accept payments for certain products from individuals in those states, and then illegally ship those products to addresses in those states. This is not accidental or incidental: They acknowledge that their conduct is illegal—some even do business *only* in states where their conduct is illegal, and others send 95% of their monthly shipments to such states.

3. Our constitutional system does not tolerate such blatant disregard for a state's sovereign authority. That is true regardless of the nature of the products being unlawfully shipped into the forum state. It does not matter whether the package contains anthrax, mail bombs, or chemical weapons intended to harm individuals within that state, or (as is the case here) abortion drugs.

4. That is why Plaintiffs Louisiana, Arkansas, and Alabama bring this suit. As sovereign states, they wield traditional police powers within their borders, enforcing democratically enacted laws for the health and safety of their citizens. Among such laws are specific restrictions on abortion, including a general prohibition on abortion with narrow exceptions and a prohibition on the

dispensing of abortion drugs by mail. Those laws protect the lives and health of unborn babies and their mothers—and they reflect careful policy choices adopted through each State’s democratic process. Some may disagree with these policy choices, but they are the law within Plaintiff States. Indeed, this was the Supreme Court’s promise in *Dobbs v. Jackson Women’s Health Organization*, 597 U.S. 215 (2022): that each sovereign state may “regulate abortion as its citizens wish.” *Id.* at 230.

5. Notwithstanding the promise of *Dobbs*—and notwithstanding Plaintiff States’ laws—abortions have proliferated by the thousands within Plaintiff States’ borders. Not because of local doctors and nurses, or even underground abortionists, risking arrest by violating those laws. Rather, it is because of an army of individuals and organizations in *other* states like California, New York, and Massachusetts fixed on perpetrating “a scheme to undermine [the Supreme Court’s] decision in *Dobbs*.” *Danco Lab’s, LLC v. Louisiana*, 146 S. Ct. 1192, 1193 (2026) (Alito, J., dissenting). They are some of the defendants in this case—and their mission is “to operationalize [their] middle-finger rage,” “thwart red-state attorneys general,” and “thwart draconian anti-abortion laws.”¹

6. The scheme is simple. The organizations operate websites advertising abortion drugs in Plaintiff States. The organizations use a short questionnaire in which website users (anonymous men, women, and children) can represent (or misrepresent) their alleged pregnancy status. The website users then pay a fee for the abortion drugs or represent that they cannot afford the fee (in which case most organizations will assume the cost). Some organizations then use mail-order pharmacies to ship the drugs (predominantly from California) to addresses in Plaintiff States; others handle their own shipments after “pill-packing parties [] fueled by pizza and wine.”² The drugs are then used to abort

¹ See generally Nina Martin, *She’s Remaking the Abortion Landscape One Pill at a Time*, Mother Jones (July 31, 2026), perma.cc/E8AJ-N8P6 (attached as Ex. 1).

² *Id.* at 4.

babies in Plaintiff States and, in documented instances, send women to emergency rooms with severe bleeding and excruciating pain.



A typical daily run to the nearby post office includes hundreds of packages bound for all 50 states. Emily Schiffer

7. The organizations carry out this scheme by widely advertising that abortion drugs are “safer than Tylenol” or even “driving a car.” They also severely downplay the rate and nature of adverse reactions to abortion drugs that frequently demand emergency care. And if emergency care is necessary, they actively encourage women to lie to healthcare providers in Plaintiff States by saying that they are simply suffering a miscarriage.

8. All this violates Plaintiff States’ laws. The organizations openly acknowledge as much. But they think themselves invincible because their agents swear to never set foot in Plaintiff States (thereby avoiding arrest), and their home states have enacted so-called “shield laws” intended to thwart legal liability for individuals perpetrating this interstate abortion scheme.

9. By abridging Plaintiff States’ traditional authority to regulate the practice of medicine, this interstate scheme places the lives and health of women, girls, and unborn babies in Plaintiff States at risk. Plaintiff States’ laws exist for a reason: to protect life and to ensure that appropriate safeguards are in place in the narrow circumstances where an abortion might be permitted. Today, however, abortion drugs are flooding into Plaintiff States in open defiance of their laws—and Plaintiff States alone are bearing the human and economic costs of that scheme.

10. The organizations and individuals behind this scheme are free to disagree with Plaintiff States’ policy decisions—but they are not free to disregard them, especially at the expense of women, girls, and babies in Plaintiff States. Accordingly, Plaintiff States have taken extraordinary measures to counter this attack on their sovereign authority. Those include cease-and-desist letters, subpoenas, criminal enforcement actions, and even a lawsuit against the U.S. Food and Drug Administration. So far, however, nothing has stopped the deliberate flood of abortion drugs into Plaintiff States.

11. Louisiana’s own experience well illustrates the problem. Of Louisiana’s request for assistance in holding a New York doctor accountable for the death of a teenager’s baby, Governor Kathy Hochul said, “[T]here’s no way in hell that I’ll ever respond to a request to extradite [the doctor] and face criminal charges.”³ Responding to Louisiana’s similar request concerning a California doctor responsible for the death of a domestic abuse victim’s baby, Governor Gavin Newsom was more pointed: “@AGLizMurrill: Go fuck yourself.”⁴

³ Press Release, Office of N.Y. Governor Kathy Hochul, *Protecting Reproductive Freedom: Governor Hochul Signs Legislation Affirming New York’s Status as a Safe Haven for Reproductive Health Care* (Feb. 3, 2025), perma.cc/G5PY-7VHD (attached as Ex. 2). The audio recording linked in the release is available at perma.cc/8L5R-VEBJ.

⁴ Gavin Newsom (@GavinNewsom), X (Feb. 5, 2026), perma.cc/5532-P3BS (attached as Ex. 3).



Louisiana plans to sue me because I won't extradite a doctor for providing an abortion.

@AGLizMurrill: Go fuck yourself. California will never help you criminalize healthcare.

12. This cross-border assault on Plaintiff States is clear and undeniable—and it is a “classic” public nuisance under federal common law. *Arizona v. Biden*, 40 F.4th 375, 386 (6th Cir. 2022) (citation omitted); *accord Cranor v. 5 Star Nutrition, L.L.C.*, 998 F.3d 686, 691–92 (5th Cir. 2021).

13. At its core, the federal common law of public nuisance protects a sovereign state’s “interest in the abatement of public nuisances, instances in which the injury to the public health and comfort [is] graphic and direct.” *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 604 (1982). A state thus may, for example, sue to enjoin an out-of-state entity’s “noxious” discharge of items across state lines and into the suing state. *See id.* at 603–04 (citing *Missouri v. Illinois*, 180 U.S. 208 (1901); *Ga. v. Tenn. Copper Co.*, 206 U.S. 230 (1907)). Similarly, a state may sue over “the keeping of diseased animals,” “the practice of medicine by one not qualified,” or any number of other interferences with “the public health” that fall within the “broad category” of public nuisances. *Cranor*, 998 F.3d at 691 (citation omitted); *accord Michigan v. U.S. Army Corps of Eng’rs*, 667 F.3d 765, 771–72 (7th Cir. 2011) (applying federal common law and emphasizing that “[p]ublic nuisance traditionally has been understood to cover a tremendous range of subjects” (citing examples)).

14. Relevant here, a state also may sue to enjoin conduct “not warranted by law, ... which obstructs or causes inconvenience or damage to the public in the exercise of rights common to all.” *Cranor*, 998 F.3d at 691 (quoting Restatement (Second) of Torts § 821B cmt. a (Am. L. Inst. 1979)). Put otherwise, “conduct ... proscribed by a statute” presents a quintessential public nuisance, especially where it involves “a significant interference with the public health” and the perpetrator “knows” of that “continuing” harm. Restatement (Second) of Torts § 821B(2) & cmt. d; *accord City of*

Huntington v. AmerisourceBergen Drug Corp., 157 F.4th 547, 566–69 (4th Cir. 2025) (“One means of demonstrating an unreasonable interference with a public right is to show that a defendant’s act or causal contributions to that act were ‘unlawful.’” (citing the Restatement)); *Baptiste v. Bethlehem Landfill Co.*, 965 F.3d 214, 220 (3d Cir. 2020) (applying the Restatement to find a public nuisance based on the defendant’s “alleged failure to operate its facility in accordance with [state law]”).

15. The federal common law of public nuisance squarely forecloses the defendants’ interstate scheme to circumvent Plaintiff States’ laws. The very act of dispensing abortion drugs by mail throughout Plaintiff States is “proscribed by” Plaintiff States’ laws. Restatement (Second) of Torts § 821B(2)(b). The drugs are “a significant interference with the public health,” *id.* § 821B(2)(a)—by design, they are intended to terminate pregnancies, thereby ending the lives of thousands of unborn babies in Plaintiff States and sending mothers to emergency rooms because of drug complications. Worse, the organizations behind this scheme and their facilitators “know[]” about this “continuing” harm *because that is their mission. Id.* § 821B(2)(c). They advertise in, and send abortion drugs into, Plaintiff States for the avowed purpose of undermining our pro-life laws. Recently asked about this point, one defendant’s employee giggled: “It made me so happy ... when [Justice Alito] wrote, ‘They’re undermining *Dobbs*.’ I was like, *yeah, exactly*.”⁵

16. The federal common law of public nuisance, moreover, is uniquely suited and necessary to resolve this cross-border conflict. Federal common law governs “areas of national concern,” including “where the basic scheme of the Constitution so demands” and where a suing state’s harm “emanat[es] from another State.” *Am. Elec. Power Co. v. Connecticut*, 564 U.S. 410, 421 (2011) (citation omitted). That is precisely the case here given the functional nullification of Plaintiff States’ laws—and Plaintiff States’ subordination to the policy preferences of pro-abortion states and

⁵ Ex. 1 at 7.

their citizens. *See Alfred L. Snapp & Son, Inc.*, 458 U.S. at 607 (noting the propriety of a state suit where the “injury is one that the State, if it could, would likely attempt to address through its sovereign lawmaking powers”); *id.* at 607–08 (recognizing a state’s “[d]istinct” “interest in securing observance of the terms under which it participates in the federal system”). Indeed, in circumstances like this, the application of federal common law in federal court is virtually a “duty” because Plaintiff States have “surrendered” “the right to make war,” which otherwise would provide a defense against out-of-state aggressors. *Missouri*, 180 U.S. at 241.

17. In “our historic tradition,” “the States enjoy ‘equal sovereignty.’” *Nw. Austin Mun. Utility Dist. No. One v. Holder*, 557 U.S. 193, 203 (2009) (citing *United States v. Louisiana*, 363 U.S. 1, 16 (1960)); *accord Shelby County v. Holder*, 570 U.S. 529, 544 (2013) (“[T]he constitutional equality of the States is essential to the harmonious operation of the scheme upon which the Republic was organized.” (quoting *Coyle v. Smith*, 221 U.S. 559, 580 (1911))). That was the tradition the *Dobbs* Court upheld by “return[ing]” to “the citizens of each State” the authority to regulate abortion as they see fit. 597 U.S. at 302. This is the tradition that the defendants avowedly seek to undermine by deliberately violating Plaintiff States’ laws designed to protect human life. And that is the tradition this lawsuit will vindicate.

18. If state sovereignty means anything, it means that states like Louisiana, Arkansas, and Alabama cannot be forced to endure open violations of their laws, deaths of their babies, and harms to their women and girls simply because an out-of-state actor disagrees with their sovereign prerogative to choose life within their borders.

PARTIES

19. Plaintiff Louisiana is a sovereign state of the United States. This action is brought on behalf of Louisiana by Attorney General Liz Murrill, who is legally authorized to sue on its behalf. Her offices are located at 1885 N. Third St., Baton Rouge, Louisiana 70802.

20. Plaintiff Arkansas is a sovereign state of the United States. This action is brought on behalf of Arkansas by Attorney General Tim Griffin, who is legally authorized to sue on its behalf. His offices are located at 101 W. Capitol Ave., Little Rock, Arkansas 72201.

21. Plaintiff Alabama is a sovereign state of the United States. This action is brought on behalf of Alabama by Attorney General Steve Marshall, who is legally authorized to sue on its behalf. His offices are located at 501 Washington Ave., Montgomery, Alabama 36104.

22. Defendant Cambridge Reproductive Health Consultants, Inc. (d/b/a The Massachusetts Medication Abortion Access Project (The MAP)) is a 501(c)(3) tax-exempt organization, with its principal place of business at 98 Electric Ave., Suite #1, Somerville, Massachusetts 02144. The MAP is “a non-profit, asynchronous telemedicine Shield Law practice in Massachusetts that provides medication abortion care to patients from all 50 states.”⁶ The MAP operates under the domains themap.wspr.health, cambridgereproductivehealthconsultants.org, and cambridgereproductivehealthconsultants.org/map.

23. Defendant Angel Foster is the president and a co-founder of Cambridge Reproductive Health Consultants, Inc. She also serves as its registered agent for service of process at 98 Electric Ave., Apt. #1, Somerville, Massachusetts 02144. In September 2023, Foster launched The MAP within Cambridge Reproductive Health Consultants, Inc., and runs its daily operations today.⁷

24. Defendant Susan Yanow is The MAP’s director of community engagement. She is a resident of Massachusetts.

25. Defendant Maureen Paul is The MAP’s medical director. She is a resident of Massachusetts.⁸

⁶ The MAP, *Abortion Pills by Mail—Private & Affordable Abortion Care*, perma.cc/2MRU-YZ7J (last visited Sept. 24, 2026) (attached as Ex. 4).

⁷ See Ex. 1 at 2–3, 21.

⁸ See *id.* at 6.

26. Defendant Remy Coeytaux is a resident of California.

27. Defendant Margaret Simeone is a resident of California.

28. Defendant A Safe Choice Inc. is a California corporation formerly known as Abortion Care at Home Inc. It was incorporated by Defendant Coeytaux in June 2024. The corporation's address is 548 Market St. #752820, San Francisco, CA 94104. The registered agent for the corporation is United States Corporation Agents, Inc., 500 N. Brand Blvd. Glendale, CA 91203.

29. Defendant A Safe Choice Network Inc. is a California corporation initially registered by Defendant Coeytaux as incorporator in January 2026. Also in January 2026, Coeytaux signed a statement of information listing Defendant Simeone as chief executive officer, chief financial officer, and secretary of A Safe Choice Network Inc. A Safe Choice Network Inc. operates the domain asafechoicenetwork.com. The corporation's address is 455 Market St., Ste. 1940 #611906, San Francisco, CA 94105. The registered agent for the corporation is United States Corporation Agents, Inc., 500 N. Brand Blvd. Glendale, CA 91203.

30. Defendant Remy Coeytaux, MD, PC (d/b/a Choix ReproductiveHealth) is a California corporation located at 8911 Lakewood Dr., Ste. 25B, Windsor, CA 95492.⁹ Defendant Coeytaux is its chief executive officer, chief financial officer, and secretary. Its mailing address is P.O. Box 215, Healdsburg, CA 95448. The registered agent for the corporation is United States Corporation Agents, Inc., 500 N. Brand Blvd. Glendale, CA 91203.

31. Defendant OPTIO Women's Health, Inc. is a California corporation located at 8911 Lakewood Dr., Ste. 25B, Windsor, CA 95492. OPTIO Women's Health, Inc. operates the domain optiowomenshealth.com. Its mailing address is P.O. Box 215, Healdsburg, CA 95448.

⁹ Remy Coeytaux, MD, PC, Statement of Information Corporation (attached as Ex. 5).

32. Defendant Abuzz, LLC is a Massachusetts limited liability company located at 125 Westgate Center Drive #1036, Hadley, MA 01035. Abuzz, LLC operates the domain abuzzhealth.com. Its resident agent is Registered Agents Inc., 82 Wendell Ave., Ste. 100, Pittsfield, MA 01201.

33. Defendant Manisha Kumar is a Massachusetts resident.

34. Defendant Ishani Village LLC is a Massachusetts limited liability company. Ishani Village LLC operates the domain ishanivillage.com. Its resident agent is Registered Agents Inc., 82 Wendell Ave., Ste. 100, Pittsfield, MA 01201.

35. Defendant Christie Pitney is a Maryland resident.

36. Defendant Christie Pitney Nursing and Reproductive Health Inc. (d/b/a Forward Midwifery, Nursing, and Reproductive Health) is a California corporation with its principal office located at 17879 Harbaugh Valley Rd., Sabillasville, MD 21780 and a California address of 100 Willow Plaza 400, Visalia, CA 93291. Forward Midwifery operates the domain forwardmidwifery.org. Defendant Christie Pitney is its chief executive officer, chief financial officer, and secretary, located at the same address. Its agent for service of process is Darryl W. Hitchman, 100 Willow Plaza 400, Visalia, CA 93291.

37. Defendant Forward Midwifery PLLC is a Washington, D.C. professional limited liability company.

38. Defendant Robin Tucker is a Maryland resident.

39. Defendant R. Tucker Limited (a/k/a R. Tucker Chartered) is a Washington, D.C. corporation that is registered as a foreign corporation in Maryland.¹⁰ Defendant Tucker signed the Maryland incorporation document as president. Signing as owner of R. Tucker Limited, Defendant

¹⁰ R. Tucker Limited (F22036503), Foreign Corporation Qualification (attached as Ex. 6).

Tucker also has secured the trade name “Metro Area Advanced Practice Healthcare” for R. Tucker Limited in Maryland. R. Tucker Limited’s early principal office address was 4848 Battery Lane, Ste. 100, Bethesda, MD 20814. In May 2026, R. Tucker Limited changed its principal office address to its current resident agent’s address: Registered Agents Inc., 306 W. Redwood St., Ste. 200, Baltimore, MD 21201.

40. Defendant Metro Area Modern Reproductive Care, LLC (d/b/a Roxy Clinic) is a Maryland limited liability company. Defendant Tucker was its original resident agent at 4848 Battery Lane, Ste. 100, Bethesda, MD 20814. Defendant Tucker also is its president. Its principal office address is its current resident agent’s address: Registered Agents Inc., 306 W. Redwood St., Ste. 200, Baltimore, MD 21201.

41. Defendant Charlene Eisenberg Reproductive Health Collaborative, Inc. (a/k/a CE Repro, a/k/a CE Repro Fund) is a Maryland corporation and a 501(c)(3) organization. Defendant Tucker was CE Repro’s original resident agent in Maryland. CE Repro obtained its tax-exempt status in 2023 via an Internal Revenue Service letter mailed to CE Repro in care of Defendant Tucker.¹¹ For tax year 2025, the Internal Revenue Service lists Defendant Tucker as CE Repro’s principal officer at CE Repro’s address: 10770 Columbia Pike, Ste. 1005, Silver Spring, MD 20901.¹² CE Repro’s current resident agent is Registered Agents Inc., 306 W. Redwood St., Ste. 200, Baltimore, MD 21201.

42. Defendant Pea Conn LLC (d/b/a Southern Woven) is a Delaware limited liability company (incorporated in August 2025) that is registered in New York as a foreign limited liability company. Southern Woven owns and operates the website www.southernwoven.com. Southern

¹¹ Letter from Stephen A. Martin, Dir., Exempt Orgs. Rulings & Agreements, Internal Revenue Serv., to Charlene Eisenberg, Reproductive Health Collaborative Inc. (Mar. 7, 2023), perma.cc/PK9Z-9GVE (attached as Ex. 7).

¹² Charlene Eisenberg Reproductive Health Collaborative Inc., IRS (last visited Sept. 28, 2026), perma.cc/7BKA-ULYN (attached as Ex. 8).

Woven's agent for service of process on the Secretary of State is Registered Agents Inc., 418 Broadway Ste. R, Albany, NY 12207.

43. Defendant Southern Woven Health PLLC (a/k/a Woven Health Partners) is a Maine limited liability company. Its agent for service of process is Registered Agents Inc., 439 U.S. Route 1 Ste. A, York, ME 03909.

44. Defendant One Plus Four LLC (d/b/a We Take Care Of Us) is a California limited liability company formed in December 2025 with one manager: WTCOU LLC, 1209 Mountain Road Pl. NE, Ste. R, Albuquerque, NM 87110. One Plus Four LLC "own[s] and operate[s]" the domain wetakecareof.us.¹³

45. Defendant Robin Hewlett is a New Jersey resident.

46. Defendant CSA ASC LLC (d/b/a We Take Care Of Us) is a New Jersey limited liability company. Defendant Robin Hewlett is the member-owner of CSA ASC LLC.

47. Defendant Timothy Paik-Nicely is a California resident.

48. Defendant With Open Arms Center for Reproductive Choices, Inc. (d/b/a Choices Rising) is a California corporation. Defendant Timothy Paik-Nicely is the chief executive officer of this entity.

49. Defendant Jessica Nouhavandi is a California resident.

50. Defendant Brandon Nouhavandi is a California resident.

51. Defendant JBN Operations LLC is a California limited liability company operating as a mail-order pharmacy. Defendant Brandon Nouhavandi is the managing member of JBN Operations LLC.

¹³ One Plus Four LLC, *We Take Care of Us Terms of Use* (last updated Apr. 1, 2026), perma.cc/LUX6-ECUQ (attached as Ex. 9).

52. Each individual defendant is sued both in his or her personal capacity as well as in his or her capacity as agent, employee, or volunteer for the Defendant entities with which the individual is affiliated.

JURISDICTION AND VENUE

53. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because Plaintiff States' public nuisance claim arises under federal common law. *See, e.g., Sam L. Majors Jewelers v. ABX, Inc.*, 117 F.3d 922, 926 (5th Cir. 1997) ("Federal jurisdiction exists if the claims in this case arise under federal common law." (citing *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972))); *accord Torres v. S. Peru Copper Corp.*, 113 F.3d 540, 543 (5th Cir. 1997); *Clem Perrin Marine Towing, Inc. v. Panama Canal Co.*, 730 F.2d 186, 189 (5th Cir. 1984).

54. This Court also has subject-matter jurisdiction under 28 U.S.C. § 1331 because Plaintiff States' claims necessarily raise substantial and disputed questions of federal law and constitutional order, including state sovereignty and self-governance. *See Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 314 (2005).

55. This Court has supplemental jurisdiction over Plaintiff States' state-law claims under 28 U.S.C. § 1367.

56. Venue is proper in this district under 28 U.S.C. § 1391(b)(2) because "a substantial part of the events or omissions giving rise to [Plaintiff States' claims] occurred," and are occurring, in this district. As detailed further below, each Defendant advertises the sale and shipment of abortion drugs in this district; engages in financial transactions regarding such drugs with individuals in this district; prescribes or prepares such drugs for delivery in this district; or dispenses, ships, or delivers such drugs in this district or to out-of-state individuals for delivery in this district. To take one example, Defendant Angel Foster of The MAP has posed in front of a map confirming that The MAP sends abortion drugs to Louisiana (including to Lake Charles specifically), as well as Arkansas and Alabama:

Inside the legal fight over the telehealth clinics that help women defy abortion bans

Massachusetts, Maine, Vermont, and Rhode Island are among some states that have shield laws with specific provisions protecting them from criminal prosecution or civil lawsuits even if the patient is in another state, according to nonprofit KFF.



Dr. Angel Foster, co-founder of Massachusetts Medication Abortion Access Project, points out on a map of the United States where her organization provides care, May 13, 2025, in Somerville, Mass. AP Photo/Charles Krupa

57. For the same reasons and those detailed below, the Court has personal jurisdiction over each Defendant.

FACTUAL ALLEGATIONS

I. Plaintiff States Prohibit Abortion After *Dobbs*.

58. In 2022, the Supreme Court “heed[ed] the Constitution and return[ed] the issue of abortion to the people’s elected representatives.” *Dobbs*, 597 U.S. at 232. In so doing, the Supreme Court recognized that the citizens of the several states would disagree over the proper approach to abortion. “In some States, voters may believe that the abortion right should be even more extensive than the right that [*Roe v. Wade*, 410 U.S. 113 (1973), and its progeny] recognized.” *Id.* at 256. But “[v]oters in other States may wish to impose tight restrictions based on their belief that abortion destroys an ‘unborn human being.’” *Id.* That inevitable disagreement is a feature, not a bug, of our

constitutional system—and nothing prevents “the people’s elected representatives from deciding [each state for itself] how abortion should be regulated.” *Id.*

59. In the wake of *Dobbs*, each Plaintiff State chose life, prohibiting abortion in all but the narrowest circumstances and specifically prohibiting the remote dispensing of abortion drugs in Plaintiff States.

60. Each Plaintiff State treats an unborn baby as fully human from the moment of conception. *See* La. R.S. § 14:2(A)(11) (defining “[u]nborn child” to mean “any individual of the human species from fertilization and implantation until birth”); La. R.S. § 22:1014(A)(4) (“It is the longstanding policy of this state that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child’s right to life and is entitled to the right to life from conception under the laws and constitution of this state.”); Ark. Const. amend. 68 § 2 (“The policy of Arkansas is to protect the life of every unborn child from conception until birth”); Ark. Code § 20-16-1503(6) (defining “[u]nborn child” as “the offspring of human beings from conception until birth”); Ala. Const. art. I, § 36.06(b) (“This state further acknowledges, declares, and affirms that it is the public policy of this state to ensure the protection of the rights of the unborn child in all manners and measures lawful and appropriate.”); Ala. Code § 26-23H-3(7) (“A human being, specifically including an unborn child in utero at any stage of development, regardless of viability.”).

61. Each Plaintiff State generally prohibits the abortion of an unborn baby except to save the life of the mother. *See* La. R.S. § 40:1061(C), (F) (“No person may knowingly” perform an abortion unless a licensed physician determines “in reasonable medical judgment” that abortion is necessary “to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman.”); Ark. Code §§ 5-61-304(a), 5-61-404(a) (“A person shall not purposely perform or attempt to perform an abortion except to save

the life of a pregnant woman in a medical emergency.”); Ala. Code § 26-23H-4(a), (b) (“It shall be unlawful for any person to intentionally perform or attempt to perform an abortion except” “if an attending physician licensed in Alabama determines that an abortion is necessary in order to prevent a serious health risk to the unborn child’s mother.”).

62. Each Plaintiff State likewise proscribes the sale and prescription of abortion drugs to terminate pregnancies. *See* La. R.S. § 40:1061(C) (“No person may knowingly administer to, prescribe for, or procure for, or sell to any pregnant woman any medicine, drug, or other substance with the specific intent of causing or abetting the termination of the life of an unborn human being.”); La. R.S. § 14:87.9(A) (“Criminal abortion by means of an abortion-inducing drug is committed when a person knowingly causes an abortion to occur by means of delivering, dispensing, distributing, or providing a pregnant woman with an abortion drug.”); Ark. Code §§ 5-61-303(1)(A), 5-61-403(1)(A) (“defining “[a]bortion” to include “the act of using, prescribing, administering, procuring, or selling of any ... medicine, drug, or any other substance, device, or means with the purpose to terminate the pregnancy of a woman, with knowledge that the termination by any of those means will with reasonable likelihood cause the death of the unborn child”); Ala. Code § 26-23H-3(1) (defining “abortion” to include the “prescription of any ... medicine, drug, or any other substance or device with the intent to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child”); Ala. Code § 13A-13-7 (punishing “[a]ny person who willfully administers to any pregnant woman any drug or substance ... to induce an abortion, miscarriage or premature delivery or aids, abets or prescribes for the same”).

63. In the narrow circumstances where an abortion via abortion drugs is permitted, each Plaintiff State criminally prohibits the dispensing of abortion drugs without an in-person examination by a state-licensed physician. *See* Ark. Code § 20-16-1504(c) (“Before providing an abortion-inducing drug, the physician prescribing, administering, dispensing, or otherwise providing the abortion-

inducing drug shall ... [e]xamine the pregnant woman in person”); Ala. Code § 26-23E-7 (“[T]he physician giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug must first examine the pregnant woman in person and document, in the woman’s medical chart, the gestational age and intrauterine location of the pregnancy prior to giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug.”); *see also* La. R.S. §§ 1061.1.5(A), 1061.10 (requiring pre-abortion examination).

64. In those limited circumstances, the abortion drugs likewise must be administered in person with the prescribing physician. *See, e.g.*, La. R.S. § 40:1061.11(A) (“When any drug or chemical is used for the purpose of inducing an abortion, the physician who prescribed the drug or chemical shall be in the same room and in the physical presence of the pregnant woman when the drug or chemical is initially administered, dispensed, or otherwise provided to the pregnant woman.”); Ark. Code § 20-16-603(b)(1) (“[T]he initial administration of the drug or chemical shall occur in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug or chemical to the patient.”).

65. On top of these broadly applicable laws, Louisiana and Arkansas have repeated in other statutes their prohibition of the sale, prescription, and delivery of abortion drugs within their borders. *See* La. R.S. § 962.2(A) (“Except as provided in R.S. 40:1061.11, no abortion-inducing drug may be sold, prescribed, dispensed, distributed, or delivered in this state in violation of this Section.”); La. R.S. § 962.2(B) (“Notwithstanding any other provision of law to the contrary, delivery to a person in Louisiana by mail-order, courier, or as a result of a sale made via the internet in violation of this Section is strictly prohibited.”); Ark. Code § 20-16-1504(b) (“It is unlawful for any manufacturer, supplier, physician, or any other person to provide any abortion-inducing drug via courier, delivery, or mail service.”). Louisiana and Alabama also criminally prohibit abortion advertising, *i.e.*, “the placing

and carrying of any advertisement of abortion services by the publicizing of the availability of abortion services.” La. R.S. § 14:87.4(A); *see* Ala. Code § 13A-4-1(a)(1).

II. Defendants Effect a Cross-Border Scheme to Facilitate Abortion in Plaintiff States.

66. Notwithstanding the promise of *Dobbs*—and notwithstanding Plaintiff States’ laws detailed above—abortions have proliferated by the thousands in Plaintiff States after *Dobbs*. According to one study considering data through December 2025, approximately 1,000 abortions occur in Louisiana every month; approximately 300 every month in Arkansas; and approximately 700 every month in Alabama.¹⁴

67. This is the direct and intended result of a nationwide scheme to force abortion into Plaintiff States.

68. This nationwide scheme has three essential components. *First*, the Biden Administration’s 2023 decision to remove a longstanding in-person dispensing requirement for the abortion drug mifepristone, for the avowed purpose of allowing FDA-approved mifepristone to be illegally mailed from pro-abortion states into pro-life states. That unlawful decision is at issue in Louisiana’s pending lawsuit against the U.S. Food and Drug Administration. *See Louisiana v. FDA*, No. 25-cv-1491 (W.D. La.). *Second*, the decisions of states like New York, California, and Massachusetts to enact so-called “shield laws,” which purport to immunize residents of those states from liability for illegally sending abortion drugs into Plaintiff States. Those illegal shield laws are at issue in *Louisiana v. New York*, filed today as an original action in the United States Supreme Court. *Third*, the unilateral decisions of pharmacies, non-profit organizations, prescribers, and others to facilitate the flood of

¹⁴ Society of Family Planning, #WeCount Report April 2022 to December 2025 (June 10, 2026), perma.cc/B4LV-KJXJ (attached as Ex. 10). Data for each state can be found by searching the individual state via the search bar, or by downloading the comprehensive report. Plaintiff States’ graphs can be found in Exhibit 10.

abortion drugs into Plaintiff States and thereby “thwart draconian anti-abortion laws.”¹⁵ This lawsuit addresses those actors.

69. No single lawsuit can deliver complete relief to Plaintiff States—but each lawsuit can provide meaningful relief. And relief in each of these pending lawsuits will bring Plaintiff States extraordinarily close to complete relief. To realizing the promise of *Dobbs*: that each sovereign state may decide for itself “how abortion should be regulated.” *Dobbs*, 597 U.S. at 256.

A. Abortion Drug Manufacturers Encourage Abortions in Plaintiff States.

70. This story begins with abortion drugs themselves. The abortion drug mifepristone causes an embryo or fetus to detach from the uterine lining, killing the embryo or fetus.¹⁶ Mifepristone commonly is dispensed in conjunction with the drug misoprostol, which initiates contractions to expel the dead embryo or fetus. Misoprostol also can be used standing alone to effectuate an abortion—and some defendants in this case have threatened to switch to a misoprostol-only regimen if they lose the ability to mail mifepristone.¹⁷ Accordingly, the terms “abortion drugs” and “abortion-inducing drugs” in this complaint refer to both drugs individually and together, as well as any other drug intended to cause an abortion.

71. Mifepristone can be foreign-made, but, as relevant here, FDA also has approved mifepristone manufactured by two American companies, Danco Laboratories, LLC and GenBioPro Inc.

72. Danco manufactures Mifeprex, which is the branded drug and appears in an orange box. Danco uses a company called Cencora, Inc. to distribute Mifeprex.

¹⁵ Ex. 1 at 20.

¹⁶ The term embryo and fetus refer to different stages of a human’s development in the womb, similar to how the terms infant and toddler are used to refer to different stages of a human’s development outside of the womb.

¹⁷ Ex. 1 at 6–7, 10–11.



73. GenBioPro manufactures generic mifepristone, which appears in a blue-and-white box. GenBioPro uses a company called R&S Northeast, LLC to distribute generic mifepristone.



74. Both Danco¹⁸ and GenBioPro¹⁹ direct “patients” on their websites to INeedAnA.com—a website that promises to “help you learn about all your abortion options and find the most up to date information about abortion clinics, pills by mail, state abortion laws, and support.”²⁰

¹⁸ Mifeprex, *How Do I Get Mifeprex?*, perma.cc/GVM8-PBSS (last visited Sept. 24, 2026) (attached as Ex. 11).

¹⁹ GenBioPro, *About Medical Abortion*, perma.cc/PP3Y-GLXA (last visited Sept. 24, 2026) (attached as Ex. 12).

²⁰ I Need an A, *Find Verified Clinics, Pills by Mail, and Support*, perma.cc/RE5K-4FCU (last visited Sept. 24, 2026) (attached as Ex. 13).

75. I Need An A acknowledges that abortions in Plaintiff States are illegal. For example, as to Louisiana, I Need An A states that “[a]bortion is mostly banned in Louisiana” save for “very limited situations, such as to prevent a serious health risk to the [woman].”²¹ I Need An A even emphasizes that “telehealth abortion is not permitted in Louisiana.”²² But I Need An A assures a reader that only a “provider[]” is subject to the ban, “not the [woman] having an abortion.”²³



Current Louisiana Abortion Laws

Abortion is mostly banned in Louisiana, but you still have options ♥

Under [Louisiana Revised Statutes § 40:1061.1.3](#), providers can only provide abortion care in very limited situations, such as to prevent a serious health risk to the pregnant person.

These laws apply to providers — not the person having an abortion. In fact, the law specifically says it cannot be used to punish the person who has an abortion. In simple terms, self-managed abortion is [not a crime in Louisiana](#).

Here are other key pieces of legal context to consider when exploring your options in Louisiana:

- Abortion pills by mail are available in every state including Louisiana. Self-managed abortion is not a crime.
- Although telehealth abortion is not permitted in Louisiana, [people can still order abortion pills online](#). Louisiana law does not criminalize taking abortion pills, but what the law says can be different than what [happens in reality](#).

76. Having assured the website user they can lawfully obtain abortion drugs from providers who themselves are violating state law, I Need An A then offers abortion options at the zip code entered by the user.

77. So, for example, with a Lake Charles zip code, I Need An A tells a user: “Doctors have been banned from performing abortions in Louisiana in most cases, but you’ve still got options.” Besides driving or flying to an out-of-state clinic, I Need An A proposes that the user “[o]rder abortion

²¹ I Need an A, *Abortion Access Guide in Louisiana*, perma.cc/8SU5-T66M (last visited Sept. 24, 2026) (attached as Ex. 14).

²² *Id.* at 2 (expand to see all state legal info).

²³ *Id.*

pills online”—although it “may come with legal risk.” If a user clicks that option, I Need An A displays various websites hosted by organizations that advertise the prescription, sale, and shipment of abortion drugs in Plaintiff States (and every other state). Those are defendants in this case.

Need an abortion?
We're here to help.

To find your best options, we need a bit of information from you. None of what you enter will be stored or shared, ever. [Learn why we ask for this.](#)

Location *Required
Lake Charles, LA, USA This may save

Pick first day of last period This may save
07/30/2026 (6 weeks, 3 days)

If you're under 18, enter your age ?
How old are you?

Search

[Advanced Search](#)

Doctors have been banned from performing abortions in Louisiana in most cases, but you've still got options.

Order abortion pills online

Ordering pills costs \$150 or less, with most services offering a "pay what you can" option. Pills arrive in as few as 2 days. Taking pills on your own is medically very safe, but may come with legal risk. [Learn more](#)

Your results are filtered to pills-by-mail

Fly to an abortion clinic

Given your distance from your closest clinic, flying may be faster and cheaper than shipping. [Learn more about flying to get an abortion](#)

Showing providers that offer **pills by mail**

Gestational age **6 weeks or more**

Accessible to you by **Mail** Open on **Any day** Sorted by **Most practical**

Online We Take Care of Us • Nos Cuidamos This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information	Online Abuzz This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information	Online Choices Rising This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information (707) 200-8291
Online Southern Woven This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information	Online The MAP / Cambridge Reproductive Health Consultants This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information	Online Aid Access This service is verified, but it may come with legal risk in your state. Learn more Pills By Mail Go to website More Information

B. Defendants Prescribe, Sell, and Dispense Abortion Drugs Within Plaintiff States.

78. Although each organization’s website is structured differently, each runs materially the same operation. Each operates a website specifically advertising abortion drugs for sale and shipment in Plaintiff States; each accepts payments from individuals in Plaintiff States for those drugs; and each ships the drugs to addresses in Plaintiff States.

1. The Massachusetts Medication Abortion Project (The MAP)

79. Start with The MAP. Run by Cambridge Reproductive Health Consultants, The MAP “believe[s] abortion care should be available and accessible to everyone.”²⁴ The MAP acknowledges “abortion is illegal or restricted in some states,” but promises “[d]octors and medical professionals in certain states where abortion is protected may prescribe abortion pills by mail, even if you live in a state where it is banned or restricted.”²⁵

80. To carry out that promise, The MAP “work[s] with doctors in Massachusetts to prescribe FDA-approved abortion medication to patients anywhere in the US who meet eligibility for the medications and apply through our website.”²⁶ As of July 31, 2026, The MAP claimed to operate through “five prescribers.”²⁷

81. The process to obtain abortion drugs from The MAP is extraordinarily simple. The MAP asks for a zip code, birth date, and date of a last known period—and then confirms that “[y]ou are eligible for abortion pills from The MAP.” So that a user may understand The MAP’s promise to “discreetly” send abortion pills, The MAP offers more information explaining the process: (1) “You can order abortion pills online right now, shipped directly to all 50 states”; (2) it takes only “2-5

²⁴ Ex. 4.

²⁵ The MAP, *Frequently Asked Questions*, perma.cc/G8EU-9WL3 (last visited Sept. 24, 2026) (“Is abortion legal in the US?”) (attached as Ex. 15).

²⁶ *Id.* (“How does The MAP work?”) (attached as Ex. 16).

²⁷ Ex. 1 at 22.

minutes” “to give some basic information about you, your pregnancy, and your medical history,” and “the price you pay is up to you”; (3) a doctor will “prescribe you pills” within “1-12 hours”; and (4) “[p]ills should arrive 1-5 days from the approval at the address you provide.”

You are 11 weeks, 3 days pregnant in Lake Charles, Louisiana.

You are eligible for abortion pills from The MAP.

[Order Pills](#)

Abortion in Louisiana

Clinics are not allowed to do abortions in Louisiana. But you still have options.

Abortion Pills by Mail



Our doctors will discreetly mail abortion pills to you, so you can take them at home or wherever is comfortable for you. We offer a pay-what-you-can-afford model, which means you decide the amount that you can pay. We only provide pills by mail during the first 80 days of pregnancy.

[Learn More](#)

[Learn About Other Options](#)

Pills by Mail ×

You can order abortion pills online right now, shipped directly to all 50 states.

What you get

We will connect you with a doctor who can figure out if abortion pills are right for you.

The pills you get in the mail are the same you would get in a clinic, are prescribed by a doctor, and packaged in a plain envelope.

How does it work?

- 1 Complete the form**
 You will need to give some basic information about you, your pregnancy, and your medical history. Then, you'll add shipping and payment details. We use a pay-what-you-can model, meaning the price you pay is up to you.
2-5 minutes
- 2 Medical review**
 A doctor will look at the information you provided. If your pregnancy is under 80 days and abortion pills are safe for you to take, they will prescribe you pills.
Within 1-12 hours
- 3 Pills are shipped**
 Pills should arrive 1-5 days from the approval at the address you provide
Delivery in 1-5 days



Your data is encrypted before it leaves your device and we use secure systems to help protect your personal health information. For more information, please read our Privacy Policy.

Order Pills by Mail

82. The user completes the order using a payment platform called Stripe that The MAP uses to bring in its profits.

83. Once the order is complete, it slots into an ongoing production process at The MAP. To carry out its mission, The MAP has “thousands and thousands”²⁸ of Mifeprex (manufactured by Danco and distributed by Cencora) and misoprostol (packaged by a California company called

²⁸ Ex. 1 at 2.

PharmPak, Inc.) pills. To fill orders, The MAP hosts “pill-packing parties [] fueled by pizza and wine,” during which volunteers and others stuff packages (typically 500 per party) with Mifeprex and misoprostol. Those parties “are a little competitive,” and The MAP has “a long waiting list of volunteers eager for a chance to help thwart draconian anti-abortion laws.”²⁹



84. Defendant Angel Foster created The MAP and even today runs “the famous MAP assembly line” at pill-packing parties, while also “be[ing] front and center” when “constantly fundraising.”³⁰

85. Defendant Susan Yanow is The MAP’s director of community engagement who—as part of her role—“deploy[s] volunteers” to package abortion drugs.³¹ Similarly, Defendant Maureen Paul—The MAP’s medical director—oversees the medical side of the operation.

86. The MAP then ships those packages from Massachusetts to their destinations, including thousands shipped to addresses in each of Plaintiff States. The MAP claims to send “more

²⁹ See Ex. 1 at 2–3, 5, 6.

³⁰ See *id.*

³¹ *Id.* at 7.

than 6,000” shipments every month, 95% of which go to states “where abortion is subject to harsh restrictions and near-total bans.”³²

87. Plaintiff States have confirmed through public-protection investigations that The MAP will send, and has sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. The MAP never conducted a telehealth consultation or otherwise spoke with the person identified as the patient. Nor did The MAP meaningfully verify that the person submitting the request was the person identified as the patient. The identification submitted depicted a woman, but the person completing the process was, in fact, a man. The name associated with the payment method did not match the identified patient, and the billing address did not match the shipping address. Had The MAP spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, The MAP approved the requests and shipped the drugs. This includes specific shipments to Louisiana in June 2026 and Arkansas in April 2026.

³² *Id.* at 2–3.



2. A Safe Choice Network/OPTIO

88. Where The MAP tries to mask its operations behind anonymous individuals all under the same MAP umbrella, other organizations use a complex web of corporate entities, prescribers, and pharmacies to carry out an identical scheme. That is well illustrated by Defendant Remy Coeytaux's California-based operation, which involves A Safe Choice Network and OPTIO.

89. A Safe Choice Network (asafechoicenetwork.com)³³ is another of the organizations identified by I Need An A (and thus by mifepristone-manufacturers Danco and GenBioPro).³⁴ A Safe Choice Network claims to be “a referral network of caring and experienced medical doctors who

³³ Defendant A Safe Choice Inc. plainly is related to Defendant A Safe Choice Network Inc.—and to the extent that any allegations here regarding A Safe Choice Network Inc. also (or only) apply to A Safe Choice Inc., Plaintiffs make the same allegations as to A Safe Choice Inc.

³⁴ A Safe Choice, *Medication Abortion. Discreetly Delivered.*, perma.cc/FRE3-CB7Y (last visited Sept. 24, 2026) (attached as Ex. 17).

provide safe, private, and effective medication abortions to women nationwide.” A Safe Choice Network emphasizes that it ships abortion drugs “discreetly to all 50 states.”



90. A Safe Choice Network tells website users that, to obtain abortion drugs, they need only “complete our quick, confidential, secure, HIPPA compliant online consultation form (no phone call required)” and pay \$140. “After reviewing your information, a doctor in A Safe Choice network will send abortion pills (mifepristone and misoprostol) to you discreetly via Priority Mail. The package will not identify the contents.”

91. A Safe Choice Network recognizes that “[t]he legal risk for having an abortion depend[s] on the state in which you live.” Accordingly, for information on legal risks, A Safe Choice

Network directs³⁵ website users to a website called Plan C, which, in turn, links back to I Need An A's "expla[nation] [of] current Louisiana abortion laws" (and the laws of the other Plaintiff States).³⁶

92. The connection between A Safe Choice Network and Plan C (and thus I Need An A) is no accident. Defendant Remy Coeytaux is the president and CEO of A Safe Choice Inc., as well as the incorporator of A Safe Choice Network Inc.³⁷ A family member, Francine Coeytaux, is a co-founder of Plan C.³⁸

93. An "Order Now" button on A Safe Choice Network's website takes the user to another website associated with OPTIO Women's Health, which announces "Medication Abortion via Telehealth." In a blog post, A Safe Choice Network claims to "partner with Optio Women's Health, an online clinic operating under California's shield law."³⁹

94. The OPTIO website copies much of the language verbatim from A Safe Choice Network's website, including, for example, the \$140 price and the promise to send "a discreet envelope" with abortion drugs "everywhere in the United States."⁴⁰ The OPTIO website claims that "OPTIO is proud to be A Safe Choice network member," although it is obvious the two websites and corporations are one and the same. The OPTIO website also links articles, including one entitled "U.S. Clinicians Can Now Mail Abortion Pills to States Banning Abortion, Thanks to Shield Laws in Five

³⁵ A Safe Choice, *FAQs*, perma.cc/HKN6-G48A (last visited Sept. 24, 2026) ("Possible legal risks to you") (attached as Ex. 18).

³⁶ Plan C, *Comprehensive clinic and support finder*, perma.cc/4VXT-YYX3 (last visited Sept. 24, 2026) (attached as Ex. 19).

³⁷ A Safe Choice Network Inc., Statement of Information Corporation (attached as Ex. 20).

³⁸ Plan C Movie, *About*, perma.cc/5AV8-PBWJ (last visited Sept. 24, 2026) (attached as Ex. 21).

³⁹ A Safe Choice, *How Mississippi Residents Can Get Abortion Pills in 2026: 3 Private Paths* (June 26, 2026), perma.cc/AAJ8-Q54N (attached as Ex. 22).

⁴⁰ Optio Women's Health, *Medication Abortion via Telehealth*, perma.cc/KVL2-XBWQ (last visited Sept. 24, 2026) (attached as Ex. 23).

States.”⁴¹ It likewise directs users to the I Need An A website for “trusted information, support services, and guidance.”⁴²

95. An “Order Now” button on the OPTIO website promises a “simpl[e]” process involving brief information, a \$140 payment (“billed as OPTIO WOMEN’S HEALTH”), and “[d]iscreet shipping via US Postal Service Priority Mail.”⁴³ Payment is submitted via the payment platform Clover.

96. As promised, completion of the process results in the delivery of a GenBioPro mifepristone pack and a bottle of misoprostol pills. They arrive in a package with a return address for “OWH” (*i.e.*, OPTIO Women’s Health) and P.O. Box 1259, Windsor, CA 95492. The labels are generated by a shipping-label company called Shippo.

⁴¹ Optio Women’s Health, *Support and Resources*, perma.cc/AC3Q-VLZR (last visited Sept. 24, 2026) (attached as Ex. 24).

⁴² *Id.* at 1.

⁴³ Optio Women’s Health, *Request Medication*, perma.cc/8BN5-QKH6 (last visited Sept. 24, 2026) (attached as Ex. 25).



97. The phone number that the A Safe Choice Network website lists for assistance is the same number the OPTIO website lists: (707) 710-8866. That phone number is tied to an account with RingCentral, a cloud-based communications system. Defendant Remy Coeytaux is responsible for that account. Both Coeytaux (through the address remyco@gmail.com) and the current chief executive officer of A Safe Choice Network Inc., Defendant Margaret Simeone (through the address megsimeone@proton.me), use that account.

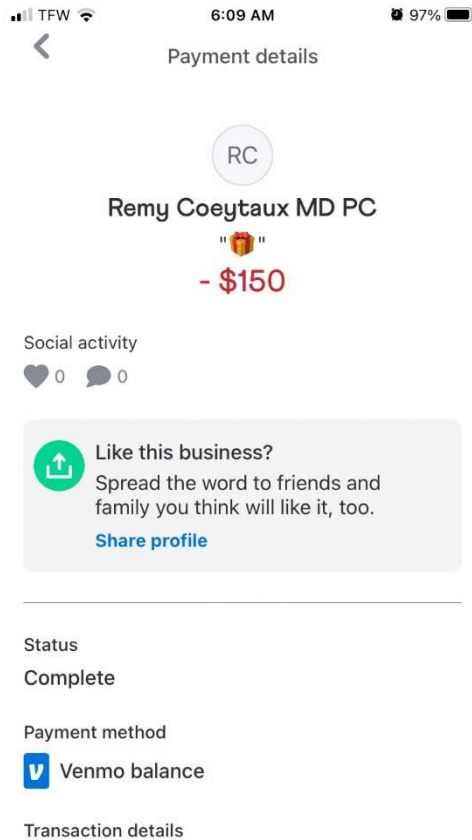
98. Defendant Coeytaux also is behind the shipment of packages bearing the “OWH” return address. He has an account with Shippo—the shipping-label company that processes the OWH shipping labels—and he set that account up through another email address (coeytaux@proton.me). Using that account, he prepares and ships packages linked with the same return address that appears on those packages (OWH, P.O. Box 1259, Windsor, CA 95492), and the same email address that the OPTIO website lists for assistance (doctor@optiowomenshealth.com). Defendant Coeytaux pays approximately \$11-12 in shipping costs for each such shipment.

99. The Coeytaux-run operation through A Safe Choice Network, OPTIO Women's Health, and Remy Coeytaux, MD, PC (d/b/a Choix ReproductiveHealth) unsurprisingly makes extraordinary sums of money from the enterprise. Coeytaux used a usual email address (remyco@gmail.com), his corporation Remy Coeytaux, MD, PC (d/b/a Choix ReproductiveHealth), and his signature as president of his corporation to open an account with the payment platform Clover, which facilitates his profits. Predictably, his average sale price is around \$140 or \$150—and his total sales are astonishing. By processing dozens to hundreds of abortion-drug packages per day, it was not uncommon for Coeytaux to clear tens of thousands of dollars a month in 2024. And that was just the start: In 2026, he has been responsible for hundreds of abortion-drug packages every month, resulting in over \$100,000 in profits every month.

100. Coeytaux's operation and profits, moreover, are not limited to orders processed through A Safe Choice Network and OPTIO Women's Health. He also partners with another organization, Aid Access,⁴⁴ which likewise advertises abortions drugs in “all 50 U.S. states including Louisiana,” Arkansas, and Alabama.⁴⁵ For orders that he fills through Aid Access—including transactions with individuals in Louisiana, as reflected in the picture below—he has been paid through a Venmo handle (@RemyCoeytaux) bearing the name of his corporation, Remy Coeytaux, MD, PC.

⁴⁴ Due to unique issues surrounding foreign service of process, Plaintiff States will soon file a separate lawsuit against Aid Access.

⁴⁵ Aid Access, *Get Abortion Pill Online in Louisiana · Order Here*, perma.cc/A2ZR-3XAB (last visited Sept. 24, 2026) (attached as Ex. 26).



101. A Safe Choice Network and OPTIO are responsible for quite literally hundreds of such packages mailed to addresses within each Plaintiff State. Although Plaintiffs do not yet know the full extent of these operations, A Safe Choice Network/OPTIO/Coeytaux at least mailed nearly 500 abortion-drug packages to Louisiana addresses between 2025 and mid-2026; over 200 abortion-drug packages to Arkansas addresses between 2025 and mid-2026; and over 500 abortion-drug packages to Alabama addresses between 2025 and mid-2026.

102. Plaintiff States have confirmed through public-protection investigations that A Safe Choice Network/OPTIO will send, and has sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. A Safe Choice Network/OPTIO never conducted a telehealth consultation or otherwise spoke with the person identified as the patient. Nor did A Safe Choice Network/OPTIO meaningfully verify that the person submitting the request was

the person identified as the patient. The identification submitted depicted a woman, but the person completing the process was, in fact, a man. The name associated with the payment method did not match the identified patient, and the billing address did not match the shipping address. Had A Safe Choice Network/OPTIO spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, A Safe Choice Network/OPTIO approved the requests and shipped the drugs. This includes specific shipments to Louisiana in August 2026 and Arkansas in March 2026.

3. Abuzz

103. Abuzz, LLC—based in Massachusetts—takes a similar tack involving prescribers and entities in the Northeast.

104. Abuzz engages in a widespread marketing campaign on social media that tries to glamorize abortion drugs, making them appear safe, easy, and normal. For example, Abuzz posts memes lauding access to abortion drugs to everyone “regardless of a zip code.” It also posts images placing abortion drugs alongside everyday items like sunglasses and wallets.



105. Through its website abuzzhealth.com, Abuzz advertises abortion drugs via “fast, discreet shipping.”⁴⁶



106. Abuzz characterizes the process for obtaining drugs as “simple, confidential, and designed to meet your needs.”⁴⁷ A website user need only answer “a few basic questions,” “mak[e] a payment,” and then receive the drugs within “1-5 business days.”⁴⁸ No phone or video call is required—“[e]verything is done through the intake form.”⁴⁹

107. Abuzz does not provide any in-person screening for known contraindications of abortion drugs, such as bleeding disorders, certain medications, IUDs, gestation age, and ectopic

⁴⁶ Abuzz, *Need abortion care at home?*, perma.cc/K2QF-GRAW (last visited Sept. 24, 2026) (attached as Ex. 27).

⁴⁷ Abuzz, *How it Works*, perma.cc/QYZ6-TUZ8 (last visited Sept. 24, 2026) (attached as Ex. 28).

⁴⁸ *Id.* at 1, 3.

⁴⁹ Abuzz, *FAQs*, perma.cc/JU3K-6VXR (last visited Sept. 24, 2026) (attached as Ex. 29).

pregnancy. To the contrary, Abuzz discourages women from receiving this type of care, stating that the need for an ultrasound is a “myth,” that patients with IUDs do not need to take them out, and that blood tests (or knowledge of blood type) is not needed because patients with Rh-negative blood type do not need to worry about negative effects until after twelve weeks of pregnancy.⁵⁰



Can I use abortion pills if I have an IUD in place?

It is very rare to become pregnant with an IUD in place. If you are pregnant with an IUD, there is a higher risk of it being an ectopic pregnancy. Ectopic pregnancies are dangerous because they can burst suddenly and cause severe internal bleeding. While an ultrasound is not required, it would show the location of the pregnancy and the IUD. **You don't need to have the IUD taken out before taking abortion pills.** They will still work (unless it is an ectopic pregnancy) and a risk is that the IUD may come out with the pregnancy. Since you have become pregnant, it also means you will need to have the IUD replaced after the abortion since it is no longer working correctly.

108. A “Get access today” button redirects the website user to an intake process. One of the first questions asks for a website user’s state. If the user selects a state like New York, the website takes the user to questions about pregnancy status. But if the user selects a state like Louisiana, the website warns the user of “potential legal risks of getting abortion pills by mail in the state you selected.”

⁵⁰ See *id.*

109. At the same step, the website links to third-party websites such as Plan C and Repro Legal Helpline for further information. Repro Legal Helpline carefully states that “using abortion pills to end your own pregnancy is not a crime in Louisiana” and also that “[h]ealthcare professionals in the state of Louisiana cannot provide abortions except to save the life or health of the pregnant [woman]”—by omission, Repro Legal Helpline concedes that the mailing of drugs itself is illegal.⁵¹ The same is true of Plan C, which obliquely states that “[p]eople in Louisiana access abortion pills by mail from online clinics and providers outside of the state, despite laws that restrict in-state services.”⁵² Plan C also links to I Need An A, which, as explained above, expressly states that “telehealth abortion is not permitted in Louisiana.”⁵³

110. So long as the website user clicks through Abuzz’s warning, a few questions and a few dollars (on the payment platform Square) later, abortion drugs—including GenBioPro mifepristone—are delivered to addresses in Plaintiff States.

111. Plaintiff States do not know every prescriber behind Abuzz, but they know of at least two: Defendant Christie Pitney and Defendant Manisha Kumar.

112. Pitney runs her own companies, Defendants Christie Pitney Nursing and Reproductive Health Inc. (d/b/a Forward Midwifery, Nursing, and Reproductive Health) and Forward Midwifery PLLC. Pitney also operates forwardmidwifery.org. Pitney and Forward Midwifery claim to offer mail-order abortion only “in California, Colorado, Maryland, Massachusetts, New Mexico, Oregon, & Washington.”⁵⁴ That is not true. Pitney has an account with a shipping-label company called Pirate Ship—an account in her name and Forward Midwifery’s name, using her

⁵¹ Repro Legal Helpline, *Is abortion legal in Louisiana?*, perma.cc/EC2Z-AWJ2 (last visited Sept. 24, 2026) (attached as Ex. 30).

⁵² Plan C, *Abortion pill access: Louisiana*, perma.cc/U2XR-GQG5 (last visited Sept. 24, 2026) (attached as Ex. 31).

⁵³ Ex. 14 at 2 (expand to see all state legal info).

⁵⁴ Forward Midwifery, *Promoting patient autonomy through empowering healthcare for all*, perma.cc/2E9Y-4MXF (last visited Sept. 24, 2026) (attached as Ex. 32).

Forward Midwifery address (christie@forwardmidwifery.com). Through that account, Pitney/Forward Midwifery prescribe and mail abortion drugs to addresses in Plaintiff States—on behalf of Abuzz and also as “an Aid Access provider” (the same organization with which Defendant Coeytaux is affiliated).⁵⁵ Pitney has confirmed that she has an “account[] with GenBioPro,” which explains the GenBioPro drugs she is prescribing and mailing.⁵⁶

113. On behalf of Abuzz, Pitney/Forward Midwifery are responsible for dozens of packages of abortion drugs mailed to addresses in each of Plaintiff States between 2024 and 2026.

114. Underscoring their work for Abuzz, Pitney/Forward Midwifery routinely use social media to amplify Abuzz content—such as this post proclaiming that “[a]bortion pills are SAFE, EFFECTIVE, and AVAILABLE in all 50 states!”

⁵⁵ Carrie N. Baker, *Online Abortion Provider Christie Pitney of Forward Midwifery: “Fast, Convenient Care”*, Ms. Magazine (Jan. 28, 2022) perma.cc/P7DM-EXCG (attached as Ex. 33).

⁵⁶ *Id.* at 13.

How to Use Mifepristone + Misoprostol

Before taking abortion pills:

- ✓ Take a pregnancy test to make sure you are pregnant. This is not required, but it can avoid confusion later.
- ✓ Check your dates. Count the time from the first day of your last period to today. Or get an ultrasound.

How to take the pills:

STEP 1 Swallow 1 mifepristone 200mg pill

Wait 24-48 hours

STEP 2 Take misoprostol any one of these effective ways:

- 1 Inside the cheek**
Hold the pills between the gums and cheek (like how a chipmunk holds food) for 30 minutes. Then swallow or spit out what's left.
- 2 Under the tongue**
Hold the pills under the tongue for 30 minutes. Then swallow or spit out what's left.
- 3 In the vagina**
Put the pills in the vagina and lie down for 30 minutes. Note: Pill pieces could be found during a vaginal exam.

How much misoprostol to take depends on how far along the pregnancy is:

Less than 9 weeks	9-12 weeks	12+ weeks
Take 4 pills at once	Take 4 pills at once. 4 hours later, take 4 more pills	Take 2 pills every 3 hours until the pregnancy is out
If you haven't started bleeding after 24 hours, take another 4 pills.		
You may have pills left over. Keep them for at least 1 month in case you are advised to take more.		

forwardmidwifery • Follow

... **forwardmidwifery** #Repost before from @abuzzhealth

Abortion pills are SAFE, EFFECTIVE, and AVAILABLE in all 50 states!

Part of what makes the pills so safe and effective is knowing how to use them. Save this post so that you always KNOW THE PROTOCOL. And send it to a friend so they know too! [Abuzzhealth.com/knowtheprotocol](https://abuzzhealth.com/knowtheprotocol)

Need abortion pills? Visit us at abuzzhealth.com or go to plancpills.org

#knowtheprotocol #planc #mife #miso #mifeandmiso #abortionpills #athomeabortion #abortion #abortionaccess #abortionissafe #abortionisnormal @plancpills

129w

lara_iiiii so helpful! 🙏🙏🙏

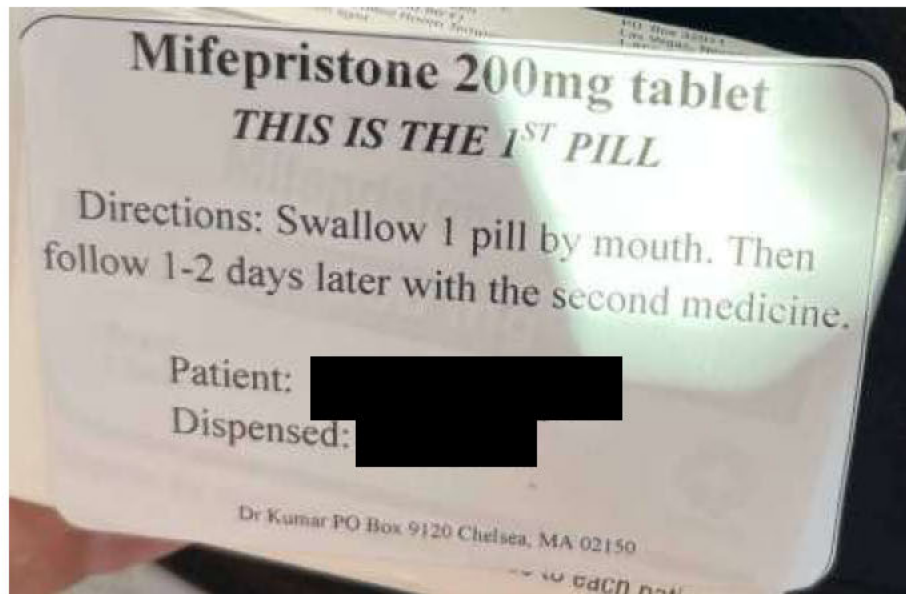
128w 1 like Reply

332 likes
March 29, 2024

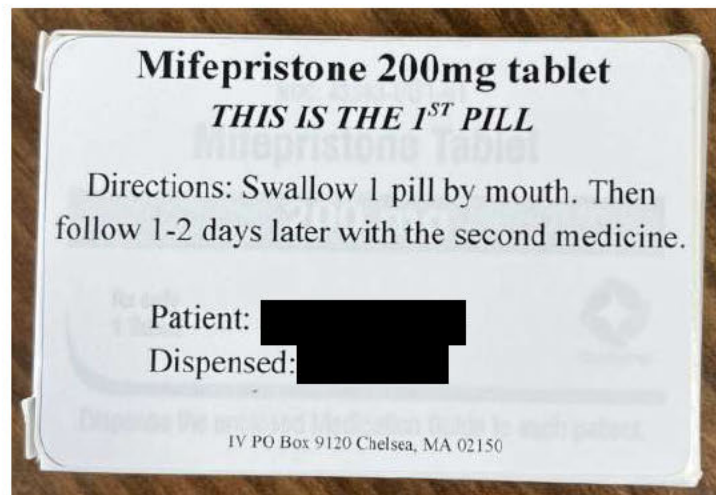
Add a comment... Post

115. Defendant Kumar and her company Defendant Ishani Village carry out the same mission under Abuzz, using the same shipping-label company, Pirate Ship, that Pitney uses to mass mail abortion drugs. Both based in Massachusetts, Kumar/Ishani Village use Massachusetts' Address Confidentiality Program (ACP), which allows users to hide their addresses behind P.O. Box 9120, Chelsea, MA 02150.⁵⁷ In some instances (or at least some instances in the past), Kumar/Ishani Village disclose their identity despite using the ACP address.

⁵⁷ Address Confidentiality Program Fact Sheet (attached as Ex. 34).



116. Kumar/Ishani Village also, however, use the more-cryptic initials "IV" (*i.e.*, Ishani Village) when hiding behind the ACP while sending drugs for Abuzz.



117. Here, too, although Plaintiff States do not yet know the full extent of these operations, on behalf of Abuzz, Manisha Kumar and Ishani Village sent at least more than 1,300 abortion-drug packages to Louisiana addresses between 2024 and mid-2026; over 2,700 abortion-drug packages to Arkansas addresses between 2024 and mid-2026; and over 900 abortion-drug packages to Alabama addresses in fewer than 12 months spanning 2025 and mid-2026.

118. Plaintiff States have confirmed through public-protection investigations that Abuzz and its agents will send, and have sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. Abuzz never conducted a telehealth consultation or otherwise spoke with the person identified as the patient. Nor did Abuzz meaningfully verify that the person submitting the request was the person identified as the patient. The identification submitted depicted a woman, but the person completing the process was, in fact, a man. The name associated with the payment method did not match the identified patient, and the billing address did not match the shipping address. Had Abuzz spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, Abuzz approved the requests and shipped the drugs. This includes a specific shipment to Arkansas in February 2026 from Kumar/Ishani Village (and their hidden address).



4. Southern Woven

119. A web of Southern Woven entities and actors follows a similar pattern. The central piece is Defendant Robin Tucker. Tucker is a nurse practitioner and certified nurse midwife who lives and works in Maryland and Washington, D.C. She worked and, on information and belief, continues to work as a prescriber for the same organization associated with Defendants Remy Coeytaux and Christie Pitney (Aid Access), as well as the same organization associated with Defendants Manisha Kumar and Christie Pitney (Abuzz).⁵⁸ But more recently, she has created Southern Woven, which claims to be “southern” and which exclusively sells abortion drugs to individuals in pro-life states where abortion is prohibited.

120. Southern Woven’s story rests on Tucker’s entities—Defendants R. Tucker Limited, Metro Area Modern Reproductive Care, LLC (d/b/a Roxy Clinic),⁵⁹ and CE Repro (the 501(c)(3) organization). Through these entities, Tucker publicly purports to provide abortion drugs by mail only in states where abortion is lawful.⁶⁰ She does so through the same shipping-label company used by Pitney and Kumar—Pirate Ship—with an account registered in her name and Metro Area’s name. Tucker typically generates labels with the same return address: MA (*i.e.*, Metro Area), P.O. Box 29, Cabin John, MD 20818.

121. The filing party that created Tucker’s Metro Area entity (in May 2022) was the same Plano, Texas attorney (Heidi Kocher of a law firm called Liles Parker⁶¹) who created Christie Pitney’s Forward Midwifery PLLC entity (in April 2022).⁶² In addition, Pitney/Forward Midwifery use the

⁵⁸ Carrie N. Baker, *Online Abortion Provider Robin Tucker: ‘I’m Trying To Remove Barriers.... It Feels Great To Be Able To Help People This Way’*, Ms. Magazine (Jan. 4, 2022), perma.cc/WBE7-7RXS (attached as Ex. 35).

⁵⁹ Roxy Clinic, *About*, perma.cc/TFS6-ZC36 (last visited Sept. 25, 2026) (attached as Ex. 36).

⁶⁰ Mara Gordon, *With Telehealth Abortion, Doctors Have to Learn to Trust and Empower Patients*, NPR (Jan. 17, 2023), perma.cc/P6DP-ZN6F (attached as Ex. 37).

⁶¹ Liles Parker, *Heidi Kocher*, perma.cc/RE47-6TV2 (last visited Sept. 25, 2026) (attached as Ex. 38).

⁶² Forward Midwifery PLLC, Articles of Organization for Domestic Limited Liability Company (attached as Ex. 39).

address 1331 H St. NW, Washington, D.C. 20005—the same address Tucker has used as an origin address and a return address for her shipments. These shared operational details reinforce that Tucker is not an isolated actor but part of a broader, coordinated network facilitating the sale and shipment of abortion drugs.

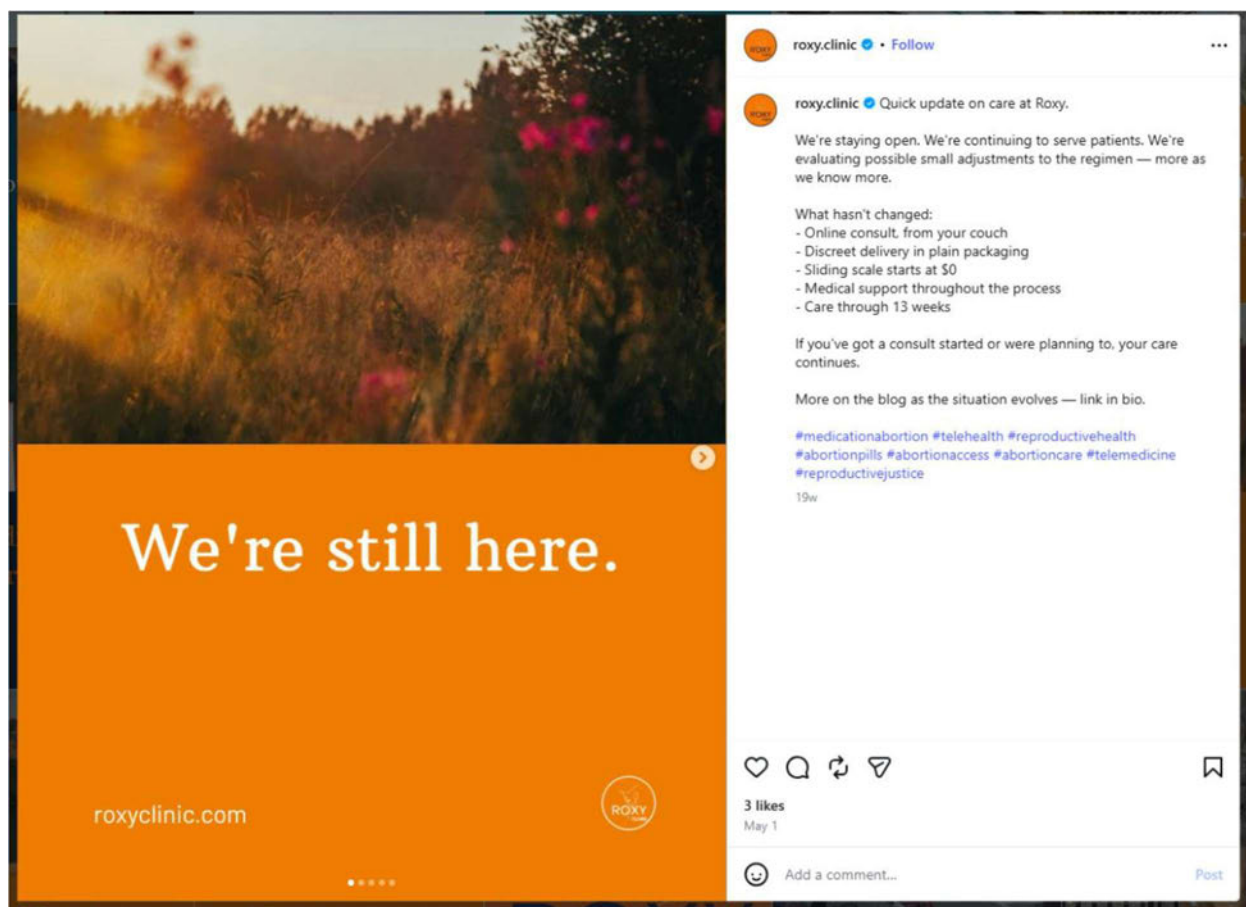
122. Despite her public representations, Tucker has repeatedly sent abortion drugs to addresses in states where such mailing is unlawful (including Louisiana and Arkansas) via the same shipping account—*i.e.*, in her name, in Metro Area’s name, with a Pirate Ship label, and with the MA, P.O. Box 29, Cabin John, MD 20818 return address. She did so in 2023, 2024, and 2025. Tucker claims that Metro Area’s providers “are licensed in each state we serve.”⁶³ On information and belief, neither Tucker nor any agent of Metro Area is licensed in Louisiana and Arkansas.

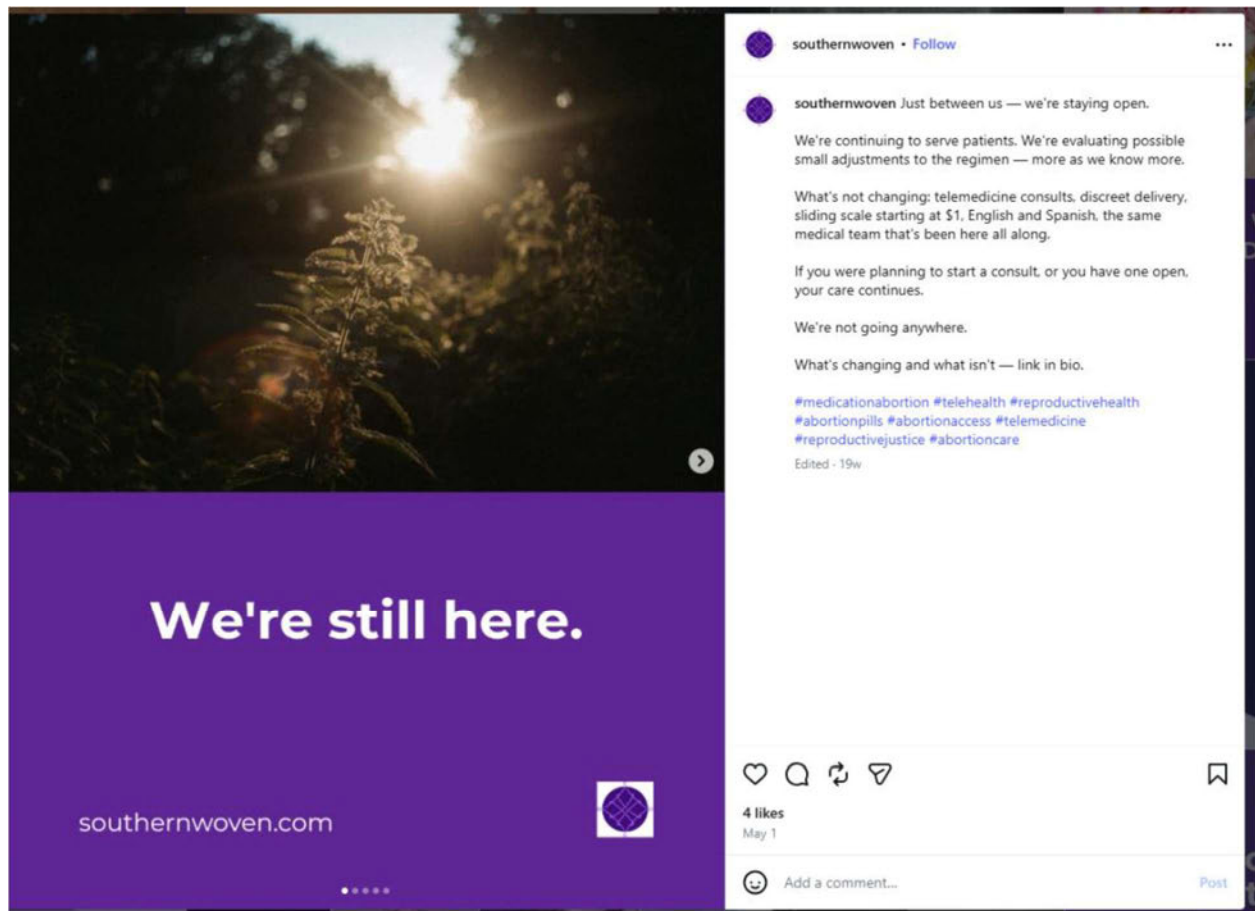
123. In an apparent effort to cover up mailing abortion drugs to states where abortion is unlawful, Tucker tried to set up a shadow system in 2025: Southern Woven—a Delaware company registered to do business in New York, but really operating out of Maryland and Washington, D.C.

124. Tucker runs social media accounts for both Southern Woven and Metro Area (d/b/a Roxy Clinic) that publish the same content on the same days, which often appears to be AI-generated (as Southern Woven’s website acknowledges).⁶⁴

⁶³ Ex. 36.

⁶⁴ Southern Woven, *Medical Review and Clinical Standards*, perma.cc/B2X6-CWRS (last visited Sept. 25, 2026) (attached as Ex. 40).





125. Southern Woven’s website claims to provide “Safe Abortion pill access For Southerners By Southerners.”⁶⁵ According to the website, Southern Woven “was built” for “[t]he states with the most restrictive abortion laws.”⁶⁶ “Telehealth is the way we do that. Mail is the way we do that.” “Serving the South,” Southern Woven promises, with “[s]afe and discreet delivery to your door.”⁶⁷ “Our Mission,” Southern Woven emphasizes, is “expand[ed] access to medication abortion in the South by connecting people with licensed telehealth clinicians.”⁶⁸

⁶⁵ Southern Woven, *Get the Abortion Pill Online*, perma.cc/X8GJ-XFKP (last visited Sept. 25, 2026) (attached as Ex. 41).

⁶⁶ Southern Woven, *For Southerners, By Southerners*, perma.cc/3HHL-ZUH4 (last visited Sept. 25, 2026) (attached as Ex. 42, at 3).

⁶⁷ Southern Woven, *Get the Abortion Pill Online*, *supra* n.65 (attached as Ex. 43).

⁶⁸ Southern Woven, *Support Abortion Access*, perma.cc/8S8S-6VGE (last visited Sept. 25, 2026) (attached as Ex. 44).

126. “Clinical care at Southern Woven is overseen by a Certified Nurse Midwife with more than a dozen state licenses and clinical experience going back to 2010 across labor and delivery, women’s health, and complex gynecology”—*i.e.*, Robin Tucker.⁶⁹ And the process is much the same as with other schemes detailed above. According to Southern Woven, “[t]he model is simple on purpose: someone fills out a confidential intake,” then “a licensed clinician reviews it,” and then “FDA-approved medications are mailed in discreet packaging.”⁷⁰ All for a sliding-scale fee between “\$0 to \$145” depending on a user’s ability to pay.⁷¹

127. Southern Woven touts its status as “a referral partner of some of the most trusted organizations in the reproductive health space,” including I Need An A.⁷² Southern Woven also is open and “honest” about the illegality of its conduct: “We do **not** claim that accessing care through telemedicine is ‘legal’ in every state. What we say is that people across all 50 states are safely accessing care, and that shield laws protect the providers who prescribe.”⁷³

128. Payments for abortion drugs processed by Southern Woven’s website—including payments for drugs mailed into Plaintiff States—are routed through a separate entity, Defendant Southern Woven Health PLLC (a/k/a Woven Health Partners), which is a Maine limited liability company.

129. Southern Woven is inextricably intertwined with Tucker’s Metro Area entity—as well as Defendant CE Repro, Tucker’s 501(c)(3) funding Southern Woven.

130. Southern Woven solicits donations on its website through CE Repro: “We partner with CE Repro Fund, our fiscal sponsor, to process donations securely and transparently. CE Repro

⁶⁹ Ex. 42 at 6.

⁷⁰ *Id.* at 4.

⁷¹ *Id.* at 5.

⁷² Southern Woven Medical Team, *Is Southern Woven Legit? Here’s What You Should Know*, Southern Woven (Apr. 10, 2026), perma.cc/M4E7-K4BH (attached as Ex. 45, at 2).

⁷³ *Id.* at 4.

Fund is a 501(c)(3) nonprofit organization.”⁷⁴ The website confirms that “100% of your donation goes directly to supporting abortion access through Southern Woven.”⁷⁵ And it directs users to “[c]lick the button below to make a secure donation through our fiscal sponsor, CE Repro Fund.”⁷⁶ When clicked, that button takes the user to a third-party donation website that states (a) it is “[o]rganized by CE Repro Fund” (identifying CE Repro’s EIN number), (b) it is “[p]owered by the CE Repro Fund (a licensed 501(c)(3) nonprofit),” and (c) “CE Repro is a funding partner who ensures that your donation goes to Southern Woven, while still allowing you to make a tax deductible donation.”⁷⁷

Southern Woven Healthcare

Donate to Southern Woven

Powered by the CE Repro Fund (a licensed 501(c)(3) nonprofit)

Why Southern Woven?

Southern Woven is a community-driven organization that creates safe, dignified pathways for people in the South to access essential reproductive health services and related counseling. By weaving together local clinics, tele-medicine providers, and grassroots outreach, Southern Woven ensures that:

- Everyone gets timely, confidential care, even if they live in an area where care is difficult to access.
- Financial barriers are lowered through a sliding-scale model that covers medication, clinical support, and after-care.

Your contribution helps keep that safety net intact.

CE Repro is a funding partner who ensures that your donation goes to Southern Woven, while still allowing you to make a tax deductible donation.

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hello@cepro.org

131. Southern Woven also is using the same shipping scheme that Tucker built under Metro Area. It has mailed and is mailing abortion drugs—including GenBioPro mifepristone—to addresses in Plaintiff States via the same Pirate Ship shipping-label account and bearing the same familiar return address: MA, P.O. Box 29, Cabin John, MD 20818.

⁷⁴ Ex. 44.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ CE Repro Fund, *Southern Woven Healthcare*, Givebutter, perma.cc/244M-CVPB (last visited Sept. 25, 2026) (attached as Ex. 46).



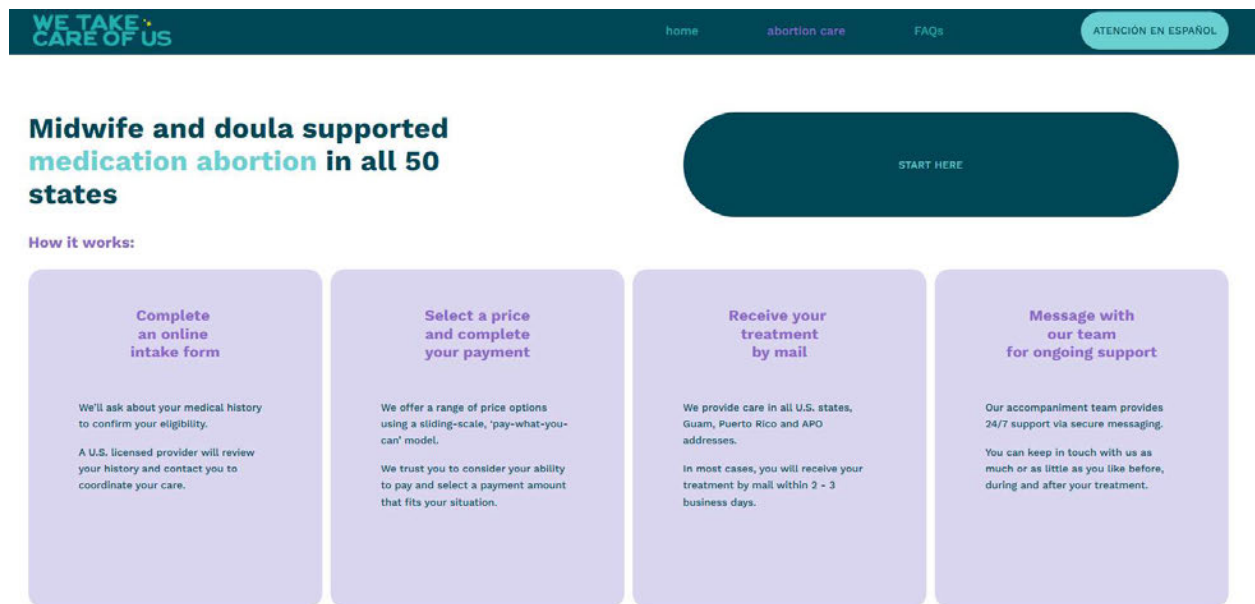
132. Plaintiff States have confirmed through public-protection investigations that Southern Woven will send, and has sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. Southern Woven never conducted a telehealth consultation or otherwise spoke with the person identified as the patient. Nor did Southern Woven meaningfully verify that the person submitting the request was the person identified as the patient. The identification submitted depicted a woman, but the person completing the process was, in fact, a man. The name associated with the payment method did not match the identified patient, and the billing address did not match the shipping address. Had Southern Woven spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, Southern Woven approved the requests and shipped the drugs. This includes specific shipments to Louisiana and Arkansas in August 2026.

5. We Take Care Of Us

133. Defendants One Plus Four LLC, CSA ASC LLC, and Robin Hewlett similarly operate under the name We Take Care Of Us (at the domain wetakecareof.us). We Take Care Of Us's website

originally listed CSA ASC LLC as its owner—and Hewlett, a midwife in New Jersey, owns and operates CSA ASC LLC. More recently, however, We Take Care Of Us’s website lists One Plus Four LLC as its owner. Because the unlawful conduct by We Take Care Of Us alleged in this complaint spans both periods of alleged ownership, Hewlett is a named Defendant alongside both CSA ASC LLC and One Plus Four LLC.

134. We Take Care Of Us advertises abortion drugs “in all 50 states” and emphasizes that “[w]e provide care in all U.S. states.”⁷⁸



135. We Take Care Of Us warns that “[t]he legal context of abortion care is different in every state,” and so directs website users to the Repro Legal Helpline website. As discussed above, Repro Legal Helpline states that, in Louisiana (and the other Plaintiff States), “[h]ealthcare professionals in the state of Louisiana cannot provide abortions except to save the life or health of

⁷⁸ We Take Care of Us, *Abortion Care*, perma.cc/7RCH-2ZVX (last visited Sept. 25, 2026) (attached as Ex. 47).

the pregnant [woman].”⁷⁹ The website also links to I Need An A’s website, which states that “telehealth abortion is not permitted in Louisiana.”⁸⁰

136. We Take Care Of Us claims that “Certified Nurse Midwives” facilitate the organization’s abortion drug scheme.⁸¹

137. The “Start Here” button on We Take Care Of Us’s website takes the website user to a brief questionnaire that “should take about 5-7 minutes to complete.”⁸² The user must first answer the questions to determine “if you are eligible for care with one of our affiliated U.S. licensed providers.”⁸³ “If you are eligible and you wish to continue,” We Take Care Of Us will then collect the user’s name, shipping address, and payment.⁸⁴ No video or telephone call is required—website users need only complete the online intake form.

138. Unlike with the MAP, A Safe Choice Network/OPTIO, Abuzz, and Southern Woven operations, We Take Care Of Us works through a mail-order pharmacy—the same pharmacy used by Aid Access, the organization affiliated with Coeytaux, Pitney, and Tucker. *See supra* ¶¶ 100, 112, 119. Once an unknown prescriber behind We Take Care Of Us receives payment, therefore, the prescriber sends the prescription to the mail-order pharmacy, which then directly mails the abortion drugs (GenBioPro mifepristone) into Plaintiff States. Those packages nearly always come through FedEx.

139. Plaintiff States have confirmed through public-protection investigations that We Take Care Of Us will send, and has sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. We Take Care Of Us never conducted a telehealth

⁷⁹ Ex. 30.

⁸⁰ Ex. 14 at 2 (expand to see all state legal info).

⁸¹ We Take Care of Us, *Frequently Asked Questions*, perma.cc/67C5-4KV9 (last visited Sept. 25, 2026) (“Who are the providers?”) (attached as Ex. 48).

⁸² We Take Care of Us, *Medical Request Form*, perma.cc/XQZ9-PDR4 (last visited Sept. 25, 2026) (attached as Ex. 49).

⁸³ *Id.*

⁸⁴ *Id.*

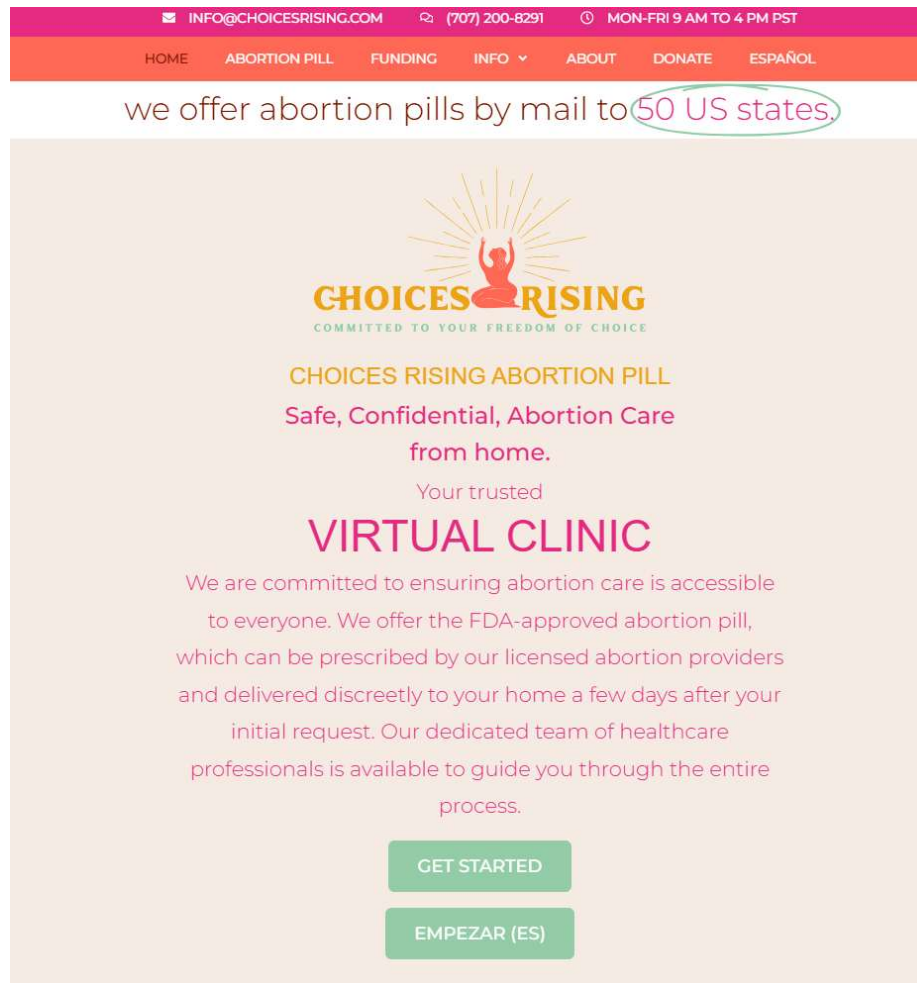
consultation or otherwise spoke with the person identified as the patient. Nor did We Take Care Of Us meaningfully verify that the person submitting the request was the person identified as the patient. The name associated with the payment method did not match the identified patient, and the billing address did not match the shipping address. Had We Take Care of Us spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, We Take Care Of Us approved the requests and shipped the drugs. This includes specific shipments to Louisiana in June 2026 and Arkansas in August 2025.



6. Choices Rising

140. For all practical purposes, With Open Arms Center for Reproductive Choices, Inc. (d/b/a Choices Rising)—created by Defendant Anthony Paik-Nicely—operates materially identically to how We Take Care Of Us operates.

141. Choices Rising’s website (choicesrising.com) advertises “abortion pills by mail to 50 US states.”



142. Choices Rising states that only “4 Easy Steps” are necessary to secure “convenient and discreet abortion pills delivered by mail”: (1) complete a request form and provide requested information (including payment via Stripe); (2) sign consent forms; (3) receive Choices Rising’s approval that “you have been medically cleared to receive the service”; and (4) receive abortion drugs by mail “within 3-5 days” “in an unmarked box.”⁸⁵ No video or telephone call is necessary.

⁸⁵ Choices Rising, *Choices Rising Abortion Pill Virtual Clinic*, perma.cc/W3BN-HJ7Y (last visited Sept. 25, 2026) (attached as Ex. 50).

143. Choices Rising claims to have a “small team” of “board-certified physicians and [a] registered nurse”—presumably including Defendant Paik-Nicely—that “provid[es] access to the FDA-approved medications for safe in-home abortion treatment.”⁸⁶

144. Choices Rising also tells website users to visit I Need An A’s website “[t]o find out more about what is legal in your state.”⁸⁷ Choices Rising likewise directs website users to The Guttmacher Institute, whose website states that “[a]bortion is completely banned with very limited exceptions” in Louisiana—and “[m]edication abortion can only be provided after in-person visit because state requires pills to be dispensed in person.”⁸⁸

145. Through its website and people like Paik-Nicely, Choices Rising sends prescriptions for mail abortion drugs (including GenBioPro mifepristone) to the same mail-order pharmacy used by We Take Care Of Us and Aid Access. The mail-order pharmacy has then sent abortion drugs to addresses in each Plaintiff State, including (in Louisiana) addresses in Abbeville, Baton Rouge, Breaux Bridge, and Cheneyville.

146. Plaintiff States have confirmed through public-protection investigations that Choices Rising will send, and has sent, abortion drugs to addresses in Plaintiff States based on entirely fabricated pregnancy and patient information. Choices Rising never conducted a telehealth consultation or otherwise spoke with the person identified as the patient. Nor did Choices Rising meaningfully verify that the person submitting the request was the person identified as the patient. The identification submitted depicted a woman, but the person completing the process was, in fact, a man. The name associated with the payment method did not match the identified patient, and the

⁸⁶ Choices Rising, *About Us*, perma.cc/N77J-SSKE (last visited Sept. 25, 2026) (attached as Ex. 51).

⁸⁷ Choices Rising, *FAQs*, perma.cc/6RR4-UJXX (last visited Sept. 25, 2026) (“How will state specific laws affect my pregnancy options?”) (attached as Ex. 52).

⁸⁸ Guttmacher, *Interactive Map: US Abortion Policies – Louisiana*, perma.cc/UA35-RWZR (last visited Sept. 25, 2026) (attached as Ex. 53).

billing address did not match the shipping address. Had Choices Rising spoken with the identified patient or meaningfully attempted to verify her identity, it would have discovered that she did not exist and that the information submitted through its screening process was false. Instead, Choices Rising approved the requests and shipped the drugs. This includes a specific shipment to Arkansas in March 2026.



C. Mail-Order Pharmacies and Common Carriers Facilitate This Scheme.

147. For Defendants We Take Care of Us and Choices Rising (and for the related organization, Aid Access), their operations would not work if they did not have a mail-order pharmacy to which their prescribers could send prescriptions for priority mailing to addresses in Plaintiff States. Those pharmacies thus are indispensable to the interstate mail-order abortion scheme. Relevant here

are Honeybee Health Inc., a Delaware corporation based in California, and its shadow corporation, Defendant JBN Operations—which is behind We Take Care of Us, Choices Rising, and Aid Access.

148. Honeybee Health Inc. is an online pharmacy founded by Defendant Jessica Nouhavandi. During the COVID-19 pandemic, Nouhavandi and Honeybee seized the opportunity to use Honeybee as a vehicle for mail-order abortion drugs. According to Francine Coeytaux, it was Honeybee and Nouhavandi who were “the first to actually look at the restrictions and say, ‘Hey wait a minute, they don’t mention anything about mailing.’”⁸⁹ “She (Nouhavandi) stepped up and starting doing this,” says Coeytaux.⁹⁰ “By mid-2021,” Honeybee was making millions of dollars off of mail-order abortion drugs.⁹¹ As Nouhavandi has put it, “[w]e’re really the main hub for mailing abortion pills.... Almost everything comes out of California, and mainly from Honeybee.”⁹² In fact, Choices Rising has gone so far as to list Honeybee Health as one of its partners.

149. Honeybee recently has filed a court brief claiming that “Honeybee dispenses the highest volume of mifepristone by mail of any U.S. mail-order pharmacy.”⁹³ Honeybee qualified that statement by also saying that “Honeybee only dispenses mifepristone by mail in jurisdictions whose laws permit it to do so (currently thirty-one states and the District of Columbia) and does not ship mifepristone to Louisiana.”⁹⁴

150. Honeybee and Nouhavandi’s word choice is significant because, although they have attempted to protect Honeybee itself from the consequences of mailing abortion drugs to pro-life

⁸⁹ James Brock, *Abortion Activists*, Los Angeles Business Journal (July 10, 2023), perma.cc/H88X-QGZT (attached as Ex. 54, at 2).

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Patrick Adams, *Abortion drugs: Bill would allow doctors to prescribe anonymously*, LAist (Sept. 10, 2025), perma.cc/S9PH-ARAC (attached as Ex. 55, at 4).

⁹³ Br. of Amicus Curiae Honeybee Health, Inc. In Support Of Applications By Danco And GenBioPro To Stay Or Vacate The Fifth Circuit’s Stay Pending Appeal, *Danco Lab’s, L.L.C. v. Louisiana*, No. 25A1207, at 1 (May 7, 2026), perma.cc/R6FG-NABP (attached as Ex. 56, at 1).

⁹⁴ *Id.*

states in violation of state laws (“we don’t want to jeopardize our licenses to sell [ordinary medications that have nothing to do with abortions] in those states,” says Nouhavandi⁹⁵), Nouhavandi formed a shadow company with her brother Defendant Brandon Nouhavandi to carry out that illegal activity.

151. That company is Defendant JBN Operations LLC—*i.e.*, Jessica and Brandon Nouhavandi Operations LLC. JBN is a pharmacy business located at 3751 S. Hill St., Los Angeles, CA 90007. Brandon Nouhavandi—who was and, on information and belief, continues to be a Honeybee employee—is a manager or member of JBN. JBN’s California pharmacy license expired in 2026—yet JBN has continued to ship abortion drugs to each of Plaintiff States after that expiration.

152. The idea behind JBN—“a U.S. pharmacy in a state with a shield law [that] would fill the orders, cutting delivery times”—came from Aid Access prescribers looking for a way to facilitate mailing abortion drugs into “red states.”⁹⁶ It also came from Jessica Nouhavandi who told The New York Times Magazine that “she was exploring setting up a legally separate pharmacy in Massachusetts so that her company [Honeybee] could also take advantage of the state’s shield law.”⁹⁷ She ultimately did not have to move across the country because, after California passed its own shield law, she and her brother, Brandon, created JBN in California.

153. JBN is the lifeline for We Take Care of Us, Choices Rising, and Aid Access. When individuals in Plaintiff States accept their offer to sell abortion drugs, the corporations and prescribers behind those websites transmit the prescriptions to JBN. JBN then fills those prescriptions and ships the abortion drugs from California to the addresses in the Plaintiff State.

154. Although Plaintiff States do not yet know how many abortion-drug packages JBN has sent into each Plaintiff State, public reports suggest that Honeybee and JBN are responsible—through

⁹⁵ Ex. 54 at 3.

⁹⁶ Emily Bazelon, *The Doctors Risking Everything to Offer Abortions Across State Lines*, The New York Times Magazine (Oct. 4, 2022) (attached as Ex. 57).

⁹⁷ *Id.*

Aid Access alone—for “12,000 pills a month to people all over the country.”⁹⁸ And on information and belief, JBN has shipped thousands of abortion-drug packages to each of Plaintiff States over the past three years.

155. JBN continues to ship abortion drugs to each of Plaintiff States today. That includes a specific shipment to Louisiana in June 2026. JBN’s packages uniformly bear JBN’s return address: 3751 S. Hill St., Los Angeles, CA 90007.



156. JBN’s role in this scheme leads to the related role of common carriers themselves.

157. FedEx Corporation is responsible for approximately half of the scheme. Jessica and Brandon Nouhavandi—through JBN Operations LLC—have been FedEx customers since March 2024. FedEx has assigned a customer number to JBN Operations LLC (#200669519). It has logged

⁹⁸ Ex. 55 at 6.

JBN's return address as 3751 S. Hill St., Los Angeles, CA 90007. And it lists Brandon Nohavandi as JBN's primary shipper contact. FedEx also tracks each of JBN's shipments into each of Plaintiff States.

158. FedEx has its own label-generating service, which appears to be what JBN uses in shipping thousands of abortion drugs into each of Plaintiff States on behalf of We Take Care of Us, Choices Rising, and Aid Access (and perhaps other unknown entities and individuals).



159. For its part, USPS is responsible for the remainder of the interstate mail-order abortion scheme. It has delivered, and continues to deliver, thousands of abortion drugs to addresses in Plaintiff States on behalf of The MAP, A Safe Choice Network/OPTIO, Abuzz, and Southern Woven.

160. USPS's responsibility for The MAP, in particular, is most egregious. Not only does USPS handle 100% of the shipments from The MAP into Plaintiff States, but USPS also creates—through an account(s) held by an agent(s) of The MAP—the shipping labels enabling the mass

shipment of the abortion drugs. USPS knows that The MAP is responsible for the shipments both because The MAP has a registered account and because the labels themselves expressly identify The MAP by name and by its return address:



161. The MAP is extraordinarily open about this scheme, centering USPS in almost every picture showcasing its operation to the media.







MAP volunteers haul bins of packaged abortion pills to a nearby post office. Emily Schiffer



A typical daily run to the nearby post office includes hundreds of packages bound for all 50 states. Emily Schiffer

III. Defendants Actively Misrepresent Key Facts Surrounding Abortion Drugs.

162. One key theme across Defendants’ websites is a blatant disregard for the truth and women and girls’ safety. That includes frivolous claims such as A Safe Choice Network’s claim to be “[a] woman-owned business” (when the whole operation is run by Remy Coeytaux).⁹⁹ It includes the frivolous claim by Robin Tucker (a Maryland resident) that Southern Woven is “For Southerners By Southerners.”¹⁰⁰ And it includes the frivolous claims by Tucker and Christie Pitney that their businesses (Metro Area and Forward Midwifery) mail abortion drugs only to states where abortion is legal.

163. Beyond those frivolous claims, there are six general buckets of misleading claims appearing across all websites.

164. *First*, Defendants mislead consumers by suggesting medication abortion in Plaintiff States is lawful. They do so by emphasizing that self-administered abortion by a pregnant woman in a Plaintiff State is *not* a crime—but they omit that the act of dispensing abortion drugs by mail in each Plaintiff State *is* a crime. For example:

- The MAP claims that “[d]octors and medical professionals in certain states where abortion is protected may prescribe abortion pills by mail, even if you live in a state where it is banned or restricted.”¹⁰¹
- A Safe Choice Network/OPTIO claims¹⁰² Plaintiff States’ laws “expressly exempt[] the pregnant [woman] from prosecution” and individuals in such states may lawfully obtain abortion drugs: “Because in-state access is nonexistent, many Mississippians [and those in Plaintiff States] now rely on telehealth providers based

⁹⁹ A Safe Choice, *About Us*, perma.cc/JV9T-3G69 (last visited Sept. 26, 2026) (attached as Ex. 58).

¹⁰⁰ See Ex. 42.

¹⁰¹ Ex. 15.

¹⁰² Ex. 22.

in states with shield laws. These laws protect doctors who prescribe and mail abortion pills to people in Mississippi and other restricted states. It is a proven, legal pathway that thousands of people use every year to get abortion pills in Mississippi and other banned states.”

- We Take Care Of Us claims: “There are no laws directly criminalizing the ingestion of abortion pills in any state”¹⁰³

165. Defendants Tucker/Southern Woven concede the misleading nature of the statements above: “We do **not** claim that accessing care through telemedicine is ‘legal’ in every state. What we say is that people across all 50 states are safely accessing care, and that shield laws protect the providers who prescribe.”¹⁰⁴ But even that concession elides the fact that their conduct *is illegal* in Plaintiff States.

166. *Second*, Defendants mislead consumers by overstating the safety, and understating the risks and effects, of abortion drugs. For example:

- A Safe Choice Network/OPTIO claims that “[s]erious complications (such as infection requiring hospitalization or blood transfusion) occur in about 0.2% of cases.”¹⁰⁵
- Abuzz claims that abortion drugs “are very safe—safer than Tylenol and safer than driving in a car! The risk of severe, life-threatening complications requiring hospitalization is less than 1%.”¹⁰⁶

¹⁰³ We Take Care of Us, *Frequently Asked Questions*, perma.cc/67C5-4KV9 *supra* n.81 (“Is it legal to take abortion pills where I live?”) (attached as Ex. 59).

¹⁰⁴ Ex. 45 at 4.

¹⁰⁵ A Safe Choice, *Living in Alabama and Safely Ordering Abortion Pills Online* (Nov. 13, 2025), perma.cc/ZDL3-8C6X (attached as Ex. 60).

¹⁰⁶ Ex. 29 at 2.

- Southern Woven claims abortions are “[e]xtremely safe” (“[s]afer than Tylenol, wisdom teeth removal, and childbirth”), that “[s]erious complications occur in less than 0.4% of cases,” and that “[l]ess than 1% need to visit an ER.”¹⁰⁷
- We Take Care Of Us claims “[m]edication abortion is extremely safe. For every 100 people, about 99 will have a completely uncomplicated experience. Abortion medications have a better safety record than many common over-the-counter medications, including Tylenol.”¹⁰⁸
- Choices Rising claims abortion via medication “is one of the SAFEST medical procedures,” that “[c]omplications occur in less than 0.4% of patients,” and “[c]omplications are rare and most are not serious.”¹⁰⁹



167. Those representations squarely contradict FDA’s own representations. The FDA-approved label states that up to 4.6% of women who take mifepristone for pregnancies under ten

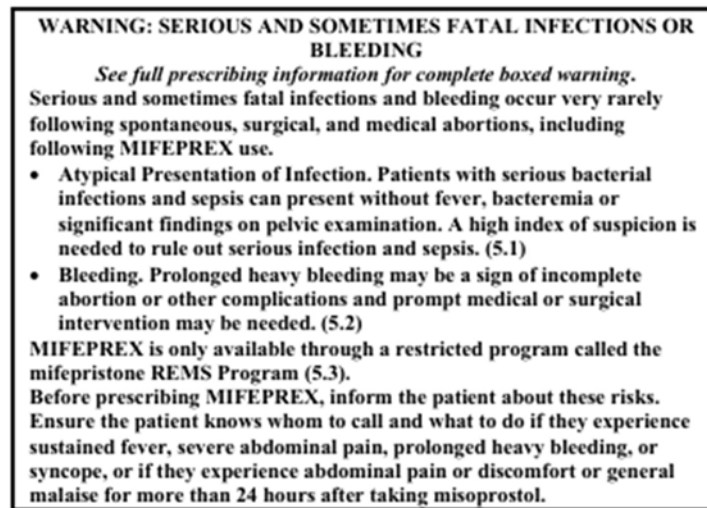
¹⁰⁷ Southern Woven, *Frequently Asked Questions About Abortion Pills & Our Services*, perma.cc/UPF4-2RMF (last visited Sept. 26, 2026) (“Are abortion pills safe?”) (attached as Ex. 61).

¹⁰⁸ We Take Care of Us, *Frequently Asked Questions*, *supra* n.81 (“Is Medication abortion safe?”) (attached as Ex. 62).

¹⁰⁹ Choices Rising, *Abortion Pill (Medicated Abortion)*, perma.cc/R758-JTH2 (last visited Sept. 26, 2026) (attached as Ex. 63).

¹¹⁰ We Take Care of Us, Post on Instagram (Sept. 20, 2024), perma.cc/ZF63-8BYH (attached as Ex. 64).

weeks experience serious adverse events requiring emergency room care.¹¹¹ The label states that “[a]bout 2 to 7 out of 100 women taking [mifepristone] will need a surgical procedure because the pregnancy did not completely pass from the uterus or to stop bleeding.”¹¹² In fact, 8% of women may bleed for more than 30 days.¹¹³ So severe are these risks that FDA has imposed a Black Box warning on mifepristone, stating: “WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING.”¹¹⁴



168. A recent analysis in the peer-reviewed journal *BioTech* also explains claims like these are “unfounded, misleading, and entirely dangerous,” indicative of “a complete disregard for the need to communicate comprehensive and truthful safety information to patients.”¹¹⁵ More: “It is essential to state unequivocally that there has never been a single study appropriately comparing the safety of mifepristone and acetaminophen [Tylenol] or any of the common drugs presented in these claims.”¹¹⁶

¹¹¹ Mifeprex FDA Label (approved by FDA Jan. 2023), available at perma.cc/YJF2-MSY5 (attached as Ex. 65, at 8).

¹¹² *Id.* at 17.

¹¹³ *Id.* at 4.

¹¹⁴ *Id.* at 1.

¹¹⁵ Cameron Louttit, *The Origins and Proliferation of Unfounded Comparisons Regarding the Safety of Mifepristone*, 14 *BioTech*, no. 2, art. 39 (May 24, 2025), <https://www.mdpi.com/3326836> (attached as Ex. 66, at 12–13).

¹¹⁶ *Id.* at 3.

169. *Third*, Defendants mislead consumers by claiming the abortion drug regimen they are selling is “FDA-approved.” For example:

- The MAP claims: “We work with doctors in Massachusetts to prescribe FDA-approved abortion medication to patients anywhere in the US who meet eligibility for the medications and apply through our website.”¹¹⁷
- A Safe Choice Network/OPTIO claims: “A medication abortion, also known as a medical abortion, refers to an abortion that results from taking a combination of two FDA-approved medications, mifepristone and misoprostol.”¹¹⁸
- We Take Care Of Us claims: “Yes, the US Food and Drug Administration (FDA) approved mifepristone (the first of two medicines used in a medication abortion) in 2000.”¹¹⁹
- Choices Rising claims: “Get the FDA-approved abortion pill prescribed by licensed abortion providers and delivered discreetly to your door a few days after your initial request.”¹²⁰

170. FDA, however, has approved mifepristone only “in a regimen with misoprostol, to end an intrauterine pregnancy through ten weeks gestation (70 days or less since the first day of a patient’s last menstrual period.)”¹²¹ Indeed, FDA’s mifepristone label is unambiguous: “Do not take [mifepristone] if you ... [h]ave a pregnancy that is more than 70 days (10 weeks).”¹²²

¹¹⁷ Ex. 16.

¹¹⁸ Safe Choice, *Medication Abortion via Telehealth*, perma.cc/P8PU-DBN8 (last visited Sept. 25, 2026) (attached as Ex. 67).

¹¹⁹ We Take Care of Us, *Frequently Asked Questions*, *supra* n.81 (“Are abortion pills FDA approved?”) (attached as Ex. 68).

¹²⁰ Ex. 63.

¹²¹ FDA, *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (current as of Jan. 17, 2025), perma.cc/Z75Z-ZJ5Z (attached as Ex. 69, at 1).

¹²² Ex. 65 at 17.

171. Defendants by contrast actively advertise abortion drugs for delivery where the gestational period *exceeds* FDA’s ten-week limit: The MAP (through 11.5 weeks¹²³), A Safe Choice Network/OPTIO (through 13 weeks¹²⁴), Abuzz (through 13 weeks¹²⁵), Southern Woven (through 12 weeks, 6 days¹²⁶), We Take Care Of Us (through 12 weeks¹²⁷), Choices Rising (through 12 weeks¹²⁸). In fact, Choices Rising separately claims that “[a]bortion pills are safe for pregnancies up to 13 weeks and 6 days in gestation.”¹²⁹ Similarly, Abuzz has combined the “safer than Tylenol” misrepresentation above with a claim that “it’s also medically *safe* to take the pills after 12 weeks.”¹³⁰



Yes, it's also medically *safe* to take the pills after 12 weeks. The risk of life-threatening complications (like needing a blood transfusion) is less than 1%. It's safer than many commonly used medications, including penicillin and Tylenol.

172. In addition, FDA expressly recommends *against* “buying mifepristone online” where the purchase would fall outside FDA’s current approved program for mifepristone—which includes

¹²³ The MAP, *Frequently Asked Questions*, *supra* n.25 (“Do my abortion options depend on how many weeks pregnant I am?”) (attached as Ex. 70).

¹²⁴ Ex. 23 at 2.

¹²⁵ Ex. 27 at 5.

¹²⁶ Southern Woven, *Frequently Asked Questions About Abortion Pills & Our Services*, *supra* n.107 (“How far in pregnancy can I use abortion pills?”) (attached as Ex. 71).

¹²⁷ We Take Care of Us, *Medication Request Form* (last visited Sept. 28, 2026), perma.cc/3CFH-7S5Q (attached as Ex. 90) (click through until date of last menstrual period).

¹²⁸ Ex. 63.

¹²⁹ Choices Rising, *FAQs*, *supra* n.87 (“Who is eligible for medication abortion services from Choices Rising?”) (attached as Ex. 72).

¹³⁰ AbuzzHealth, Post on Instagram (Oct. 22, 2024), perma.cc/N4ND-MV66 (attached as Ex. 73).

the ten-week limit.¹³¹ By advertising the prescription, sale, and use of abortion drugs for pregnancies well beyond ten weeks, therefore, Defendants are advocating a use of abortion drugs that emphatically is *not* “FDA-approved.”

173. *Fourth*, and relatedly, Defendants (*e.g.*, The MAP,¹³² Abuzz,¹³³ Choices Rising,¹³⁴ and We Take Care of Us¹³⁵) mislead consumers by claiming a 98% rate of efficacy. That is deeply misleading because, as A Safe Choice Network/OPTIO recognize, that number (if it were valid at all) is (a) more like “96%-98%” and (b) only as to abortion drugs “[t]aken within the first 10 weeks (70 days) of pregnancy”¹³⁶—not through 12 and 13 weeks as Defendants advertise.

174. *Fifth*, Defendants mislead consumers by claiming that pre-abortion care is unnecessary. For example:

- A Safe Choice Network/OPTIO claims: “It is important to know that an ultrasound and in-person visits with a local healthcare provider are not necessary for the vast majority of people, either before or after a medication abortion.”¹³⁷
- Choices Rising claims: “There is no need to have a Telehealth consultation.”¹³⁸
- Abuzz claims an ultrasound is unnecessary.¹³⁹
- We Take Care Of Us claims “an ultrasound is not required.”¹⁴⁰

¹³¹ Ex. 69 at 1.

¹³² The MAP, *Frequently Asked Questions*, *supra* n.25 (“How do I know if the abortion pills worked?”) (attached as Ex. 74).

¹³³ Ex. 29 at 2.

¹³⁴ Ex. 63.

¹³⁵ We Take Care of Us, *Frequently Asked Questions*, *supra* n.81 (attached as Ex. 75).

¹³⁶ Ex. 60 at 5.

¹³⁷ A Safe Choice, *How to Safely Buy Abortion Pills Online in 2026: Your Comprehensive Guide from A Safe Choice* (July 20, 2025), perma.cc/88QZ-CHBU (attached as Ex. 75, at 7).

¹³⁸ Choices Rising, *Abortion Pill (Medicated Abortion)*, *supra* n.109 (attached as Ex. 76).

¹³⁹ Ex. 29 at 4.

¹⁴⁰ We Take Care of Us, *Medical Request Form*, *supra* n.82 (attached as Ex. 78) (click through to ultrasound question).

175. The lack of an accurate assessment of gestational age can be fatal. Similarly, the lack of an in-person assessment for contraindications, such as the presence of an ectopic pregnancy or an Rh blood type, can be seriously detrimental—and can be fatal—to a woman’s health. The lack of in-person care also prevents a healthcare provider from ensuring a woman’s consent and that she is free from coercion in seeking an abortion. Indeed, all this is why Plaintiff States’ laws specifically require an in-person examination before an abortion (if otherwise lawful) may be effectuated.

176. *Sixth*, Defendants facilitate confusion and mistreatment by healthcare providers in Plaintiff States by urging individuals to lie about the reasons for their symptoms.

- The MAP claims: “[I]f you are worried, you can get an ultrasound at an emergency department or through a primary care doctor or gynecologist. If you get an ultrasound, you do not need to tell them you used abortion pills. You can tell them you are pregnant and had some bleeding, and want to know if everything is OK.”¹⁴¹
- A Safe Choice Network/OPTIO claims: “If you need emergency medical care at any point, you do not have to tell anyone you took abortion pills. Simply tell the provider you are pregnant and bleeding. They are trained to treat complications from pregnancy loss and will take care of you.”¹⁴²
- Abuzz claims: “The only way for the providers to know [you took abortion drugs] is if you tell or you took the pills vaginally and they see them on an internal exam. You do not need to say that you took abortion pills.”¹⁴³ In response to the question “If I have to go to the hospital, what should I say?” Abuzz answers: “The

¹⁴¹ The MAP, *Frequently Asked Questions*, *supra* n.25 (“I am worried that something went wrong with the abortion. What do I do?”) (attached as Ex. 79).

¹⁴² Ex. 22 at 6.

¹⁴³ Ex. 29 at 8 (“Will anyone be able to tell that I took abortion pills?”).

treatment for a miscarriage and abortion are the same, so you can just say something like ‘I’m bleeding but it doesn’t feel like my usual period. I’m afraid something is wrong’ or ‘I’m pregnant and bleeding. I’m scared there’s something wrong’ and you should get the care you need.”¹⁴⁴

- Southern Woven says: “If you need ER care for any reason, ‘I’m having a miscarriage’ is medically accurate, and the care protocols are identical either way.”¹⁴⁵
- Choices Rising says: “In the unlikely event that follow-up care is necessary ... you can simply describe your symptoms as they are identical to those of a miscarriage. Any requisite follow-up treatment would also be consistent for both an abortion and a miscarriage.”¹⁴⁶

177. Defendants’ deception is not limited to what they say—it also includes what they leave out. In particular, Defendants fail to adequately disclose material information about what women may experience after taking abortion drugs. That includes the nature and severity of potential complications, the possibility of emergency or surgical intervention, the limitations of a remote screening process, the lack of integrated local follow-up care, and the physical realities of the abortion itself.

178. Start with the nature and severity of the physical and psychological pain. Participants in a Norwegian study on abortion drugs, for example, described pain that was “out of this world,” “much worse than giving birth,” and “a day in hell.”¹⁴⁷ One participant “cried and screamed for eight

¹⁴⁴ *Id.*

¹⁴⁵ Southern Woven, *How to Get the Abortion Pill Online: Step-by-Step Guide*, perma.cc/E578-AVTF (last visited Sept. 27, 2026) (attached as Ex. 80).

¹⁴⁶ Choices Rising, *Secure Message* (attached as Ex. 81).

¹⁴⁷ Idun Røseth et al., “*Out of This World*”: Norwegian Women’s Experiences of Medical Abortion Pain, 16 J. Multidisciplinary Healthcare 889, 892–93 (2023), <https://pubmed.ncbi.nlm.nih.gov/37038454/> (attached as Ex. 82).

hours” but was turned away from the emergency hospital and told her experience was “quite normal.”¹⁴⁸ Another study surveying 1,596 abortion-drug patients found that 41.5% of respondents rated their pain as at least an eight on a ten-point scale.¹⁴⁹

179. Beyond failing to account for the physical and psychological pain, Defendants fail to adequately disclose the heightened risk of complications as a pregnancy progresses. One study, for example, found that women who took abortion drugs between 9-12 weeks gestation (as compared to women who took the drugs before 9 weeks gestation) were significantly more likely to experience hemorrhage and infection—and that they were four times more likely to have an incomplete abortion and over six times more likely to require a surgical procedure.¹⁵⁰ Defendants do not disclose this.

180. Defendants also do not disclose the consequences of their remotely dispensing abortion drugs. Plaintiff States’ investigations confirmed that Defendants would ship abortion drugs based on fictitious pregnancy information submitted through their online intake processes. And that points up the inherent limitations of the process: Without an examination or diagnostic testing, Defendants may not reliably identify an ectopic pregnancy, confirm gestational age, determine whether an IUD remains in place, or identify other conditions bearing on whether the drugs can be safely used. This matters because even FDA identifies ectopic pregnancy, pregnancies beyond 70 days, certain bleeding conditions, and an IUD as circumstances relevant to whether mifepristone should be used.

181. Moreover, that Plaintiff States have confirmed shipments from Defendants based on fictitious individuals and men requesting and paying for abortion drugs illustrates there are no

¹⁴⁸ *Id.* at 892.

¹⁴⁹ Hannah McCulloch et al., *Expectations and Experiences of Pain During Medical Abortion at Home: A Secondary, Mixed-Methods Analysis of a Patient Survey in England and Wales*, 51 *BMJ Sexual & Reproductive Health* 137, 140 (2025), <https://pubmed.ncbi.nlm.nih.gov/39694584/> (attached as Ex. 83).

¹⁵⁰ Maarit Niinimäki et al., *Comparison of Rates of Adverse Events in Adolescent and Adult Women Undergoing Medical Abortion: Population Register Based Study*, 342 *BMJ* d2111, 5 (2011), <https://pubmed.ncbi.nlm.nih.gov/21508042/> (attached as Ex. 84).

safeguards in place: Defendants will give the domestic abuser, the husband, and the violent boyfriend abortion drugs with impunity even where a pregnant woman does not want an abortion.

182. Finally, Defendants fail to adequately disclose the limitations of the care they can provide if complications arise. Their services are intentionally remote, but Defendants do not adequately explain the consequences of that limitation. If a woman experiences severe bleeding, an incomplete abortion, infection, or another complication requiring examination or treatment, Defendants cannot provide that care remotely. The woman must instead seek care from an unrelated Plaintiff State provider who did not prescribe the drugs and did not conduct the initial evaluation (if there was one).

183. These are not collateral details. These material misrepresentations and omissions go to the very essence of the service Defendants are selling, which both violates Plaintiff States' laws and occurs without the medical oversight required by Plaintiff States' laws that are designed to protect women and girls.

IV. Defendants' Violation of Plaintiff States' Laws Is Knowing and Intentional.

184. Defendants cannot claim ignorance of Plaintiff States' laws. Before filing this action, Plaintiff States expressly notified certain Defendants or their website hosts that their conduct violated Arkansas's and Alabama's laws and demanded that they cease their unlawful activity. The activity has not stopped.

185. Not only that, but Defendants themselves also acknowledge their conduct knowingly and intentionally violates Plaintiff States' laws—and are specifically designed to undermine Plaintiff States' laws.

186. Take The MAP. As Defendant Foster has described The MAP, “[t]he whole project is set up around distributed risk. Different people order our pills, package our pills, process the money, write the prescriptions and take the pills to the post office, which makes it harder to identify individuals

as opposed to the practice.”¹⁵¹ The idea, she said more recently, is to make it “really hard to identify an individual person who provided pills to an individual patient,” thereby “making it much harder for someone in a red state to target them for legal action.”¹⁵²

187. And that attack on pro-life states is The MAP’s entire mission. *Dobbs* was “The MAP’s origin story.”¹⁵³ After *Dobbs*, Defendant Foster “saw a perfect opportunity to operationalize her middle-finger rage.”¹⁵⁴ “[S]he settled on creating an organization—that would become The MAP—offering telemedicine nationally” Foster is thus intimately involved in leading every aspect of The MAP, including by structuring and maintaining The MAP’s “distributed risk” model. Because of her conduct, Foster “drastically limits how she moves within the US” by not entering pro-life states.¹⁵⁵

188. Similarly after *Dobbs*, The MAP’s now-medical director, Defendant Maureen Paul, joined the project “to channel her fury.”¹⁵⁶ And when Justice Alito recently wrote that schemes like The MAP’s “circumvent the [pro-life laws] that *Dobbs* made possible,” The MAP’s director of community engagement, Defendant Susan Yanow, giggled, “It made me so happy ... when he wrote, ‘They’re undermining *Dobbs*.’ I was like, *yeah, exactly*.”¹⁵⁷ Foster, for example, uses Mississippi as her “favorite example”—because Mississippi won *Dobbs*, and yet since *Dobbs*, abortions in Mississippi “have risen a mind-boggling 85 percent” due to mail-order abortion.¹⁵⁸

189. As one article glowingly concluded, “Four years after the Supreme Court’s *Dobbs* ... decision ended the national right to abortion, Foster and her allies have managed to create an

¹⁵¹ Carrie N. Baker, *Massachusetts Abortion Provider Serves Patients Living in States Banning Abortion*, Ms. Magazine (July 29, 2024), perma.cc/7U25-C7QE (July 29, 2024) (attached as Ex. 85, at 10–11).

¹⁵² Ex. 1 at 22.

¹⁵³ *Id.* at 3.

¹⁵⁴ *Id.* at 21.

¹⁵⁵ *Id.* at 23.

¹⁵⁶ *Id.* at 22.

¹⁵⁷ *Id.* at 7.

¹⁵⁸ *Id.* at 13.

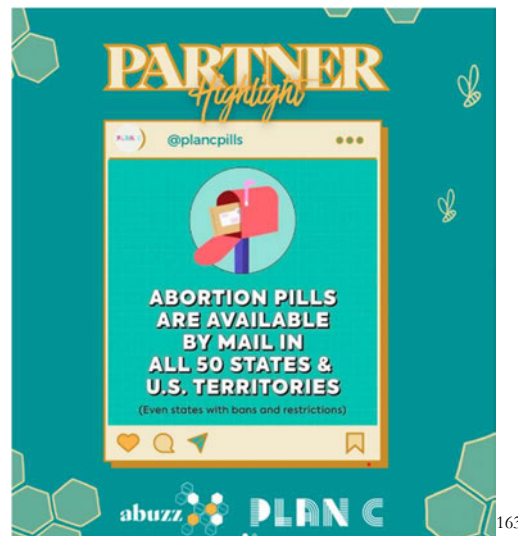
entire healthcare, legal, and financing infrastructure—what [Paul] ... calls a ‘shadow’ system—that has kept abortion pills flowing, with stunning efficiency, into some of the most abortion-hostile parts of the country.”¹⁵⁹

190. The other Defendants share the same view. They each invariably link to the Repro Legal Helpline website, which states that, in Louisiana (and the other Plaintiff States), “[h]ealthcare professionals in the state of Louisiana cannot provide abortions except to save the life or health of the pregnant [woman].”¹⁶⁰ They also link to I Need An A’s website, which states that “telehealth abortion is not permitted in Louisiana.”¹⁶¹ They thus unquestionably are aware of the illegality of their conduct—and still they persist, convinced that shield laws in their home states can protect them. And all that says nothing of their independent posts flaunting their illegal conduct.

191. Abuzz, for example, proclaims that it will mail abortion drugs to “any zip code” and “all 50 states”—“[e]ven states with bans and restrictions”:



162



163

¹⁵⁹ *Id.* at 5.

¹⁶⁰ Ex. 30.

¹⁶¹ Ex. 14 at 2 (expand to see all state legal info).

¹⁶² Abuzzhealth, Post on Instagram (Feb. 27, 2026), perma.cc/B5NY-YYKP (attached as Ex. 86).

¹⁶³ Abuzzhealth, Post on Instagram (April 7, 2026), perma.cc/9BKH-DYGY (attached as Ex. 87).

192. Similarly, We Take Care Of Us proclaims:



193. Defendants also go to extraordinary lengths to coax individuals into concealing this unlawful activity. In its online process, Choices Rising includes a message stating: “During and after an abortion in a state where it is banned, prioritizing your personal safety and well-being is paramount, which includes protecting your privacy, seeking support from trusted sources, and understanding your legal rights. To minimize the risk of exposure, please use a secure browser, delete your search history, and follow all digital security guidelines for abortion care.”¹⁶⁶ Similarly, A Safe Choice Network/OPTIO urge their users to: “Use a private email address unconnected to your regular accounts. Delete confirmation emails after saving your tracking information. If you share a device, clear your browsing history after visiting the site.”¹⁶⁷

V. Defendants’ Interstate Mail-Order Abortion Scheme Harms Plaintiff States.

194. Defendants’ conduct has had its predictable and intended effect within Plaintiff States. Abortions have proliferated by the thousands in Plaintiff States after *Dobbs*. According to one study considering data through December 2025, approximately 1,000 abortions occur in Louisiana every

¹⁶⁴ We Take Care of Us, Post on Instagram (Feb. 24, 2025), perma.cc/B6K4-P2NC (attached as Ex. 88).

¹⁶⁵ We Take Care of Us, Post on Instagram (Nov. 10, 2025), perma.cc/3E5R-BAR4 (attached as Ex. 89).

¹⁶⁶ Ex. 81.

¹⁶⁷ Ex. 22 at 5–6.

month; approximately 300 every month in Arkansas; and approximately 700 every month in Alabama.¹⁶⁸ To be clear, moreover, these numbers are not hypothetical: Defendants hold records detailing the thousands of abortion drugs that have been mailed into Plaintiff States for the avowed purpose of causing abortions in Plaintiff States.

195. Embedded within these numbers are quintessential sovereign, quasi-sovereign, and economic harms suffered by Plaintiff States.

196. *First*, the very mailing of abortion drugs in Plaintiff States violates each Plaintiff State's laws—either because such mailing itself is prohibited, or because abortion drugs must be dispensed in-person after an in-person examination, or because the narrow abortion exceptions are not satisfied. *See supra* Section I. In Louisiana and Alabama, moreover, Defendants' very act of advertising abortion drugs violates state law. La. R.S. § 14:87.4(A); *see* Ala. Code § 13A-4-1(a)(1), (d)(1).

197. *Second*, given the serious health risks surrounding abortion drugs, Plaintiff States are incurring classic quasi-sovereign harms within their borders. Their laws are intended to protect the lives of unborn babies in Plaintiff States from the moment of conception—and yet Defendants' conduct terminates those lives in violation of Plaintiff States' laws. At least some Defendants know this because they routinely receive communications through their online platforms confirming that they have succeeded in terminating unborn babies' lives. Abuzz, for example, has received pictures like (and including) the following from all over the country:

¹⁶⁸ Ex. 10.



198. Similarly, Plaintiff States' laws are intended to protect the health and safety of women and girls in Plaintiff States—and yet Defendants' conduct actively jeopardizes that health and safety

through misrepresentations, omissions, and the dispensing of drugs that have serious adverse consequences in Plaintiff States.

199. Healthcare providers have reported that their networks are having to treat women suffering complications from the abortion drugs on a daily basis. Plaintiff States have received sworn reports that such complications include hemorrhaging requiring blood transfusions, as well as incomplete abortions requiring suction dilation and curettage to complete the abortions. That includes, for example, a woman who took drugs from Abuzz and required a suction dilation and curettage as well as a blood transfusion after she began hemorrhaging in the operating room.

200. Plaintiff States also have received sworn reports about the traumatic physical and psychological effects on their women. To take one example, Defendant Remy Coeytaux sent abortion drugs to a Louisiana woman who did not want an abortion but was coerced by her ex-boyfriend to take the drugs—and she ended up on a garage floor bleeding and in excruciating pain. To take another: Aid Access (on information and belief through Defendant JBN Operations LLC) sent abortion drugs to a Louisiana woman who coerced her teenage daughter to take them—and EMTs found her daughter bleeding on a bathroom floor holding a dead fetus.

201. Here, too, Defendants well know the severe consequences of their conduct because they routinely receive communications through their online platforms confirming the symptoms women are experiencing. Abuzz, for example, has received pictures like (and including) the following from all over the country:



202. *Third*, Plaintiff States are suffering classic pocketbook injuries from Defendants' conduct. One form of such injuries is tens of thousands of dollars that Plaintiff States have been required to devote solely to investigations into Defendants' illegal conduct and concomitant enforcement actions. Another form of such injuries is Medicaid costs. The treatment detailed above

must be covered by Plaintiff States' Medicaid programs where individuals are on Medicaid. And a substantial portion, if not a majority, of women suffering complications from abortion drugs are on Medicaid. At least one healthcare provider in Louisiana has reported that approximately half of their team's patients treated for mifepristone complications are on Medicaid. That includes the individual highlighted above who took Abuzz drugs. The State of Louisiana, moreover, is aware of multiple instances of complications due to Aid Access drugs (on information and belief shipped by JBN Operations LLC) that Louisiana Medicaid was required to cover.

203. If and when Plaintiff States receive Defendants' complete identification of the individuals in Plaintiff States to whom they prescribed and dispensed abortion drugs, Plaintiff States will be able to cross check their Medicaid databases to determine the full extent of Medicaid costs that they have incurred and continue to incur.

CAUSES OF ACTION

COUNT I

Violation of Federal Common Law of Public Nuisance All Plaintiff States Against All Defendants

204. Plaintiff States reallege and incorporate by reference all preceding paragraphs.

205. Defendants' facilitation of the advertising, selling, prescribing, and mailing of abortion drugs in Plaintiff States presents a "classic" public nuisance under federal common law. *Arizona*, 40 F.4th at 386 (citation omitted); *accord Cranor*, 998 F.3d at 691–92; *see also Alfred L. Snapp & Son, Inc.*, 458 U.S. at 604 (emphasizing a sovereign state's "interest in the abatement of public nuisances, instances in which the injury to the public health and comfort [is] graphic and direct").

206. "A public nuisance is an unreasonable interference with a right common to the general public." Restatement (Second) of Torts § 821B(1). Such unreasonable interferences may arise where "the conduct involves a significant interference with the public health, the public safety, the public peace, the public comfort or the public convenience"; where "the conduct is proscribed by a statute,

ordinance or administrative regulation”; or where “the conduct is of a continuing nature or has produced a permanent or long-lasting effect, and, as the actor knows or has reason to know, has a significant effect upon the public right.” *Id.* § 821B(2).

207. Defendants’ conduct in this case satisfies each independent basis for identifying a public nuisance. *First*, Defendants’ conduct significantly interferes with the public health, safety, and comfort within each Plaintiff State. *See supra* Sections II, III, IV, V. *Second*, Defendants’ conduct facilitates conduct—the advertising, sale, and mailing of abortion drugs in Plaintiff States—that is plainly proscribed by Plaintiff States’ laws. *See supra* Sections I, II, III, IV; *see also City of Huntington*, 157 F.4th at 567 (“One means of demonstrating an unreasonable interference with a public right is to show that a defendant’s act or causal contributions to that act were ‘unlawful.’” (citing the Restatement)); *Baptiste*, 965 F.3d at 220 (applying the Restatement to find a public nuisance based on the defendant’s “alleged failure to operate its facility in accordance with [state law]”). And *third*, Defendants’ conduct is continuing and they know or have reason to know of its ongoing consequences in Plaintiff States. *See supra* Sections II, III, IV, V.

208. Accordingly, Plaintiff States request injunctive relief, damages, and all other appropriate equitable and monetary relief necessary to abate this nuisance.¹⁶⁹

COUNT II
Violation of the Louisiana Unfair Trade Practices Act
(Conduct in Violation of La. R.S. § 40:962.2)
Plaintiff Louisiana Against All Defendants

209. Louisiana realleges and incorporates by reference all preceding paragraphs.

¹⁶⁹ Given the allegations in this complaint, Plaintiff States believe that Defendants—or at least a subset of Defendants—are violating the federal Racketeer Influenced and Corruption Organizations Act (RICO) and its state law counterparts. At this time, however, Plaintiff States lack a complete picture of the full extent of Defendants’ conduct. Accordingly, Plaintiff States reserve their rights to amend their complaint to add federal and state RICO claims if discovery confirms Plaintiff States’ belief that Defendants are violating RICO. In addition, Plaintiff States reserve their rights to amend their complaint to add further corporate entities and individuals that discovery reveals to be implicated by the schemes detailed above.

210. The Louisiana Unfair Trade Practices Act (“LUTPA”) sets forth Louisiana’s statutory program prohibiting deceptive and unfair trade practices. La. R.S. § 51:1401, *et seq.* (The full title of this Chapter of the Louisiana Code is the “Unfair Trade Practices and Consumer Protection Law.” *See id.*). LUTPA protects “consumers,” La. R.S. § 51:1402(1), and the public by declaring that “unfair or deceptive acts or practices in the conduct of any trade or commerce are ... unlawful,” La. R.S. § 51:1405(A). The Louisiana Attorney General has the power to, among other things, “investigate” and “institute legal proceedings and take such other actions” to address unfair trade practices under LUTPA. La. R.S. § 51:1404(A)(1)(a), (B).

174. Defendants’ business conduct, described above, constitutes “trade” or “commerce” under LUTPA. La. R.S. § 51:1402(10). In particular, La. R.S. § 51:1402(10)(b) defines “trade” or “commerce” to “include the advertising, offering for sale, sale, or distribution of an abortion-inducing drug in violation of R.S. 40:962.2.” La. R.S. § 40:962.2(A), in turn, generally prohibits any abortion drug from “be[ing] sold, prescribed, dispensed, distributed, or delivered in this state.” La. R.S. § 40:962.2(B) also bars “delivery [of such a drug] to a person in Louisiana by mail-order, courier, or as a result of a sale made via the internet.”

175. As detailed above, each Defendant publicly advertises, offers for sale, sells, or distributes abortion drugs in Louisiana—to be delivered by mail. That conduct plainly violates Louisiana law. And it violates the established public policy of Louisiana as expressed through its Constitution and its duly enacted statutes.

176. Defendants’ conduct has caused substantial injury to the public interest and public marketplace, including the erosion of the integrity of regulated markets within Louisiana, as well as the health, safety, and well-being of Louisiana consumers who purchased abortion drugs from Defendants or were solicited for such purchase by Defendants. It also has resulted in the deaths of unborn Louisiana babies.

211. Accordingly, Louisiana seeks a declaratory judgment that Defendants violated LUTPA, an injunction enjoining the Defendants' deceptive and unfair conduct, appropriate civil penalties per violation, damages, costs, attorneys' fees, and all other relief available under LUTPA.

COUNT III
Violation of the Louisiana Unfair Trade Practices Act
(Unfair or Deceptive Conduct)
Plaintiff Louisiana Against All Defendants

212. Louisiana realleges and incorporates by reference all preceding paragraphs.

213. Defendants also have engaged in unfair practices that offend Louisiana public policy that are substantially injurious and deceptive practices marred by deceit and misrepresentation.

214. Such practices include:

- Misrepresenting the lawfulness of medication abortion in Louisiana;
- Misrepresenting the safety, effects, and risks of abortion drugs;
- Misrepresenting FDA's approval of medication abortion;
- Misrepresenting the efficacy of medication abortion;
- Misrepresenting the need for in-person, pre-abortion care;
- Advising individuals who take their drugs to lie to healthcare providers.

198. Defendants' conduct is intentional, knowing, and reckless. Defendants' conduct has caused substantial injury to the public interest and public marketplace, including the erosion of the integrity of regulated markets within Louisiana, as well as the health, safety, and well-being of Louisiana consumers who purchased abortion drugs from Defendants or were solicited for such purchase by Defendants. It also has resulted in the deaths of unborn Louisiana babies.

215. Accordingly, Louisiana seeks a declaratory judgment that Defendants violated LUTPA, an injunction enjoining the Defendants' deceptive and unfair conduct, appropriate civil penalties per violation, damages, costs, attorneys' fees, and all other relief available under LUTPA.

COUNT IV
Violation of the Arkansas Deceptive Trade Practices Act
(Unconscionable Trade Practices)
Plaintiff Arkansas Against All Defendants

216. Arkansas realleges and incorporates by reference all preceding paragraphs. Fed. R. Civ. P. 10(c).

217. The Arkansas Deceptive Trade Practices Act (“ADTPA”) sets forth Arkansas’s statutory program prohibiting deceptive and unconscionable trade practices. Ark. Code Ann. §§ 4-88-101, *et seq.*

218. The business practices of Defendants constitute the sale of “goods” or “services.” Ark. Code Ann. § 4-88-102(4) and (7). The same business practices constitute business, commerce, or trade. Ark. Code Ann. § 4-88-107.

219. The ADTPA protects Arkansas consumers and the public interest in a legitimate business community by prohibiting certain business practices, including unconscionable behavior, during consumer transactions.

220. The Arkansas Supreme Court has defined unconscionable conduct as conduct that affronts one’s sense of justice, decency, or reasonableness, and has explicitly held that conduct violating public policy or law is an unconscionable practice under the ADTPA. *Baptist Health v. Murphy*, 226 S.W.3d 800, 811 (Ark. 2006).

221. Arkansas law prohibits “any manufacturer, supplier, physician, or any other person to provide any abortion-inducing drug via courier, delivery, or mail service.” Ark. Code Ann. § 20-16-1504(b). It also enumerates requirements for providing “an abortion-inducing drug” Ark. Code Ann. § 20-16-1504(c), and the procedures that must be followed by physicians. *See generally* Ark. Code Ann. § 20-16-1504 *et seq.*

222. Defendants, in the course of business, commerce, or trade, have engaged in unconscionable acts and practices by knowingly and systematically:

- a. Circumventing and evading Arkansas statutes governing the provision of abortion-related services and the practice of medicine;
- b. Marketing, prescribing, selling, and distributing abortion drugs into Arkansas in open defiance of Arkansas law;
- c. Structuring their telehealth operations specifically to avoid compliance with or detection by Arkansas's regulatory and licensing regulatory structures; and
- d. Encouraging, facilitating, and normalizing widespread noncompliance with Arkansas law among Arkansas residents.

223. Defendants' conduct is not only unconscionable because it violates state law, but also because it endangers the health and safety of Arkansas women and girls. In the course of business, commerce, or trade, Defendants have engaged in unconscionable acts and practices by prescribing and distributing abortion drugs to Arkansas women and girls in violation of Arkansas law designed to protect their safety.

224. Defendants' practices exposed and continue to expose Arkansas women and girls to a substantial risk of harm, including but not limited to:

- a. Dispensing abortion drugs without the in-person examination required by Arkansas law and without screening for circumstances material to their use, including ectopic pregnancy, gestational age limits, IUD placement, and blood type;
- b. Advising women and girls not to tell Arkansas medical providers they took abortion drugs, even in cases of emergency; and
- c. Advising Arkansas women and girls not to follow standard medical procedures recommended by the FDA and required by Arkansas law.

225. These practices unconscionably disregard patient safety in favor of expanding access to illegal transactions, shift the burden of risks to patients and Arkansas's healthcare system, and exploit Arkansas women and girls' vulnerabilities in making time-sensitive and high-risk medical decisions.

226. Defendants' conduct offends established public policy of Arkansas as expressed through its Constitution and its duly enacted statutes.

227. Defendants' conduct has caused substantial injury to the public interest and public marketplace, including the erosion of the integrity of regulated markets within Arkansas, as well as the health, safety, and well-being of Arkansas women and girls who purchased abortion drugs from Defendants or were solicited for such purchase by Defendants.

228. The deceptive practices alleged above were carried out through the coordinated conduct of Defendants. Each Defendant either directly engaged in a prohibited practice and is therefore liable, or knowingly facilitated, assisted, intermediated, or otherwise aided its operation or continuance, in violation of Ark. Code Ann. § 4-88-107(a)(12). To the extent a Defendant facilitated or aided another Defendant's violation, that Defendant knew or reasonably should have known of the facts giving rise to the violation and is jointly and severally liable under Ark. Code Ann. § 4-88-113(d).

229. Accordingly, Arkansas seeks a declaratory judgment that Defendants violated ADTPA, an injunction enjoining the Defendants' unconscionable conduct, civil penalties of \$10,000 per violation, damages, costs, attorneys' fees, and all other relief available under ADTPA.

COUNT V
Violation of the Arkansas Deceptive Trade Practices Act
(Knowing Misrepresentations)
Plaintiff Arkansas Against All Defendants

230. Arkansas realleges and incorporates by reference all preceding paragraphs. Fed. R. Civ. P. 10(c).

231. Under ADTPA, it is unlawful to “knowingly make a false representation as to the characteristics, ingredients, uses, benefits, alterations, source, approval, or certification of goods or services.” Ark. Code Ann. § 4-88-107(a)(1). It is similarly unlawful to make a false representation as to whether the goods are of a particular standard, quality, grade, or model. *Id.*

232. Defendants, in the course of marketing and providing abortion drugs, have made false and misleading representations regarding the safety, efficacy, legality, and risks associated with such drugs. These misrepresentations include, but are not limited to:

- a. Statements that minimize the frequency or severity of potential complications;
- b. Statements that downplay the failure rate of abortion drugs, and the associated complications;
- c. Statements that downplay the seriousness of ingesting abortion drugs;
- d. Statements that minimize the need for in-person care before receiving abortion drugs, including standard screening measures and follow-up care;
- e. Representations that state or imply that Defendants’ products and services are FDA approved or in compliance with FDA guidelines and requirements; and
- f. Representations that state or imply that Defendants’ sale and delivery of abortion drugs to Arkansas women and girls is lawful.

233. The deceptive practices alleged above were carried out through the coordinated conduct of Defendants. Each Defendant either directly engaged in a prohibited practice and is therefore liable, or knowingly facilitated, assisted, intermediated, or otherwise aided its operation or continuance, in violation of Ark. Code Ann. § 4-88-107(a)(12). To the extent a Defendant facilitated or aided another Defendant’s violation, that Defendant knew or reasonably should have known of the facts giving rise to the violation and is jointly and severally liable under Ark. Code Ann. § 4-88-113(d).

234. Accordingly, Arkansas seeks a declaratory judgment that Defendants violated ADTPA, an injunction enjoining the Defendants' unconscionable conduct, civil penalties of \$10,000 per violation, damages, costs, attorneys' fees, and all other relief available under ADTPA.

COUNT VI
Violation of the Arkansas Deceptive Trade Practices Act
(Deceptive Trade Practices—Material Omissions)
Plaintiff Arkansas Against All Defendants

235. Arkansas realleges and incorporates by reference all preceding paragraphs. Fed. R. Civ. P. 10(c).

236. The ADTPA also prohibits the use of deception, fraud, or false pretenses in connection with advertising or a sale, as well as the "concealment, suppression, or omission of any material fact with the intent that others rely upon the concealment, suppression, or omission" while selling any goods or services. Ark. Code Ann. § 4-88-108(a)(1)–(2).

237. A material fact is one that could affect the consumer's conduct or decision when deciding to purchase the product. Materiality is presumed if the practice involves the health, safety, or other significant area where a reasonable consumer would be concerned. Federal Trade Commission, FTC Policy Statement on Deception, appended to Cliffdale Assocs., Inc., 103 F.T.C. 110, 174 (1984) at pp.1–6.

238. Defendants have also engaged in material omissions, including failure to adequately disclose:

- a. The full range and likelihood of serious adverse events;
- b. The importance of in-person medical evaluation in certain circumstances;
- c. The limitations of remote screening and associated risk; and
- d. The potential need for emergency medical care and the lack of integrated follow-up services.

239. These misrepresentations and omissions are material and likely to influence a reasonable consumer's decision to obtain abortion drugs from Defendants.

240. Defendants' conduct has caused significant harm, not only to individual patients, but also to healthcare providers and emergency services within Arkansas, as well as the integrity of the medical marketplace.

241. Accordingly, Arkansas seeks a declaratory judgment that Defendants violated ADTPA, an injunction enjoining the Defendants' false representations, omissions, concealments, and suppressions described throughout this Complaint, civil penalties of \$10,000 per violation, damages, costs, attorneys' fees, and all other relief available under ADTPA.

COUNT VII
Violation of the Alabama Deceptive Trade Practices Act
(Unconscionable Trade Practices)
Plaintiff Alabama Against All Defendants

242. Alabama realleges and incorporates by reference all preceding paragraphs.

243. Alabama's Deceptive Trade Practices Act exists to protect "[t]he public health, welfare and interest" of "both the consuming public and the legitimate businessperson." Ala. Code § 8-19-2. The Act is enforceable by the Alabama Attorney General. *See* Ala. Code § 8-18-4.

244. Defendants' business conduct constitutes "trade or commerce" within the scope of the Act. Ala. Code § 8-19-3(14).

245. The Act prohibits any "unconscionable ... act or practice in the conduct of trade or commerce." Ala. Code § 8-19-5(27).

246. Defendants' conduct is "unconscionable" under the Act in at least two ways: it violates the public policy of Alabama and endangers the health and safety of Alabama women and girls.

247. Alabama law strictly prohibits "giving, selling, dispensing, administering, or otherwise providing or prescribing" "abortion-inducing drug[s]" except in very limited circumstances, which

(among other things) require an in-person examination and a determination that the abortion is necessary to prevent a serious health risk to the mother. Ala. Code § 26-23E-7; *see* Ala. Code § 26-23H-4; Ala. Code § 13A-3-7. Abortion is against the public policy of the state. Ala. Const. Art I, § 36.06.

248. Defendants have and are engaged in unconscionable acts and practices in the conduct of trade or commerce by, among other things:

- a. Circumventing and evading Alabama law governing the provision of abortion-related services and the practice of medicine;
- b. Marketing, selling, dispensing, administering, prescribing, or otherwise distributing abortion drugs into Alabama in open defiance of Alabama law;
- c. Structuring their telehealth operations specifically to avoid compliance with or detection by Alabama's regulatory and licensing regulatory structures; and
- d. Encouraging, facilitating, and normalizing widespread noncompliance with Alabama law among Alabama residents.

249. Defendants' conduct is not only unconscionable because it violates state law but also because it endangers the health and safety of Alabama women and girls. In the conduct of trade or commerce, Defendants have engaged in unconscionable acts and practices by prescribing and distributing abortion drugs to Alabama women and girls in violation of Alabama law designed to protect their safety.

250. Defendants' practices exposed and continue to expose Alabama women and girls to a substantial risk of harm, including but not limited to:

- a. Dispensing abortion drugs without the in-person examination required by Alabama law and without screening for circumstances material to their use such as ectopic pregnancy, gestational age limits, IUD placement, and blood type;

- b. Advising women and girls not to tell Alabama medical providers they took abortion drugs, even in cases of emergency; and
- c. Advising Alabama women and girls not to follow standard medical procedures recommended by the FDA and required by Alabama law.

251. These practices unconscionably disregard patient safety in favor of expanding access to illegal transactions, shift the burden of risks to patients and Alabama's healthcare system, and exploit Alabama women and girls' vulnerabilities in making time-sensitive and high-risk medical decisions.

252. Defendants' conduct offends the established public policy of Alabama as expressed through its Constitution and its duly enacted statutes.

253. Defendants' conduct has caused substantial injury to the public interest and public marketplace, including the erosion of the integrity of regulated markets within Alabama, as well as the health, safety, and well-being of Alabama women and girls who purchased abortion drugs from Defendants or were solicited for such purchase by Defendants.

254. Accordingly, Alabama seeks a declaratory judgment that Defendants violated Alabama's Act, an injunction enjoining the Defendants' unconscionable conduct, civil penalties, damages, costs, attorneys' fees, and all other relief available under Alabama's Act.

COUNT VIII
Violation of the Alabama Deceptive Trade Practices Act
(Misleading or Deceptive Trade Practices)
Plaintiff Alabama Against All Defendants

255. Alabama realleges and incorporates by reference all preceding paragraphs.

256. Under Alabama's Deceptive Trade Practices Act, it is unlawful to, "[c]aus[e] confusion or misunderstanding as to the source, sponsorship, approval, or certification of goods or services," "[r]epresent[] that goods or services have sponsorship, approval, characteristics, ingredients, uses,

benefits, or qualities that they do not have or that a person has sponsorship, approval, status, affiliation, or connection that he or she does not have,” or “[e]ngag[e] in any other unconscionable, false, misleading, or deceptive act or practice in the conduct of trade or commerce.” Ala. Code § 8-19-5(2), (5), (27).

257. In the course of marketing and providing abortion drugs, Defendants have represented that the drugs have certain qualities or approval that they do not have and have caused confusion or misunderstanding about the approval of the drugs. Such representations include but are not limited to:

- a. Representations that state or imply that Defendants’ products and services are FDA approved or in compliance with FDA guidelines and requirements; and
- b. Representations that state or imply that Defendants’ sale and delivery of abortion drugs to Alabama women and girls is lawful.

258. Defendants have also made false, misleading, or deceptive representations regarding the safety, efficacy, legality, and risks associated with the abortion drugs. These include but are not limited to:

- a. Statements that minimize the frequency or severity of potential complications;
- b. Statements that downplay the failure rate of abortion drugs, and the associated complications;
- c. Statements that downplay the seriousness of ingesting abortion drugs;
- d. Statements that minimize or misrepresent the need for in-person care before receiving abortion drugs, including standard screening measures and follow-up care;
- e. Statements that misrepresent the safety, effects, and risks of abortion drugs;
- f. Statements that advise individuals who take their drugs to lie to healthcare providers.

259. Accordingly, Alabama seeks a declaratory judgment that Defendants violated Alabama's Deceptive Trade Practices Act, an injunction enjoining the Defendants' misleading or deceptive conduct, civil penalties, damages, costs, attorneys' fees, and all other relief available under Alabama's Act.

PRAYER FOR RELIEF

Plaintiff States therefore request that the Court enter an order and judgment that grants the following relief, which it is authorized to do under 28 U.S.C. § 2201, Federal Rules of Civil Procedure 57 and 65, its equitable powers, and La. R.S. § 51:1401, *et seq.*, Ark. Code Ann. §§ 4-88-101, *et seq.*, and Ala. Code § 8-19-1, *et seq.*

- A. Declaring that the conduct alleged herein constitutes a public nuisance under federal common law;
- B. Requiring Defendants to abate the public nuisance described herein and to deter or prevent the resumption of such nuisance;
- C. Ordering an injunction against Defendants' prohibited conduct in Plaintiff States;
- D. Declaring that Defendants' conduct is in violation of LUTPA, ADTPA, and Alabama's Deceptive Trade Practices Act;
- E. Enjoining Defendants from continuing the deceptive, unfair, and unconscionable business practices as described throughout this Complaint;
- F. Disgorging all revenue derived from Defendants' unlawful, unconscionable, and deceptive acts and practices as alleged herein;
- G. Awarding actual and compensatory damages;
- H. Awarding civil penalties per each violation of Defendants' deceptive and unconscionable business practices in each Plaintiff State;
- I. Awarding statutory damages in the maximum amount permitted by law;

- J. Awarding reasonable attorneys' fees and costs of suit;
- K. Awarding pre-judgment and post-judgment interest; and
- L. Awarding any such other and further relief as the Court deems just and proper.

Respectfully submitted,

LIZ MURRILL
ATTORNEY GENERAL OF LOUISIANA

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**Application for admission pro hac vice forthcoming*

THE BIG FEATURE

She's Remaking the Abortion Landscape One Pill at a Time

Far from buckling under Dobbs, the access movement has created "a whole new way of doing healthcare."

NINA MARTIN

JULY 31, 2026



Dr. Angel Foster has spent three decades helping to build the abortion access movement as a researcher, strategist, collaborator, and cheerleader. The MAP, operating out of a bare bones office in the Boston area, is her most ambitious project yet. **Emily Schiffer**



Dr. Angel Foster has spent three decades helping to build the abortion access movement as a researcher, strategist, collaborator, and cheerleader. The MAP, operating out of a bare bones office in the Boston area, is her most ambitious project yet. **Emily Schiffer**

Get your news from a source that's not owned and controlled by oligarchs. Sign up for the free Mother Jones Daily.

For most of the three years it's existed, the second-largest telehealth abortion provider in the country has operated out of an office not much bigger than a lot of bathrooms. "That is what half a million dollars of mifepristone looks like," Dr. Angel Foster tells the Tufts University medical students crowded around the conference table, nodding toward the cubicle across the hall. The bins lining the plate-glass windows are filled with Priority Mail packages containing abortion pills, ready to be labeled and shipped. Shelves hold supplies of mifepristone and misoprostol, the two drugs in the gold-standard abortion-pill regimen, all waiting to be packed.

Foster is a leader in the movement that has revolutionized telemedicine abortion care in the post *Roe v. Wade* era. The Massachusetts Medication Abortion Access Project, or The MAP, which she co founded in 2023, is the culmination of a 30-year career on the cutting edge of global reproductive care. Figuring out how to get abortion pills to people who need them, while preparing for a future in which those pills may no longer be legal, is a core part of Foster's and The MAP's—mission.

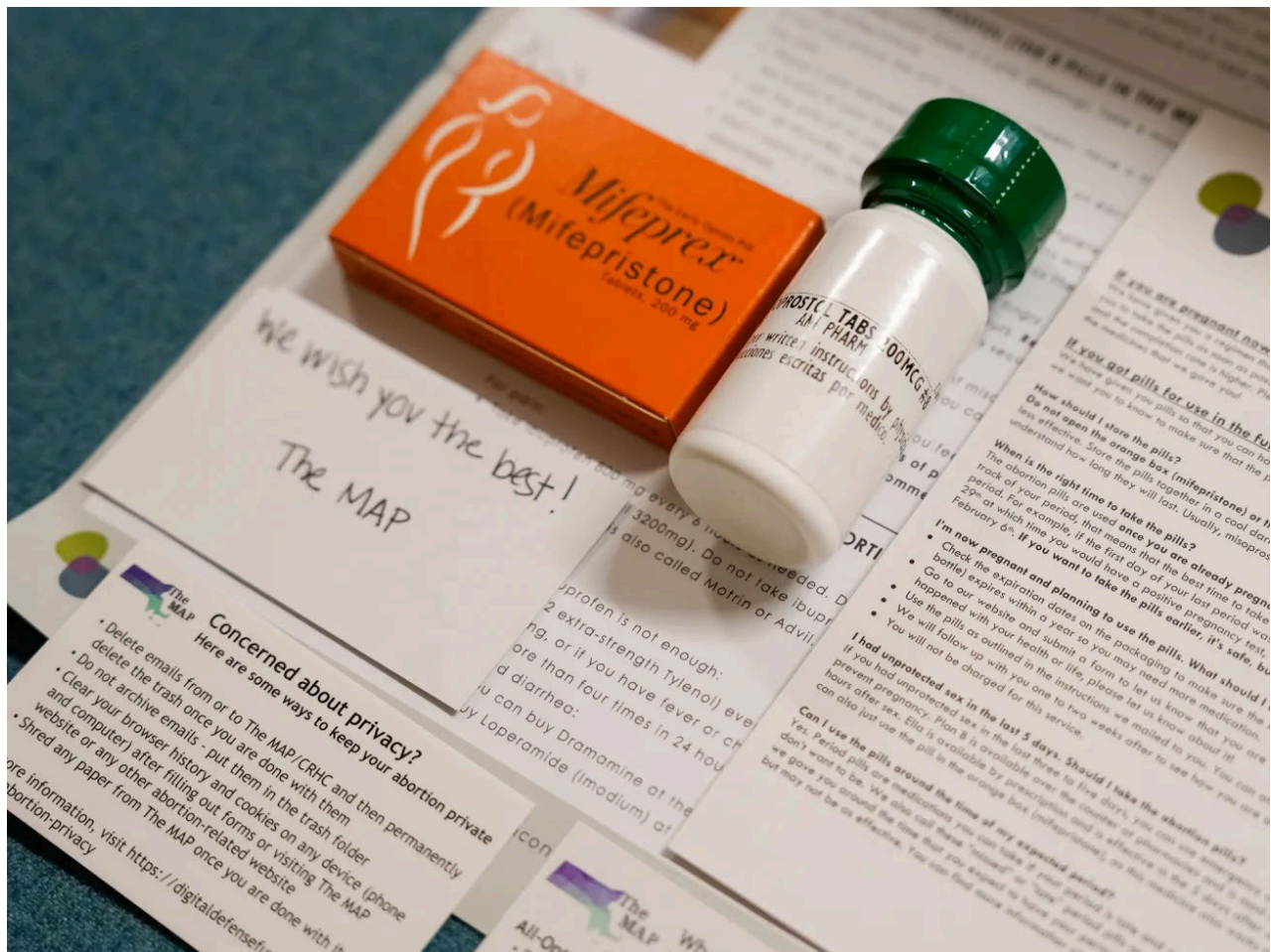
"We've got thousands and thousands of pills with the idea that we'll be able to provide care for months if we need to weather any storms," Foster tells the students, her hair pulled into a bun sturdy enough to withstand the harshest of elements. That stockpile is in addition to the more than 3,000 pill shipments The MAP was sending out every month.

“We just want to be able to provide care for as long as possible when there are disruptions,” she adds, knowing a series of Category 5 hurricanes looms on the horizon. Her personal mantra, echoing Timothy Snyder’s *On Tyranny*, is The MAP’s organizational one: “No anticipatory obedience.”

It’s a Thursday evening in mid April, and Foster—a professor of medication abortion studies at the University of Ottawa in Canada, as well as The MAP’s head of operations at its Boston-area base—has spent the past week traveling and brainstorming with her abortion access allies about how to innovate and even expand care amid the escalating threats. Although she’s renowned among her colleagues for needing half as much sleep as most people, tonight she seems distinctly tired, not that the rapt students seem to notice. They wolf down dinner—pizza from a neighborhood joint with Oregon pinot and a crisp rosé in plastic cups—as she runs through The MAP’s origin story (thank you, *Dobbs*), radical philosophy (who needs doctors?), and ever-widening ambitions. Then she asks everyone to clear away their greasy plates for the highlight of the evening: the famous MAP assembly line.



First, they put together Priority Mail cartons, big enough to hold the correct dosage of abortion meds and inconspicuous enough to pass for, say, crafting supplies from Etsy. Then they pass the cartons around the table, each person slipping in something different: orange boxes of mifepristone and white plastic bottles of misoprostol, instruction sheets, information about ectopic pregnancies and patient privacy, and a handwritten card that says, “We wish you the best, [heart drawing] The MAP.” The last student checks the contents, seals the package, and drops it into a plastic bin. Since its launch, The MAP has sent abortion pills to more than 60,000 patients, 95 percent in states where abortion is subject to harsh restrictions and near-total bans. “How are you able to get this amount of volume out?” a dark haired young woman asks incredulously.



Every package sent by The MAP includes medication, informational materials, and a handwritten card which these days includes a drawing of a heart **Kayla Bartkowski/The Boston Globe/Getty**



The MAP's pill packing parties are fueled by pizza and wine but never chardonnay **Emily Schiffer**

A big part of the answer can be found in work sessions like this one, which happen twice a week. The MAP has a long waiting list of volunteers eager for a chance to help thwart red-state attorneys general and subvert draconian laws. Not only have these events become integral to The MAP's operations, but they're a highly effective way of trolling conservative extremists who believed the end of *Roe* would mean the end of abortion access for much of the US.

Exhibit A for how much Foster has enraged "the antis" (as she calls them) is a blockbuster lawsuit by the state of Louisiana that threatens mail order mifepristone nationwide. On the gray spring afternoon we were huddled in her office, lawyers for Louisiana were putting the finishing touches on a petition asking the 5th US Circuit Court of Appeals to block Biden era FDA rules that allow the medication to be prescribed via telehealth and sent through the mail. Although Foster wasn't a defendant in the case, page 24 of the initial complaint included a photo of her presiding over a pill-packing party in 2024. Describing the gathering as a "scheme," the lawsuit quoted from the *Wall Street Journal* article in which the photo appeared, in which middle aged volunteers "sip[ped] chardonnay in red plastic cups." (The *Journal* got that part wrong, Foster insisted later, in mock outrage: "I would never serve chardonnay!")

The story "infuriated the anti choice movement," she tells me, sounding as gleeful as you'd expect from someone whose email signature used to include a drawing of the female reproductive system with the ovaries in the shape of middle fingers pointing up. The article also reached a vital audience for securing The MAP's future success: progressive donors. The day after it appeared, Foster says, a wealthy retiree in a neighboring state pledged \$250,000.

"Even if mifepristone became banned, medication abortion is here to stay. You can't put this genie back in a bottle."

Four years after the Supreme Court's *Dobbs v. Jackson Women's Health* decision ended the national right to abortion, Foster and her allies have managed to create an entire healthcare, legal, and financing infrastructure what The MAP's medical director, Dr. Maureen Paul, calls a "shadow" system—that has kept abortion pills flowing, with stunning efficiency, into some of the most abortion-hostile parts of the country. In the process, they've mainstreamed pills to such an extent that even a nationwide abortion ban, the anti abortion movement's No. 1 priority, might be futile. "Even if mifepristone became banned, medication abortion is here to stay," Foster says. "You can't put this genie back in a bottle."

The irony is that while abortion foes see The MAP as an existential threat, many of the patients it serves still can't quite believe it's real. Imagine being a woman in an environment where abortion is painted as dangerous, evil, and illegal, Foster tells the students. "You get pregnant, you don't want to be, you go online, and you find out that there's this group of clinicians in Massachusetts that will send FDA-approved abortion pills to your home for \$5. It sounds absolutely bananas."

She calls this "the legitimacy challenge," and it breaks her heart to think of how desperately people want to believe. Several times a week, she says, "we'll have patients who email us saying, 'I just paid my last \$5. Please don't be a scam.' And we email 'em back and say, 'We're not promise.'"



Before the assembly line begins, volunteers organize Priority Mail boxes for maximum efficiency. They typically pack 500 shipments per session, Foster says. **Emily Schiffer**



On Friday, May 1, two weeks after my visit, the ultra conservative 5th Circuit granted Louisiana's request to suspend FDA rules allowing mifepristone to be prescribed and dispensed via telehealth. It was one of the nightmare scenarios the movement had been dreading since *Dobbs*: a rogue ruling by an extremist court that could catastrophically disrupt care for tens of thousands of patients. Nearly two thirds of abortions in the US now involve the two drug regimen, and almost 30 percent occur via telemedicine; in states with the harshest laws, it's almost 100 percent.

"There was a tremendous amount of scrambling, a lot of panicked people," says Susan Yanow, The MAP's director of community engagement and an abortion access pioneer. The ruling's timing—just before a weekend and at the beginning of the month—was guaranteed to cause maximum havoc. Hundreds of The MAP's patients had started ordering pills earlier in the week but were waiting for their paychecks to send in their money. Now they were in limbo.

But the ruling didn't affect the other medication in the standard abortion pill regimen, misoprostol. Foster knew from her decades spent working in global settings that misoprostol is a highly effective and safe abortifacient on its own. And because it has so many other uses, from treating ulcers to inducing labor and stopping postpartum hemorrhages, it is relatively easy to obtain and difficult for abortion opponents to control. If the Supreme Court didn't step in, The MAP and other telemedicine providers had a backup plan. "We're prepared to switch to misoprostol alone if we need to," Foster had said back in Boston. "No precompliance."



Four years after the end of *Roe*, clinician supported abortions are up 16 percent, thanks largely to telemedicine and shield laws. **Jacquelyn Martin/AP**

That weekend, Yanow deployed volunteers to pack mailers with jars of misoprostol alone. Meanwhile, Foster reached out to patients and answered their frantic questions: If their mifepristone was already in the mail, would the Postal Service still deliver it? Was misoprostol a *real* abortion pill? New medication instruction sheets had to be finalized, patient consent forms resubmitted, and The MAP's website revamped. Foster also recognized a rare chance to generate much needed data about misoprostol only abortions via telemedicine in the US, so she designed a study that could compare the experiences of a thousand MAP patients on the single-drug protocol with the same number using the two drug regimen.

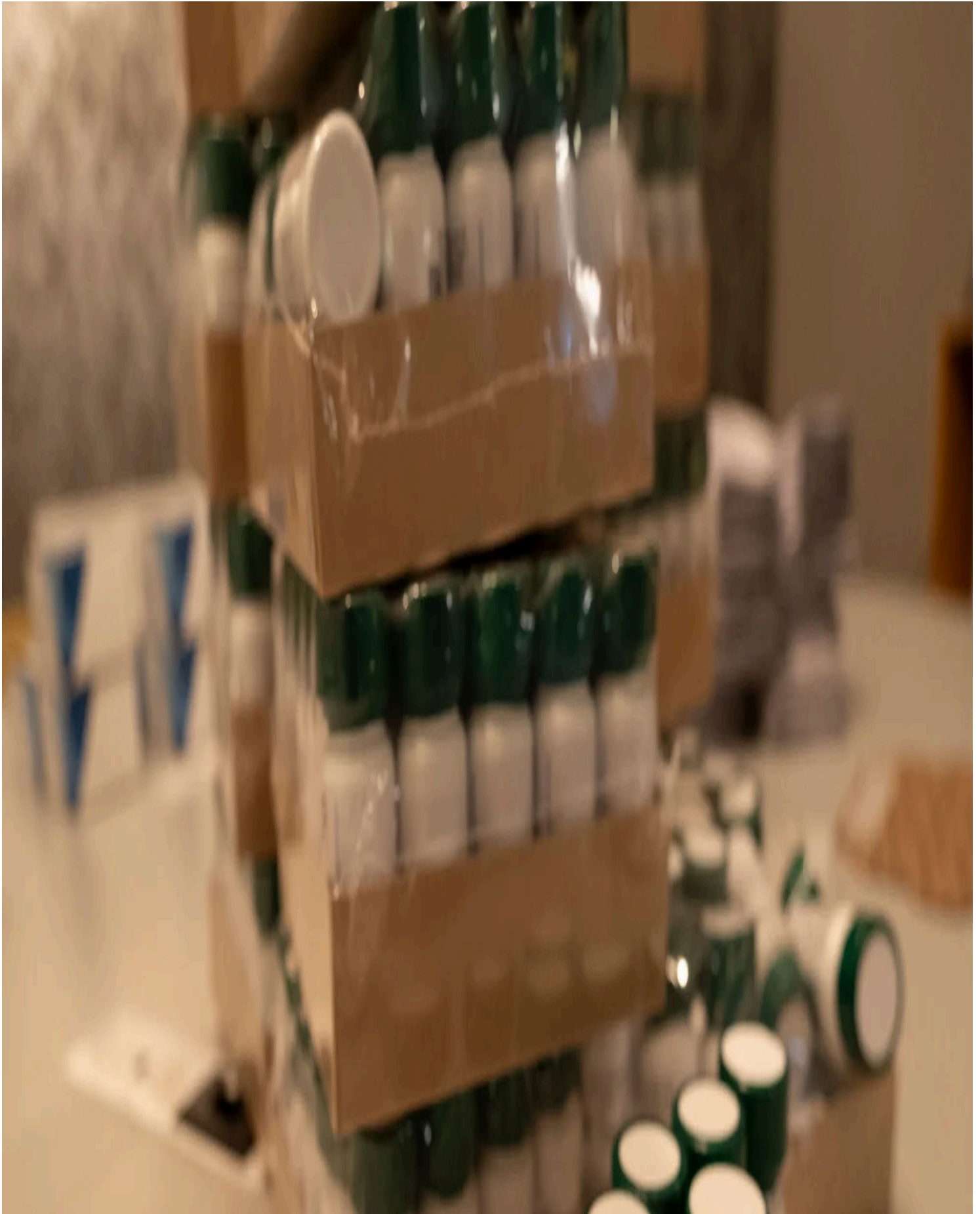
"There are people who tend to say, 'Oh my gosh, the boat's going down!'" says Yanow, who's known Foster for more than 25 years. "Angel is one of the people who looks around and says, 'Okay, where's the opportunity? How can we fix this?'"

"It made me so happy, when he wrote, 'They're undermining Dobbs.' I was like, yeah, exactly."

As it turned out, SCOTUS wasn't ready to take the politically dangerous step of stopping telemedicine abortions—yet. After temporarily pausing the 5th Circuit ruling, the justices issued a one paragraph order in mid May that kicked the case back to the lower courts. For the foreseeable future, mail-order mifepristone remained legal. Justice Samuel Alito, the anti abortion hardliner who authored the *Dobbs* decision, vociferously dissented, railing about how providers like The MAP had "perpetrat[ed] a scheme" to circumvent the red state bans that *Dobbs* made possible.

"It made me so happy," Yanow says, "when he wrote, 'They're undermining *Dobbs*.' I was like, *yeah, exactly*." As terrifying as the Louisiana case had been, Foster says, it was also confirmation of the abortion access movement's surprising resilience. (The study could wait for another time.) "I was really proud of the different groups within the

[abortion] ecosystem,” she says. “I’m really proud of how everyone rallied to make sure that patients could continue to get care.”





Misoprostol is a highly effective and safe abortifacient on its own.

“We’re prepared to switch to misoprostol alone if we need to. No precompliance.”



Now 52, Foster has spent decades helping to build and fortify that movement, often behind the scenes as a researcher, strategist, collaborator, and cheerleader, more recently as one of its most visible innovators. Four years after *Dobbs*, the infrastructure that she and her allies started creating in the 2010s includes mail order abortion pill providers, online information clearinghouses, and training initiatives for doctors and community activists. Abortion funds have helped hundreds of thousands of low income patients pay for care and travel across state lines. Medical and legal hotlines have kept untold numbers out of emergency rooms and jails. New systems have emerged for tracking abortion trends, as well as research initiatives to improve delivery of care. The sum of the parts, another abortion access leader tells me, has been “revolutionary.” Far from buckling under *Dobbs*, she says, the access movement has created “a whole new way of doing healthcare.”

The “deep irony,” Foster says, is that if the *Dobbs* ruling had been narrower, “I think we would be in a very different situation.” Had SCOTUS simply upheld the 15-week ban at the heart of the *Dobbs* case, she suspects Americans—and the mainstream pro choice movement—would have adapted as they had to all the other incremental restrictions on *Roe* over five decades.

Instead, the extremism of the decision galvanized “a new kind of creative thinking,” she says—ideas such as shield laws, blue state statutes that protect abortion providers who deliver care to patients from places where abortion is restricted or banned. Almost every Democratic-run state now has some type of shield law, and eight states explicitly protect telemedicine. By trying to crush abortion in much of the US, conservatives have paradoxically created the conditions for patients and advocates to wrest control of abortion care from the medical and legal systems that have sought to restrict it.



When the Supreme Court overturned *Roe v. Wade* in June 2022, the extremism of the decision galvanized “a new kind of creative thinking,” Foster says **Kent Nishimura/Los Angeles Times/Getty**. The result, Foster says, is that although abortion *rights* have been drastically curtailed in much of the country, abortion access has significantly expanded in some of the most unlikely places. Foster’s favorite example is Mississippi, where the *Dobbs* case originated. In 2022, the state had a single abortion clinic, Jackson Women’s Health Organization, the other party in *Dobbs*. Women there are among the poorest in the country, and the cost could be prohibitive—an average of \$600 for the abortion itself, plus travel, childcare, and time off. (For context, a minimum-wage worker in the state earns \$290 a week before taxes.)

Now, with telemedicine and sliding scale fees, “you can get abortion pills sent to your home for \$5,” Foster marvels, “without having to go through all the steps that were required for in-clinic care.” Since April 2022, clinician-supported abortions in Mississippi, as tabulated by the Society of Family Planning’s #WeCount project, have risen a mind boggling 85 percent—all thanks to shield laws and telemedicine. Across the US, according to the #WeCount data, abortions are up 16 percent.

None of this is to suggest that the end of *Roe* has been *good* for reproductive care, and many people I talked to worried that the abortion access victories of the *Dobbs* era will be misconstrued or that the herculean efforts required to achieve them will be minimized. For women with uncomplicated pregnancies in their first trimester who have some access to technology, “it’s just not as bad as you thought it was going to be,” says Tracy Weitz, an abortion policy expert who teaches at American University, “and in some ways, in some places, it’s actually better.”

But for the 70 percent of abortion patients who can’t or don’t want to rely on telemedicine—if, for example, they are later in pregnancy or have medical conditions that require clinic-based care—the picture isn’t nearly as rosy. Criminalization of pregnancy loss is on the rise. Harsh laws have wreaked havoc on medical training and emergency obstetric care. “People with wanted pregnancies are at far more risk than people with unwanted pregnancies,” Yanow says. “Because if you want to be pregnant and something goes wrong, you can’t manage it yourself. You have to have somebody empty your uterus. When doctors don’t know how to empty a uterus, pregnant people die.”

“People with wanted pregnancies are at far more risk than people with unwanted pregnancies. Because if you want to be pregnant and something goes wrong, you can’t manage it yourself.”

Foster is the first person to agree with the grim assessments. But she also sees an opportunity to “*be* the change we want to see in a dysfunctional US healthcare system.” She returns to this theme often. How can the access movement rectify the most glaring social, racial, and economic inequities of the *Roe* era? “We can use this to build back better,” she says. “What do we want to see this system look like? How can we do this differently?”



The MAP's handwritten cards are carefully worded to be supportive yet neutral "Wishing you the best" "It's the thing our patients say they like the most," Foster says. **Emily Schiffer**



Foster started thinking about abortion access when she was 10. That's when her mother, Nancy, told her about her own illegal abortion in Mexico in the late 1960s. To pay for the procedure—\$300, the equivalent of almost \$3,000 today—she had to sell some of her possessions. Then she was robbed at knifepoint by one of the gangs that preyed on American women crossing the border with purses full of cash. She returned to Los Angeles, sold more stuff, and eventually got the abortion. The whole experience "was terrifying," Nancy tells me, and deeply disturbing to her daughter. "My mom was the most important person in the world to me," Foster says. "And I thought, 'I want to be an abortion provider so nobody has to go through what my mom went through.'"

As an infant, she and her mother spent months traveling from Australia, where Foster was born, through Asia and Europe, back to the US. "I can't tell you how many women around the world held her when she was a baby," Nancy says. "I can't help but think that molded her." In high school in Portland, Oregon, in the early 1990s, Foster won a scholarship to Jordan, where she spent time with Palestinian refugees and orphans and decided she wanted to be a humanitarian as well as a doctor. Her undergraduate studies at Stanford took her to labor-and-delivery wards in Egypt filled with women her own age suffering from sepsis and perforated uteruses—"the consequences," she says, "of abortion bans." As a Rhodes scholar at Oxford, her focus turned to Tunisia, an Islamic country that had integrated abortion into its health system, leading to some of the best maternal and infant outcomes in the region. "I was just desperately curious," she recalls. "How did this happen?"

She had just begun her medical studies at Harvard when, in September 2000, the FDA approved mifepristone for use in the US. Despite the thrilling possibilities that abortion pills presented, the restrictions on its use were disheartening, as was the dearth of medical school training for abortion, “even in blue, blue Boston.” She threw herself into activism and met Yanow, a founder of what was then called the Abortion Access Project (now the Texas based nonprofit Provide), who was organizing a training with chapters of Students for Choice. “Every year, [the students] would say they would do things,” Yanow recalls, “and our staff did 99 percent of it.” So when Foster volunteered to help, Yanow was skeptical. “But within a week and a half, Angel produces this rock-star list of speakers.” She even came up with tabletop centerpieces made from gourds. Yanow decided, “This is the woman for me.”

When Foster was in her second year at Harvard, she accepted a job on top of her studies leading the Middle East portfolio for a new research group called Ibis Reproductive Health, which put her in a global network of researcher-advocates working to make medication abortion more accessible worldwide. Much of that work became the foundation on which The MAP is built. “We don’t usually think of low-resource humanitarian settings as having lessons for the United States,” she says. “But that’s absolutely what’s happened here.”

“We don’t usually think of low-resource humanitarian settings as having lessons for the United States. But that’s absolutely what’s happened here.”

One groundbreaking project took her to a Burmese refugee settlement on the Thai border, where illegal abortions and postpartum hemorrhages contributed to horrific rates of maternal mortality. Her friend Cari Sietstra, founder of Law Students for Choice, had reached out for help figuring out how to train people in the settlement to use misoprostol to bring down maternal deaths. Together, they created a community-based distribution network to get the drug into the hands of 918 abortion patients over three years, then studied how the women fared. More than 96 percent of the abortions were successful, meaning the pregnancy ended without the need for a follow-up procedure. Foster is “fearless,” says Sietstra, who now heads an incubator called Innovations in Reproductive Health Access, “a true ride-or-die.”

ANGEL M. FOSTER | Assessing the Reproductive Nursing Education in Palestine



increase in the uni

The political and economic situation in

Stanford orientation to give students facts on sex, rape

San Francisco Chronicle

PALO ALTO, Calif. — Orientation for first-year students at Stanford University this fall will focus on date rape, condoms and sexual abstinence as well as school spirit and football games.

More than 1,000 Stanford freshmen are expected to pack Memorial Auditorium for an orientation program on "Sex in the '90s," but the joy of sex is not exactly what planners of the program have in mind.

Instead, there will be information on rape, alcohol and sex, condoms, homosexuality, sexual harassment, AIDS, pregnancy and abstinence.

The program was beefed up last year and will be expanded this fall, said Caroline Mitchell, director of the Sexual Assault and Resource Center.

The program was created in response to some grim statistics.

"By the time the current freshmen graduate, three of them will have AIDS," Mitchell said.

Figures also show that 209 women and 88 men in the class will have been forced or pressured into having sex during their four years at Stanford. A survey of 32 colleges found the highest risk period for women to be assaulted on campus is the first three months of their freshman year.

Most Stanford students live in coed dorms, with male and female rooms typically alternating in corridors.

School studies have found that "a significant percentage" of Stanford students regularly have sex in their dorm rooms, said Angel Foster, a 19-year-old junior who is a student director of "Sex in the '90s."

Portland student is Rhodes scholar

Angel Foster will travel to Oxford, England, to study modern Middle Eastern studies

By CHASTITY PRATT
of The Oregonian staff

Her mother may have reinjured a bad knee celebrating, and she's been interviewed and congratulated on her brilliance, but it still hasn't sunk in.

Angel Foster, 21, of Portland, a graduate of The Cathlamet School and a graduate student at Stanford University, is one of this year's 32 Rhodes scholarship winners.

"I never thought, 'Oh, I'm going to win this,'" Foster said in Portland after the announcement was made Sunday.

Rhodes scholarships were established at the turn of the century by the estate of Cecil Rhodes, a British philanthropist and colonialist. Winners receive scholarships to Oxford University in England.

This year's scholars were chosen from 1,041 applicants from 315 colleges and universities in the United States.

Now studying international relations and biology at Stanford, Foster plans to pursue a master of philosophy degree in modern Middle Eastern studies when she



"I'm not a genius. I do more than just study. I listen to folk music, the Indigo Girls, classical rock."

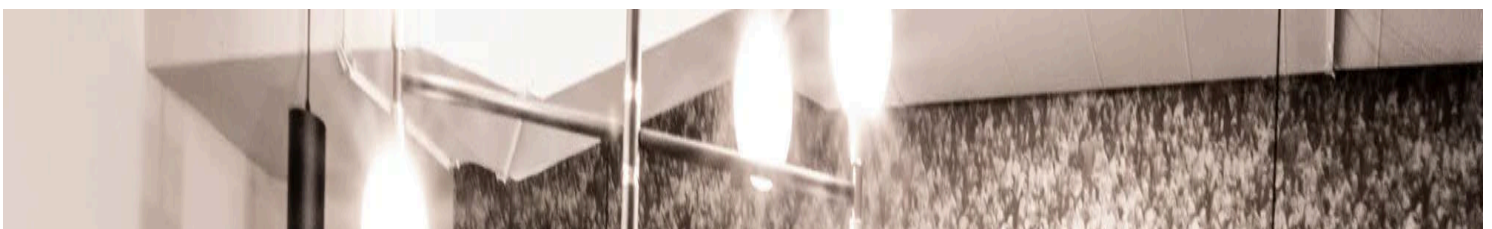
Angel Foster,
Rhodes scholar

While she was a college student, Rhodes scholar, and young researcher, much of Foster's work focused on sexual and reproductive health, often in the Middle East.

When Foster and a different group of colleagues replicated the project in rural Pakistan, the misoprostol-only success rate was 100 percent. Before then, misoprostol's promise as an abortion drug in crisis settings was undercut by the lack of rigorous studies, but this research proved it could be used safely even where there wasn't access to backup care.

The findings completely contradicted the American anti-abortion activists' cherished narrative that medication abortion was so dangerous that it needed to be strictly controlled, if not banned. According to Foster's research, "demedicalizing" abortion pills—her preferred term vs. the "self-managed" framing often used—didn't make them unsafe, any more than had demedicalizing Tylenol in 1960. "We began to feel very confident in no touch, no test protocols and the idea that routine ultrasound, bloodwork, or physical examinations were not necessary," she says. Almost more important was the element of patient autonomy.

At The MAP, Foster has returned to one of the key lessons from this time: If this model of care worked in resource starved villages and refugee camps with minimal medical infrastructure, she knew it would succeed in places with smartphones, paved roads, and functioning postal systems. "If we can trust illiterate and semi-literate women from eastern Myanmar to make decisions about their own bodies," she asks, "how is it that we can't trust women in Texas to do the same thing?"







“How are you able to get this volume out?” someone asks.

A big part of the answer is packing parties like this one.



When Foster joined the University of Ottawa health sciences faculty in 2011, Canada presented a fascinating opportunity to help improve access to medication abortion on a nationwide scale. It had a single-payer healthcare system that was the envy of American progressives. On the other hand, it hadn't decriminalized abortion until 1988, and it still hadn't approved mifepristone 11 years after the FDA had done so. A major part of Foster's new job was to help build the research argument for the drug's acceptance. Canadian authorities finally gave their blessing in 2015.

Foster's reach expanded in 2020, when she came to the rescue of *Perspectives on Sexual and Reproductive Health*, one of the few journals publishing high-level, peer-reviewed studies on abortion. When the Guttmacher Institute decided to shut it down, "there was a panic" among researchers, says Weitz, a close friend of Foster's for 20 years, "and of course, people looked to Angel, and she gets the University of Ottawa to take it." She and Weitz are now the editors, focusing exclusively on abortion related topics around the world.

The leak of the draft *Dobbs* decision in May 2022, just as the National Abortion Federation was a winding up its first in person meeting since the pandemic, was "huge gut punch," Foster recalls. Long active in the organization, she was in the middle of the planning frenzy that followed: "What do we do? How do we move on this?" The final decision a month later stunned her with its "cruelty." Not only did it overturn 50 years of precedent, "in so many places, there was an immediate change in policy with no consideration to what was happening to actual people and patients and providers on the ground."

Then Massachusetts enacted its shield law in July 2022, the first in the country to explicitly protect telemedicine providers, and Foster saw a perfect opportunity to operationalize her middle finger rage. After kicking around a few ideas with Weitz and others, including for an abortion-pill pharmacy, she settled on creating an organization—that would become The MAP offering telemedicine nationally, supported by the new Massachusetts law. It would operate within the formal medical system but use a demedicalized model. "It was like, 'We've got this law. It seems strong, but if nobody leans into it, we'll never show its strength.'"

"It was like, 'We've got this law. It seems strong, but if nobody leans into it, we'll never show its strength.'"

Foster already had an essential piece of infrastructure in place Cambridge Reproductive Health Consultants, a research nonprofit she had co-founded with Sietstra years before to do politically sensitive work, including a study on the lack of abortion access for Peace Corps volunteers. She also had an impressive brain trust. Foster's co-founder was a nationally known abortion provider who needed to stay in the background to protect her family. Yanow, a social worker by training, had spent decades leading initiatives to expand access for marginalized communities around the country, inspired in part by the killing of a young woman she'd been mentoring, in an abortion clinic shooting spree in 1994.

Dr. Maureen Paul, an OB GYN who had served as the medical director for three Planned Parenthood affiliates across the country, assumed the same role for the new organization. Paul's passion for abortion access dated to her own experience as a pregnant 18 year old in pre *Roe* Massachusetts, when women hoping for a hospital abortion had to make their case to a special committee. "The social worker came back from the committee hearing and said, 'They denied your request, but you can go to England or Puerto Rico to have an abortion,'" Paul recalls. "And she might as well have said, 'You can go to the moon.'" Paul carried the pregnancy to term and gave up the baby for adoption a

heartbreak that, all these years later, remains close to the surface. After *Dobbs*, when she was looking for a way to channel her fury, The MAP “checked all the boxes.”

Some lawyers in the pro choice mainstream were less enthused, Foster says, fretting that shield laws were untested in the courts and might end up hurting the entire abortion movement. “I finally had to say, ‘We are going to do this, I don’t want to hear about how we can’t,’” she tells me. To get the full protection of the Massachusetts law, Foster and the team decided The MAP would be completely Massachusetts based, from the doctors prescribing the medication to the malpractice insurer paying the legal bills if anyone got prosecuted or sued. This contrasts with the largest telemedicine provider, Aid Access, which has partner doctors scattered around the US but is based in Europe.

The downside was that The MAP would also have to comply with Massachusetts laws they disagreed with, such as the state’s parental involvement law for patients under 16. The goal was to show the law’s strength without provoking a backlash to be fearless but not reckless.



As the volume of pill orders has risen, the number of packing parties has increased as well. Some 95 percent of The MAP’s shipments go to states where abortion is severely restricted or banned **Emily Schiffer**

As an added layer of protection, the team adopted a distributed risk model, meaning that every step of The MAP’s operations was performed by a different person—from prescribing pills to packing shipments and lugging them to the post office. Although Foster is an MD, she is not a practicing clinician, nor is she one of the five prescribers. “To the outside world,” she says, “it is really hard to identify an individual person who provided pills to an individual patient.” Crucially, the team was the first in the US to leave doctors’ names off drug and shipping labels, making it much harder for someone in a red state to target them for legal action. If, say, a suspicious boyfriend in Texas finds a mailer and Googles “The MAP,” instead of being directed to abortion-related content, he might be drowned in links to actual maps. Seven states have now adopted similar protections as part of their shield laws.

One of the biggest innovations is the pricing structure. For the first year after its 2023 launch, The MAP charged \$250 a patient—enough to more or less break even. Then Foster and the team convinced foundations and abortion funds to

finance a bold experiment: dropping the cost of pills to a maximum of \$150 per patient with a sliding scale that allows people to pay as little as \$5 an order, though if a patient can't afford even that, The MAP will send pills anyway. "It's a very feminist vision of empowerment," Yanow says. The team makes up the difference by constantly fundraising a business model that requires Foster to be front and center.

The vast majority of patients use the medication immediately to end a confirmed pregnancy. But The MAP offers other options as well. Women who think they *might* be pregnant but can't take a test or don't want to know can pay \$75 for "period pills"—the same drugs that induce abortions can be used to "bring down" missed periods. Or for \$150, patients can purchase medication to stash away for future use. Orders for "just in case" pills tend to spike after seismic events like the 2024 election or the Louisiana FDA scare. It turns out that bad news about abortion is a form of free publicity, getting the word out to women who might otherwise not have known The MAP existed.

Amid it all, Foster must also contend with the ever present legal risks. While she has not (yet) been charged or sued by red-state authorities, Cambridge Reproductive Health, as The MAP's official sponsor, has received cease-and-desist orders from Alabama and Arkansas. Other providers in New York, California, and Delaware have been targeted by authorities in Texas and Louisiana. Massachusetts' shield laws, though among the strongest in the country, protect Foster only while she's in the state, so she drastically limits how she moves within the US—her biggest regret about her work. When she travels into and out of the country, it's always through Canada. The only state where she'll drive a car is Massachusetts. Everywhere else, her husband of almost 27 years serves as her chauffeur, "which is a little bit of a problem for him but lovely for me, because I can work in the car."

Travel to red states is too dangerous, which means Foster can no longer visit the woman who inspired her life's work: her 78-year-old mother, who now lives with Foster's stepfather in South Carolina. Last year, Foster's beloved mother-in law, who was Dutch, died in the Netherlands. "I was able to see her and say goodbye," she says. "It was very hard and sad and also really beautiful at the same time, and I'm so grateful to have been a part of that." When she and her husband were getting ready for their flight home, he asked her how she felt about the fact that if this were her mother, she wouldn't have been able to be by her side when she died. "It was really hard to absorb," Foster says. "Um, yeah, so I feel sad."



Almost two thirds of abortions in the US happen using pills. Orange boxes of mifepristone and plastic bottles of misoprostol make up the gold-standard regimen. **Emily Schiffer**



Increasingly, the anti-abortion movement has been pushing a narrative that the care offered by telemedicine providers is substandard and irresponsible, leaving women to fend for themselves in emergencies and allowing them to be cajoled or tricked into having abortions they don't want. "We are not just about mailing pills," Paul counters, "we're following people from start to finish, trying our best to help them get the care that they need." She tells a story about a woman in Texas who ordered abortion pills last fall, only to have a pregnancy test after taking them come back positive. After an ultrasound, The MAP sent her a second batch of pills that also didn't work. When she was around 10 weeks pregnant, the woman traveled to a small town in Mexico for a death in her family. She started bleeding, and a clinic diagnosed her with a type of ectopic pregnancy in which the fetus implants in cesarean scar tissue—a potentially catastrophic complication the clinic didn't have the capacity to treat.

So the Mexican doctors sent the woman back to Texas with a picture of her ultrasound. "This is where we really bumped up against how broken the healthcare system is for people living in abortion ban states," Paul says. "The patient could have died from this. The fetus wasn't viable." But doctors at the Texas emergency room "refused to even look at the ultrasound because they said those people in Mexico don't know what they're doing," Paul says. Telling the patient that bleeding during pregnancy was not unusual, they sent her home to "pray."

Instead, she got back in touch with The MAP's doctors, who reached out to their network of high-risk providers in the state, eventually finding someone two hours away who was willing to perform the lifesaving procedure. Paul was on

the phone with the woman on and off during the long drive. “She was so afraid: ‘What if they won’t see me? Am I going to be arrested?’” The procedure went well, and the woman told them it was the best medical care she’d ever received.

“I have been an abortion provider in different settings for 40 years. I have never heard stories like the ones I hear from my patients now.”

What has surprised Paul the most about her nearly three years at The MAP, she says, is the level of desperation among her patients. “I have been an abortion provider in different settings for 40 years, and I have never heard stories like the ones I hear from my patients now.” In a survey this spring, 9 percent of The MAP’s patients said they’d been victims of some type of violence or reproductive coercion in their current pregnancy. Many patients have four or more children. And the stories they share are harrowing. “I need to do this as discreetly as possible,” one woman wrote. “I’m in a relationship that I’m trying to safely get out of, and I can’t be pregnant while I do it. I can’t have a baby with him. I can’t have another baby, period.”

But the story that haunts Paul the most was from a patient in Texas who already had two small children and could afford only \$9.22 for her pills. “I read this comment,” Paul says, “and sat there trying to imagine this person figuring out what it took for her to put food on the table and clothes on her kids and pay her rent, and after counting it all up, finally say: ‘I can pay you \$9.22.’”



MAP volunteers haul bins of packaged abortion pills to a nearby post office. **Emily Schiffer**



When Foster and her team launched The MAP in September 2023, Foster didn't consider it to be just a telehealth platform. It was a demonstration project, one she hoped would inspire providers in other shield-law states to follow her lead. One of her long term goals has been to build redundancy into the US abortion access infrastructure, which is essential to ensuring its resilience. But so far, The MAP is the only telemedicine provider of its kind, with the entire medical practice based in a single state. "I think it's intimidating for folks to create a new practice," Foster acknowledges. "It feels like a heavy lift."

In June, The MAP switched to new computer software designed to streamline the patient intake process and improve protections for confidential information. To Foster's shock, the number of orders nearly doubled to more than 6,000 patients a month, which has created enormous new pressures—for more inventory, more packing parties, and a lot more money. Instead of the \$60,000 to \$70,000 The MAP had to raise each month when I visited Boston last spring, it's now closer to \$120,000 a month. "That is the biggest challenge—what it means for us financially. It's keeping me up a little bit at night, I'm not gonna lie," she says.

There's also the impact that comes with being a major player in a resource starved movement. The MAP's fee structure has made it the equivalent of a "safety-net facility," Foster says, helping to fill a gap for low-income women that goes back to the Hyde Amendment, which banned federal funds for abortion care. But most telemedicine providers haven't had the level of philanthropic support that makes those low prices possible, and clinics are even worse off: They rely on abortion pills at an average charge of \$600 per patient to subsidize care for people for whom pills aren't an option. As more patients order pills online, some clinics could be forced to close—a disaster for women who need later abortions and something the entire abortion ecosystem needs to reckon with.

At the end of June, Weitz—who as the former US program director of one of the largest funders of reproductive care, the Susan Thompson Buffett Foundation, knows the landscape better than most—convened a meeting of about 30 abortion access leaders. "It's time for an honest conversation about what it's going to take to make a service delivery sector that makes sense to both the patient and to the providers," Weitz says.

That conversation comes as the legal and political campaign to restrict mifepristone access has ratcheted up. Abortion opponents have been pressing President Donald Trump's FDA to rescind a variety of Obama and Biden era rules that have made mifepristone more accessible or to overturn approval of the drug entirely. Despite decades of evidence to the contrary, they insist mifepristone is unsafe, and to buttress their case, they have been churning out junk science, claiming abortion pills are sending large numbers of patients to emergency rooms, polluting the water supply, and enabling the coercion of women. The same abortion foes are pushing for the revival of the Comstock Act, a Victorian-era anti obscenity law that bans the mailing or transport of abortion related drugs and supplies; it hasn't been enforced for decades. But if it were, the result would be tantamount to a national abortion ban.

After almost two years of resisting such sweeping measures, the Trump administration has recently taken a series of steps—the nomination of Todd Blanche as attorney general, a stepped-up FDA review of mifepristone's safety—that could signal a willingness to give conservatives what they want, possibly after the midterms.

Meanwhile, various lawsuits against mifepristone are moving through the federal courts, including the Louisiana case. The 5th Circuit is expected to issue another ruling in the not-too-distant future, and Foster and her colleagues doubt it will go any better than the last time. Until then, Foster says, they are watching, preparing, and serving as many patients as they can. "We try not to get sucked into the noise of all the things that are bad that could happen," she says, "and just do the work."



A typical daily run to the nearby post office includes hundreds of packages bound for all 50 states **Emily Schiffer**

I'M HOPEFUL BECAUSE OF READERS LIKE YOU. WILL YOU PITCH IN TODAY?

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GOVERNOR KATHY HOCHUL



📌 [Reproductive Health \(/keywords/reproductive-health\)](/keywords/reproductive-health)

📌 [Legislation \(/keywords/legislation\)](/keywords/legislation)

FEBRUARY 3, 2025 | Albany, NY

Protecting Reproductive Freedom: Governor Hochul Signs Legislation Affirming New York's Status as a Safe Haven for Reproductive Health Care

Legislation S.36A/A.2145A Allows Providers Prescribing Medications Used To Perform Abortions To Print Their Practice's Name on the Label Rather Than Their Own

Continues Governor's Commitment To Safeguard Abortion Rights and Protect Reproductive Health Care Providers and Patients

[Traducción al español](#)

Governor Kathy Hochul today signed legislation to enable providers who prescribe medications used to perform abortions to request that the dispensing pharmacy print the name of their practice on prescription labels instead of their personal name. Despite attacks on reproductive rights from other states and the federal government, Governor Hochul affirmed her commitment that New York will remain a safe harbor for anyone seeking or providing reproductive health care.

“Reproductive freedom will always be protected in the State of New York — and I’ll never back down from this fight,” **Governor Hochul said.** “I’m taking action to strengthen protections for health care professionals and their patients, ensuring New York is a safe haven for anyone providing or receiving reproductive care. At a time when fundamental rights are under attack across the country, we are doubling down on our commitment to safeguard access to reproductive health care and defend those on the frontlines of this battle.”

<https://www.youtube.com/embed/Q9mh9QNzYRc>

AUDIO

PHOTOS

Protecting the Privacy of Providers and Strengthening New York’s Shield Law

Following the Supreme Court’s troubling decision to overturn the constitutional right to abortion in *Dobbs v. Jackson Women’s Health Organization* in June 2022, various states across the nation have taken steps to limit access to abortion services. As of October 2024, 21 states enacted laws that impose greater restrictions than those previously allowed under *Roe v. Wade*. Among these, 13 states effectively implemented a complete ban, while another four states prohibited abortions after six weeks — a time when many women may not even realize they are pregnant. Over half of women aged 18-49 live in states with some form of abortion restrictions.

Legislation S.36A/A.2145A enhances New York’s shield law by offering additional protections for doctors prescribing medications used to perform abortions to patients in hostile states. This bill would allow prescribers to ask that the dispensing pharmacy print the name of their practice instead of their personal names on the prescription labels for mifepristone, misoprostol and generic alternatives. Governor Hochul reached an agreement with the Legislature to further strengthen these protections. The new measure allows providers to request that their practice address be listed instead, requires notice to the patient, and ensures that pharmacies assist with this protective measure.

Medication abortion has emerged as a crucial option for many individuals seeking abortions in states with hostile laws. In 2023, Governor Hochul signed legislation enacting a telehealth shield law (Chapter 138 of the laws of 2023), designed to provide extensive protection for New York-based doctors serving patients in those restrictive states through telehealth. This legislation safeguards health care practitioners in New York from states that may attempt to impose criminal penalties on them and offers protection from professional disciplinary actions or adverse decisions from medical malpractice insurers.

Thanks to New York's shield law, providers in the State can provide medication used to treat abortion to patients in hostile states, assisting women who might otherwise struggle to access abortion care. Research from the Society for Family Planning indicates that one in five abortions conducted in December 2023 were via telehealth, with an estimated 48 percent of these procedures performed by doctors in states with shield laws like New York's.

“At a time when fundamental rights are under attack across the country, we are doubling down on our commitment to safeguard access to reproductive health care and defend those on the frontlines of this battle.”

Governor Kathy Hochul

State Senate Majority Leader Andrea Stewart-Cousins said, “This bill is a direct response to the growing attacks on reproductive rights nationwide. While other states escalate efforts to criminalize abortion, New York stands firm. We will not allow anti-abortion extremists to intimidate providers or block access to care. I want to thank Senator Mayer for sponsoring this bill and Governor Hochul for her unwavering commitment to reproductive justice. Together, we’re sending a clear message: New York will continue to fight against those who seek to criminalize abortion and will stand firm for everyone’s right to make decisions about their own body and future.”

Assembly Speaker Carl Heastie said, “These laws provide critical protections to our doctors and secure New York’s status as a sanctuary for women seeking access to reproductive care. The Assembly Majority is committed to fighting for a future where women can control their own healthcare decisions without the senseless intrusion of politics. We will continue to work with our state partners to ensure that our healthcare professionals have the legal protections they need to provide care to women across the country.”

State Senator Shelley B. Mayer said, “Today, we take another step to keep New York State in the national leadership in the fight to protect abortion rights. With Governor Hochul’s signature, the bill I sponsored, along with Assemblymember Karines Reyes, R.N., will help strengthen New York’s existing telehealth shield law, providing additional protection to the New York doctors who are helping women in hostile states access abortion. The threats to these doctors are no longer abstract as officials in these states have attacked New York physicians and our laws. This legislation represents a renewal of our commitment to women nationwide and the brave doctors who provide them essential health care. Thank you to Majority Leader Andrea Stewart-Cousins for your continued leadership on this key issue, and deepest thanks to Governor Hochul for signing this critical, life-saving legislation into law. Most importantly, I want to thank the providers whose service reminds us that we can never back down in a fight for our rights.”

Assemblymember Karines Reyes said, “As our country’s women and pregnant persons face the draconian policies of the new Trump Administration in the post-Dobbs landscape, creative solutions are required to achieve reproductive justice. I am honored to join my colleague, Senator Shelly Mayer, in celebrating the passage and enactment of legislation that will enhance our state’s existing abortion telemedicine law by better protecting physicians from personal prosecution and allowing the medical practices to be listed as the requesting entity for prescriptions. This will ensure that as states continue to wrongly exhibit hostility toward women and pregnant persons in our society, New York State will be a leader in promoting personal freedom and access to quality health care. I am thankful that Governor Hochul will take the bold step, as our state’s first woman Governor and mother in the role, to sign this pivotal legislation into law.”

Governor Hochul’s 2025 State of the State Commitment to Protecting Reproductive Rights and Access to Abortion

Sustaining the Reproductive Freedom and Equity Grant Fund

The Reproductive Freedom and Equity Grant Fund was created by Governor Hochul in May 2022 to enhance abortion access and was codified in the State Fiscal Year 2025 budget. This initiative addresses the need for expanded reproductive health care services in New York. The fund has supported reproductive health providers and critical support programs to ensure equitable access to abortion care across the State. This year, Governor Hochul will distribute \$25 million in funding for the program, with a focus on strengthening access to comprehensive reproductive care for all New Yorkers.

Fairly Reimbursing Providers for Abortion Services

For many years, reproductive health providers have not received funding that is adequate to cover the full costs of medication abortion care and other abortion services. As a result, too many

providers have been under immense financial pressures while trying to accomplish their mission of providing safe and accessible abortion care to individuals across the State. Governor Hochul will provide a new flexible funding stream of \$20 million to allow providers to better adapt to this possible impact of the incoming federal administration and ensure that these providers are fairly reimbursed for providing abortions.

Strengthening Reproductive Health Care Infrastructure

Many reproductive health care facilities in New York are in need of critical infrastructure updates in order to provide the full range of comprehensive services. Building on New York's investment in reproductive health providers through the Reproductive Freedom and Equity Grant Fund and security grant funding, Governor Hochul will expand the funding to support critical capital investments for providers. These funds will enable renovations, equipment upgrades, planning and construction to help facilities modernize and secure their operations. This action aims to ensure a broader network of providers can deliver high-quality reproductive health care to all New Yorkers.

Safeguarding Abortion as Emergency Medical Care

The federal Emergency Medical Treatment and Labor Act mandates that hospitals provide stabilizing care for patients with emergency medical conditions, regardless of their ability to pay. However, abortion is not explicitly defined as emergency medical care under New York law. Governor Hochul has prioritized protecting reproductive rights and ensuring equitable access to care. To address this gap, she will codify abortion as protected emergency medical care in New York State and require hospitals to provide this stabilizing emergency medical care, reinforcing access to abortion services when medically necessary.

State Senator Liz Krueger said, “Every step we take to protect abortion access in New York is critical, and I’m glad to see Governor Hochul signing this legislation to strengthen our Shield Law and protect providers delivering critical healthcare. But there is more work to be done, including signing health data privacy legislation and providing funding to expand training for more abortion providers.”

State Senator Michelle Hinchey said, “Healthcare is being criminalized in real time, and our medical professionals are being targeted, their lives and futures at risk simply for doing their jobs. The State of New York will not stand for it. We are a safe haven for reproductive freedom, and we will always fight to protect our healthcare providers and ensure that our most vulnerable neighbors can access the care they need—no matter the attacks we face from states trying to strip away these rights. I thank Governor Hochul for her steady leadership and Senator Shelley Mayer for sponsoring this vital legislation to safeguard the privacy of New York's healthcare providers.”

State Senator Lea Webb said, “As Chair of the Women’s Issues Committee, I am proud to continue championing legislation that protects the rights and safety of those providing and accessing reproductive healthcare. This legislation is a critical step in ensuring privacy and security for healthcare providers, allowing them to continue their essential work without fear. I stand with Governor Hochul, Senate Majority Leader Stewart-Cousins, Attorney General James, Senator Mayer and all my colleagues in support of our medical providers and their efforts to ensure that medication abortion— which is safe and effective — is available to all who need it.”

Assemblymember Amy Paulin said, “I thank Governor Hochul for her actions today, which reaffirm her steadfast commitment to make New York State a safe haven for reproductive freedom and care. Although women around the country are facing tremendous obstacles in accessing abortion care, Governor Hochul embodies New York’s resolve to fight back against these continued attacks on reproductive freedom.”

Assemblymember Linda B. Rosenthal said, “While the Trump administration and some hostile states wage a war on women and their bodies, New York State will remain a safe haven for those seeking or providing reproductive health care. Nearly three years ago, my bills to protect medical providers against professional misconduct charges and adverse medical malpractice actions for providing reproductive healthcare became law. However, as we've seen, there is no end to the efforts of those who want to end a woman's right to bodily autonomy. I thank Governor Hochul for signing into law today another measure that will shield medical providers and preserve access to medication abortion drugs. I look forward to further efforts to protect patients and providers, ensure fair reimbursement and protect the privacy of those seeking care.”

Assemblymember Catalina Cruz said, “In the face of relentless attacks on reproductive rights, New York is standing strong as a safe haven for both patients and providers,” said Assemblywoman Catalina Cruz. “By allowing prescribers to shield their personal information on medication abortion labels, this legislation ensures that those who provide essential reproductive health care can continue to do so without fear of harassment or retaliation. I commend Governor Hochul for her unwavering commitment to protecting reproductive freedom and ensuring that no one in New York is forced to choose between providing care and their own safety. I also congratulate Assemblymember Karines Reyes and Senator Shelley Mayer for their leadership in sponsoring this crucial legislation and for their continued dedication to protecting access to reproductive health care in our state.”

Assemblymember Jessica González-Rojas said, “The Trump administration has already proven it will be an incredibly hostile White House to our reproductive health and freedom. We must use every tool in our toolbox and outside of it to combat this rise of fascism. We cannot go back. I thank Governor Hochul for her decisive action to protect our abortion providers and sustaining the funding for the Reproductive Freedom and Equity grant program we codified into law last year. This new

wave of assaults will require us to be flexible but bold in our resistance. Whether it's reproductive healthcare or gender-affirming care New York must and will lead.”

Contact the Governor’s Press Office

Contact us by phone:

Albany: [\(518\) 474-8418](tel:(518)474-8418)

New York City: [\(212\) 681-4640](tel:(212)681-4640)

Contact us by email:

Press.Office@exec.ny.gov

Translations

Arabic Translation

الترجمة إلى العربية



[DOWNLOAD](#)

Bengali Translation

বাংলা অনুবাদ



[DOWNLOAD](#)

Chinese Translation

中文翻譯



[DOWNLOAD](#)

French Translation

Traduction en français



Post



Gavin Newsom

@GavinNewsom



Louisiana plans to sue me because I won't extradite a doctor for providing an abortion.

[@AGLizMurrill](#): Go fuck yourself. California will never help you criminalize healthcare.

STATE

Louisiana plans to sue California and New York over abortion pill cases

The move stems from two cases in which doctors are accused of mailing abortion-inducing drugs to Louisiana residents, violating state law.

7:43 PM · Feb 5, 2026 · **2.3M** Views

5.3K

9.7K

68K

1.3K





Simple. Private.

How abortion care should be.

The MAP (Massachusetts Medication Abortion Access Project) provides medication to abortion seekers throughout the United States.

We believe abortion care should be available and accessible to everyone.

On our site you can:

- Learn about your options
- Order abortion pills or find a clinic
- Get answers to your questions
- Find support

Find Care Now

Not currently pregnant? [Learn about pills for future use.](#)

Learn About Your Options

You still have options no matter where you live or how far along you are.

✉ Abortion Pills by Mail

Our doctors will discretely mail abortion pills to you, so you can take them at home or wherever is comfortable for you. We offer a pay-what-you-can-afford model, which means you decide the amount that you can pay. We only provide pills by mail during the first 80 days of pregnancy.

- ✓ Done at home
- ✓ Costs between \$5-\$75
- ✓ Effective in 95-98% of cases
- ✓ Abortion process takes 24-48 hours



STATE OF CALIFORNIA
Office of the Secretary of State
STATEMENT OF INFORMATION
CORPORATION

California Secretary of State
1500 11th Street
Sacramento, California 95814
(916) 657-5448

For Office Use Only

-FILED-

File No.: BA20252023910

Date Filed: 10/14/2025

B4084-8340 10/14/2025 11:04 AM Received by California Secretary of State

Entity Details									
Corporation Name	REMY COEYTAUX, MD, PC								
Entity No.	4644888								
Formed In	CALIFORNIA								
Street Address of Principal Office of Corporation									
Principal Address	8911 LAKEWOOD DR SUITE 25 B WINDSOR, CA 95492								
Mailing Address of Corporation									
Mailing Address	PO BOX 215 HEALDSBURG HEALDSBURG, CA 95448								
Attention									
Street Address of California Office of Corporation									
Street Address of California Office	8911 LAKEWOOD DR SUITE 25 B WINDSOR, CA 95492								
Officers									
<table><thead><tr><th>Officer Name</th><th>Officer Address</th><th>Position(s)</th></tr></thead><tbody><tr><td>☒ REMY RENE COEYTAUX</td><td>8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492</td><td>Chief Executive Officer, Chief Financial Officer, Secretary</td></tr></tbody></table>	Officer Name	Officer Address	Position(s)	☒ REMY RENE COEYTAUX	8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492	Chief Executive Officer, Chief Financial Officer, Secretary			
Officer Name	Officer Address	Position(s)							
☒ REMY RENE COEYTAUX	8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492	Chief Executive Officer, Chief Financial Officer, Secretary							
Additional Officers									
<table><thead><tr><th>Officer Name</th><th>Officer Address</th><th>Position</th><th>Stated Position</th></tr></thead><tbody><tr><td colspan="4">None Entered</td></tr></tbody></table>	Officer Name	Officer Address	Position	Stated Position	None Entered				
Officer Name	Officer Address	Position	Stated Position						
None Entered									
Directors									
<table><thead><tr><th>Director Name</th><th>Director Address</th></tr></thead><tbody><tr><td>☒ REMY RENE COEYTAUX</td><td>8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492</td></tr></tbody></table>	Director Name	Director Address	☒ REMY RENE COEYTAUX	8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492					
Director Name	Director Address								
☒ REMY RENE COEYTAUX	8911 LAKEWOOD DR STE 25B WINDSOR, CA 95492								
The number of vacancies on Board of Directors is: 1									
Agent for Service of Process									
California Registered Corporate Agent (1505)	UNITED STATES CORPORATION AGENTS, INC. Registered Corporate 1505 Agent								
Type of Business									
Type of Business	physician for medical practice								
Email Notifications									
Opt-in Email Notifications	No, I do NOT want to receive entity notifications via email. I prefer notifications by USPS mail.								
Labor Judgment									

No Officer or Director of this Corporation has an outstanding final judgment issued by the Division of Labor Standards Enforcement or a court of law, for which no appeal therefrom is pending, for the violation of any wage order or provision of the Labor Code.

Electronic Signature

☒ By signing, I affirm that the information herein is true and correct and that I am authorized by California law to sign.

Remy Coeytaux

Signature

10/14/2025

Date

B4084-8341 10/14/2025 11:04 AM Received by California Secretary of State

FOREIGN CORPORATION QUALIFICATION

*****This document must be accompanied by written proof of existence from the home state, equivalent of a Certificate of Good Standing.*****

The undersigned Corporation for the purpose of qualifying pursuant to the provisions of Title 7 of the Corporations and Associations Article of the Annotated Code of Maryland, to do intrastate, interstate and foreign business as a foreign Corporation in the State of Maryland, hereby certifies to the State Department of Assessments and Taxation:

(A) That the name of the Corporation is:

R. Tucker Limited (F22036503)

(B) The corporation was formed in the State of: District of Columbia

(C) That the address of the Corporation is:

5550 Friendship Blvd., Suite 360, Chevy Chase, MD, 20815

In order to operate in Maryland, will the registering entity require a business or industry license that is issued by the state or any other local agency? No

(D) That the name of the resident agent of the corporation in Maryland is:

Capitol Corporate Services, Inc.

whose address is:

3206 Tower Oaks Blvd., 4th Floor, Rockville, MD, 20852

(Every Foreign Corporation qualified in Maryland is required to name a Maryland Agent)

(E) *(Optional)* That the address of the principal office of the Corporation in Maryland is:

5550 Friendship Blvd., Suite 360, Chevy Chase, MD, 20815

(F) That the Corporation *(check appropriate response)*:

(1) ☐ has (2) ☒ has not done intrastate, interstate or foreign business in this State before qualification or registration as a foreign Corporation or after the qualification or registration was cancelled.

I hereby consent to my designation in this document as resident agent for this corporation.

Robin Tucker

Mary Fink, Officer

Signature of President or Vice President

Signature of Resident Agent

GOVERNMENT OF THE DISTRICT OF COLUMBIA

M

M



CERTIFICATE

THIS IS TO CERTIFY

GOOD STANDING

CERTIFICATE OF

WE FURTHER CERTIFY

IN TESTIMONY WHEREOF I



Josef G. Gasimov

JOSEF G. GASIMOV
Superintendent of Corporations,
Corporations Division

Muriel Bowser
Mayor



Department of the Treasury
Internal Revenue Service
Tax Exempt and Government Entities
P.O. Box 2508
Cincinnati, OH 45201

CHARLENE EISENBERG REPRODUCTIVE HEALTH
COLLABORATIVE INC
C/O ROBIN TUCKER
712 H ST NE STE 1107
WASHINGTON, DC 20002

Date:
March 7, 2023
Employer ID number:
92-0309271
Person to contact:
Name: Customer Service
ID number: 31954
Telephone: 877-829-5500
Accounting period ending:
December 31
Public charity status:
509(a)(2)
Form 990 / 990-EZ / 990-N required:
Yes
Effective date of exemption:
August 4, 2022
Contribution deductibility:
Yes
Addendum applies:
No
DLN:
26053458009023

Dear Applicant:

We're pleased to tell you we determined you're exempt from federal income tax under Internal Revenue Code (IRC) Section 501(c)(3). Donors can deduct contributions they make to you under IRC Section 170. You're also qualified to receive tax deductible bequests, devises, transfers or gifts under Section 2055, 2106, or 2522. This letter could help resolve questions on your exempt status. Please keep it for your records.

Organizations exempt under IRC Section 501(c)(3) are further classified as either public charities or private foundations. We determined you're a public charity under the IRC Section listed at the top of this letter.

If we indicated at the top of this letter that you're required to file Form 990/990-EZ/990-N, our records show you're required to file an annual information return (Form 990 or Form 990-EZ) or electronic notice (Form 990-N, the e-Postcard). If you don't file a required return or notice for three consecutive years, your exempt status will be automatically revoked.

If we indicated at the top of this letter that an addendum applies, the enclosed addendum is an integral part of this letter.

For important information about your responsibilities as a tax-exempt organization, go to www.irs.gov/charities. Enter "4221-PC" in the search bar to view Publication 4221-PC, Compliance Guide for 501(c)(3) Public Charities, which describes your recordkeeping, reporting, and disclosure requirements.

Sincerely,

A handwritten signature in cursive script that reads "Stephen A. Martin".

Stephen A. Martin
Director, Exempt Organizations
Rulings and Agreements



[Home](#) / [File](#) / [Charities and Nonprofits](#) / [Search for Charities](#) / [Search for Tax Exempt Organizations](#) / [Tax Exempt Organization Search](#) / Charlene Eisenberg Reproductive Health Collaborative Inc.

Charlene Eisenberg Reproductive Health Collaborative Inc.

EIN: 92-0309271 | Silver Spring, Maryland, United States

Other Names

CHARLENE EISENBERG REPRODUCTIVE HEA LTH COLLABORATIVE INC

CHARLENE EISENBERG REPRODUCTIVE HEALTH COLLABORATIVE INC

Publication 78 Data

Organizations eligible to receive tax-deductible charitable contributions. Users may rely on this list in determining deductibility of their contributions.

On Publication 78 Data List: Yes

Deductibility Code: PC [?](#)

Determination Letter

A favorable determination letter is issued by the IRS if an organization meets the requirements for tax-exempt status under the Code section the organization applied.

Final Letter(s)

[FinalLetter_92-0309271_CHARLENEEISENBERGREPRODUCTIVEHEALTHCOLLABORATIVEINC_02242023_00.pdf](#)

Form 990-N (e-Postcard)

Organizations who have filed a 990-N (e-Postcard) annual electronic notice. Most small organizations that receive less than \$50,000 fall into this category.

✓ **Tax Year 2025 Form 990-N (e-Postcard)**

✓ **Tax Year 2024 Form 990-N (e-Postcard)**

✓ **Tax Year 2023 Form 990-N (e-Postcard)**

✓ **Tax Year 2022 Form 990-N (e-Postcard)**

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Agreement to Terms of Use

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DISPUTE RESOLUTION: UNLESS YOU TIMELY OPT-OUT OF ARBITRATION IN ACCORDANCE WITH THESE TERMS AND CONDITIONS, YOU AND WE AGREE THAT ALL DISPUTES BETWEEN YOU AND US OR YOU AND THE MEDICAL GROUPS OR PROVIDERS ARISING OUT OF OR RELATED TO THESE TERMS AND CONDITIONS OR THE SERVICE, WITH LIMITED EXCEPTIONS, WILL BE RESOLVED BY BINDING AND FINAL ARBITRATION AND YOU AND WE WAIVE ALL RIGHTS TO A JURY TRIAL AND TO PARTICIPATE IN A CLASS ACTION LAWSUIT OR CLASS-WIDE ARBITRATION, AS FURTHER SET FORTH BELOW. WE EXPLAIN SOME EXCEPTIONS AND HOW YOU CAN OPT OUT OF ARBITRATION BELOW.

IF YOU HAVE A MEDICAL EMERGENCY, SEEK IN-PERSON EMERGENCY CARE IMMEDIATELY OR DIAL 911. THE SERVICE IS NOT APPROPRIATE FOR ALL MEDICAL CONDITIONS OR CONCERNS. THIS AGREEMENT IS SUBJECT TO CHANGE AS PROVIDED HEREIN.

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Community Clinical Learning Grantmaking Research Fellowship Advocacy About

#WECOUNT

#WeCount Report

April 2022 to December 2025

PUBLISHED: JUNE 10, 2026

#WeCount is a reporting effort that captures monthly shifts in the volume of abortions provided within the formal US healthcare system, nationally and by state, following the *Dobbs v Jackson Women's Health Organization* Supreme Court decision to overturn *Roe v Wade*. This report includes data from April 2022 to December 2025.

#WeCount data explorer

Categories & States

Louisiana

Date Range

Apr 2022

TO

Dec 2025

RESET

Start

End

Plot

Table

Export to CSV

State	Month	Total abortions	In-person	Total telehealth	Virtual-only telehealth	Brick-and-mortar telehealth
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Contents

- #WeCount data explorer
- Key findings
- Download the data
- National findings
- Telehealth findings
- Background
- Terminology
- Methods
- Limitations
- Contributors
- Contact us

#WeCount data explorer

Categories & States

Louisiana ▼

Date Range

Apr 2022 ▼

TO

Dec 2025 ▼

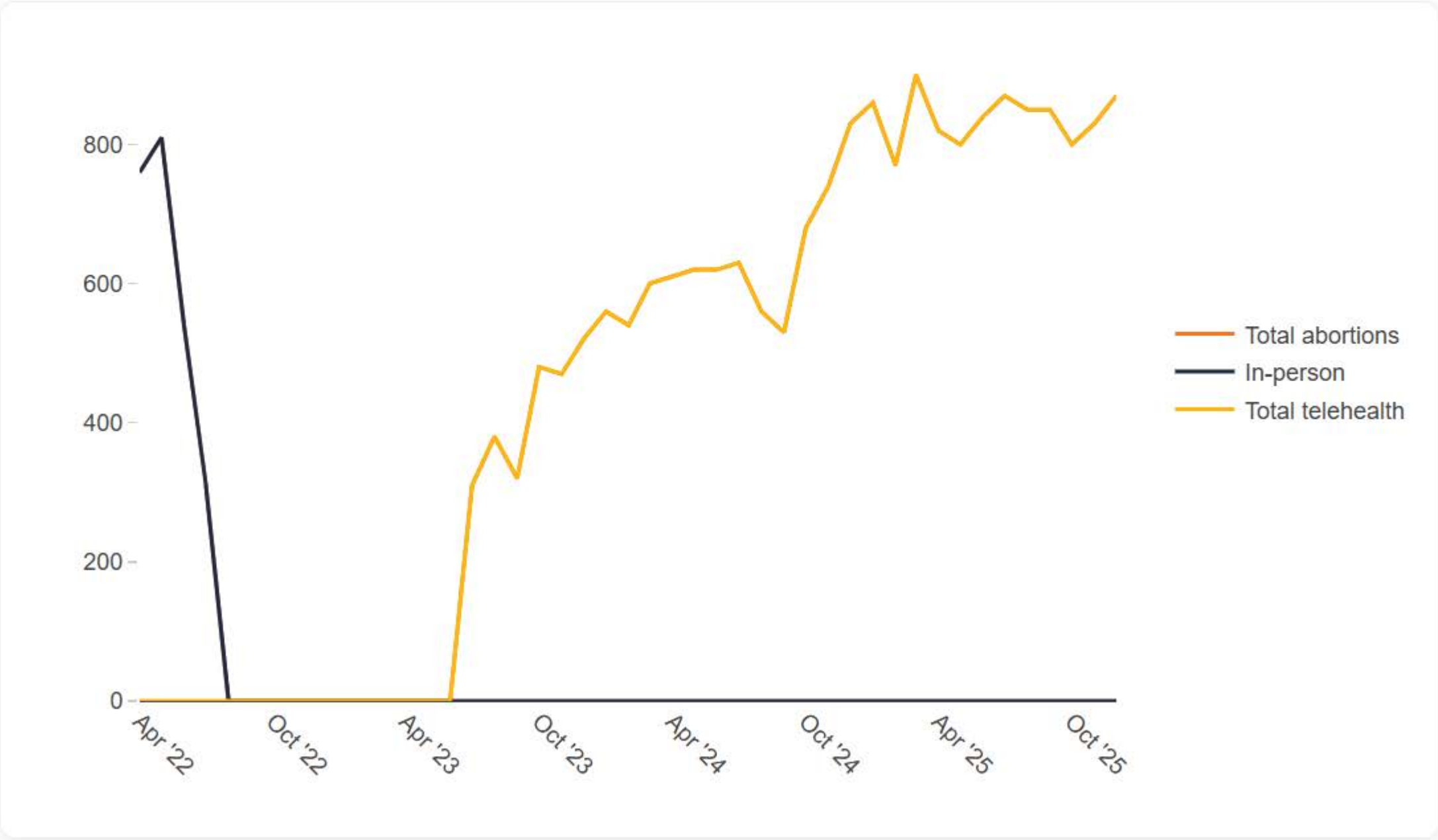
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End

RESET

Plot

Table



#WeCount data explorer

Categories & States

Arkansas

Date Range

Apr 2022

TO

Dec 2025

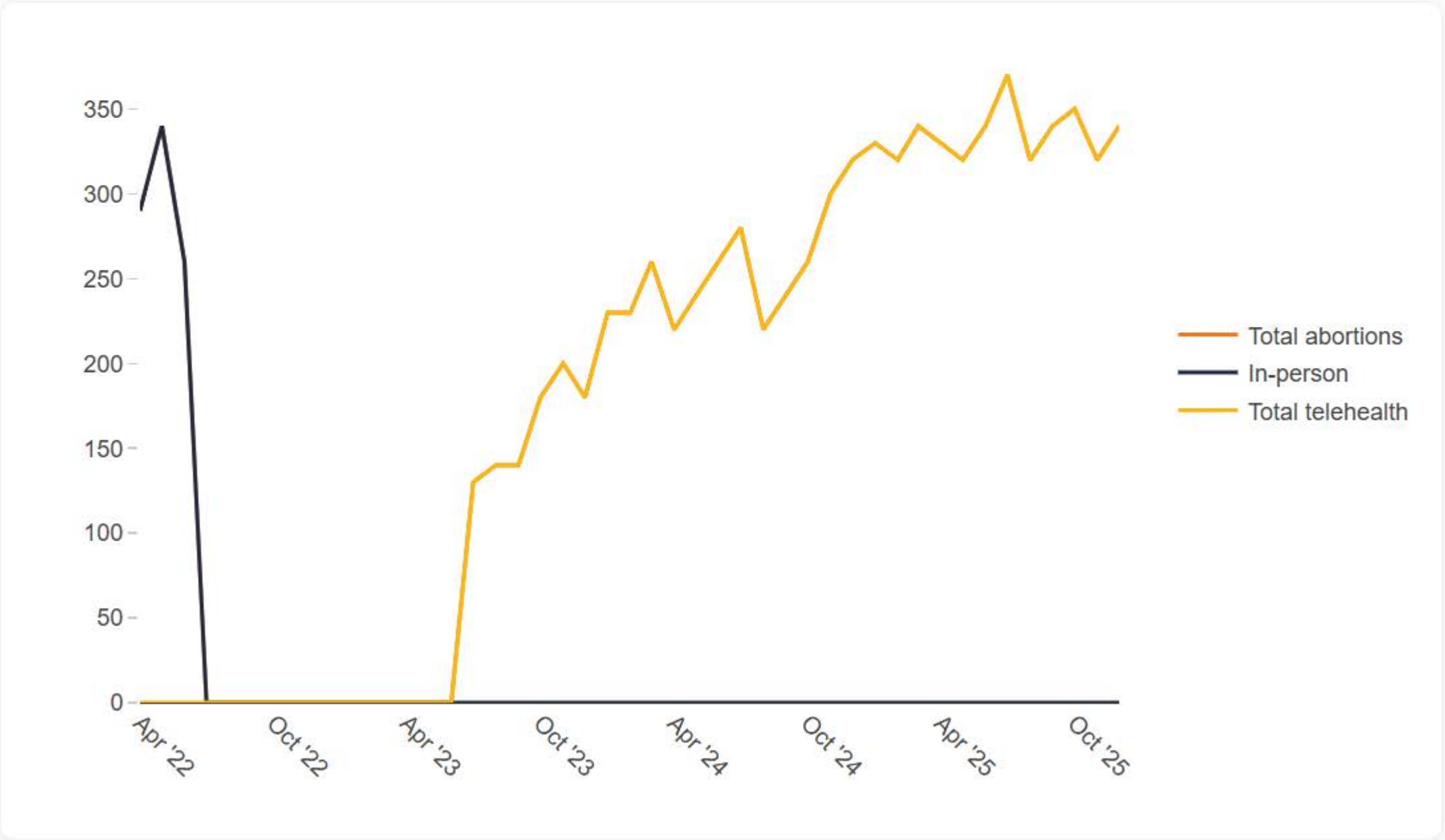
Start

End

RESET

Plot

Table



#WeCount data explorer

Categories & States

Alabama ▼

Date Range

Apr 2022 ▼

TO

Dec 2025 ▼

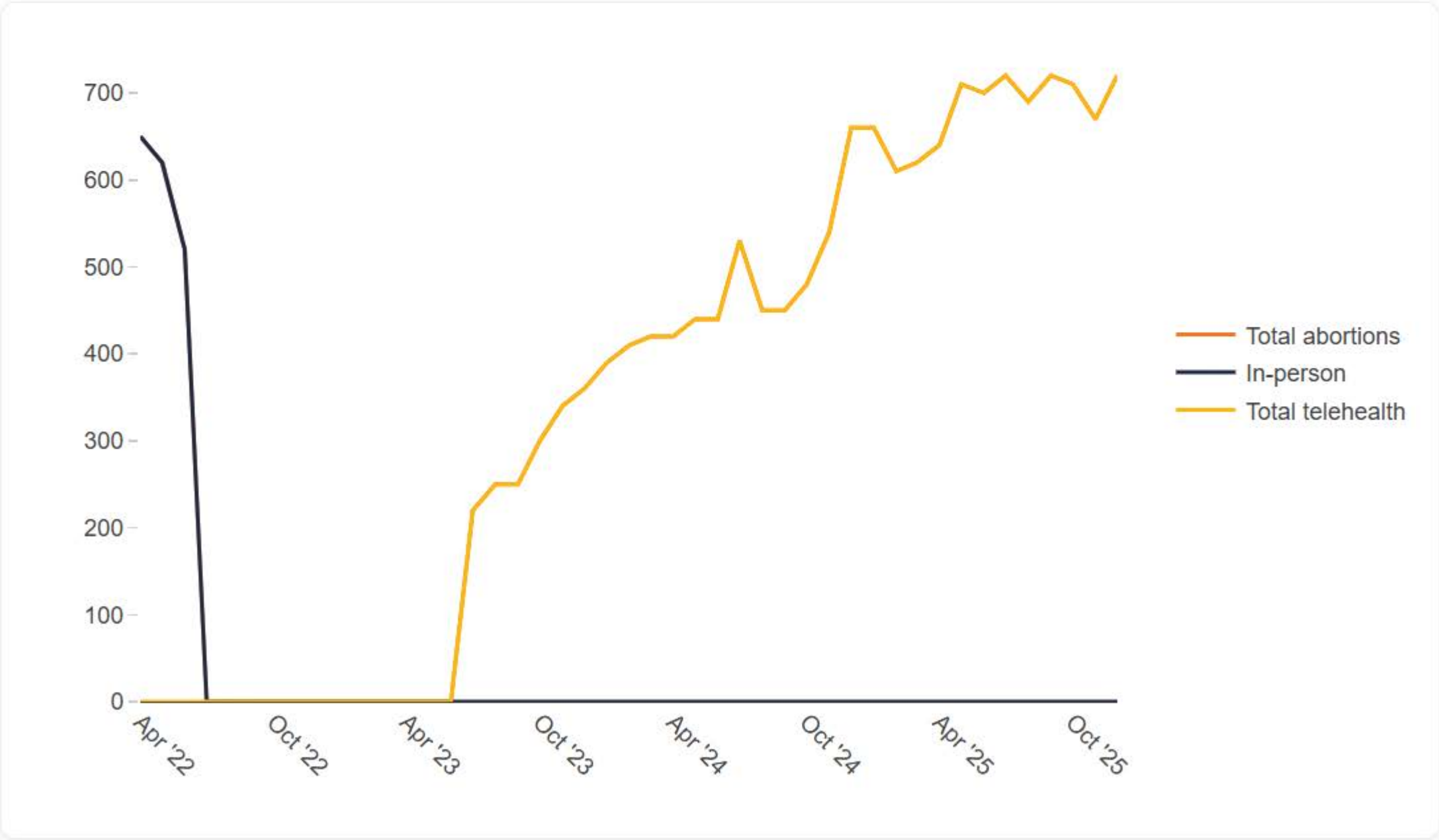
Start

End

RESET

Plot

Table





HOW DO I GET MIFEPREX?



A private & non-invasive choice for safely ending early pregnancy.

Available from a healthcare provider or pharmacy, Mifeprex*(mifepristone) can be taken from the time a woman knows she is pregnant up to ten weeks (70 days) after the beginning of her last menstrual period. Many OB/GYNs, family physicians, other clinicians and pharmacies are providing Mifeprex; you may want to ask your healthcare provider or local pharmacy if they offer Mifeprex.

If your local healthcare provider or local pharmacy is interested in offering Mifeprex, they can do so by visiting either the [Prescribing Mifeprex](#), or, [For Pharmacies](#) section of this website for information on how to become a Mifeprex provider.

For assistance with locating a healthcare provider who offers Mifeprex, you may wish to call the National Abortion Federation (NAF) hot line, 1-800-772-9100, or visit [NAF's web site](#).

Many Planned Parenthood health centers also offer Mifeprex for early pregnancy termination. If you would like to find out if the Planned Parenthood clinic near you offers the early option pill, call toll-free 1-800-230-PLAN or visit [PPFA's web site](#).

Other resources for locating a Mifeprex provider include:

- [Abortion Clinics Online \(ACOL\)](#)
- [Abortion Care Network \(ACN\)](#)
- [Abortion Finder](#)
- [I Need An A](#)

How Do I Get Mifeprex?

[Find a Certified Pharmacy](#)

[Financial support for patients](#)

[Mifeprex State Payer Policies](#)

[Find a provider →](#)



How Do I Get a Medical Abortion?

It starts with a visit to a health care provider - in person or by telemedicine, if permitted in the state where you seek care. Generic mifepristone tablets, 200 mg, are available by prescription from health care providers who have become GenBioPro Prescribers. A 200 mg GenBioPro mifepristone tablet may be given to you by your health care provider or you can fill a prescription for it with a certified pharmacy. Some certified pharmacies send GenBioPro medications by mail and some offer in-store pick up. Neither GenBioPro mifepristone tablets, 200 mg, nor misoprostol, 200 mcg, are available over the counter.

Ask your trusted health care provider or find an abortion care service near you:

Planned Parenthood health centers

Call 1-800-230-PLAN

plannedparenthood.org

National Abortion Federation (NAF) member clinics

Call 1-800-772-9100

prochoice.org

Abortion Care Network (ACN) member clinics

Call 1-202-419-1444

abortioncarenetwork.org

Abortion Clinics Online (ACOL) listings

Call 1-800-455-8130

abortionclinics.com

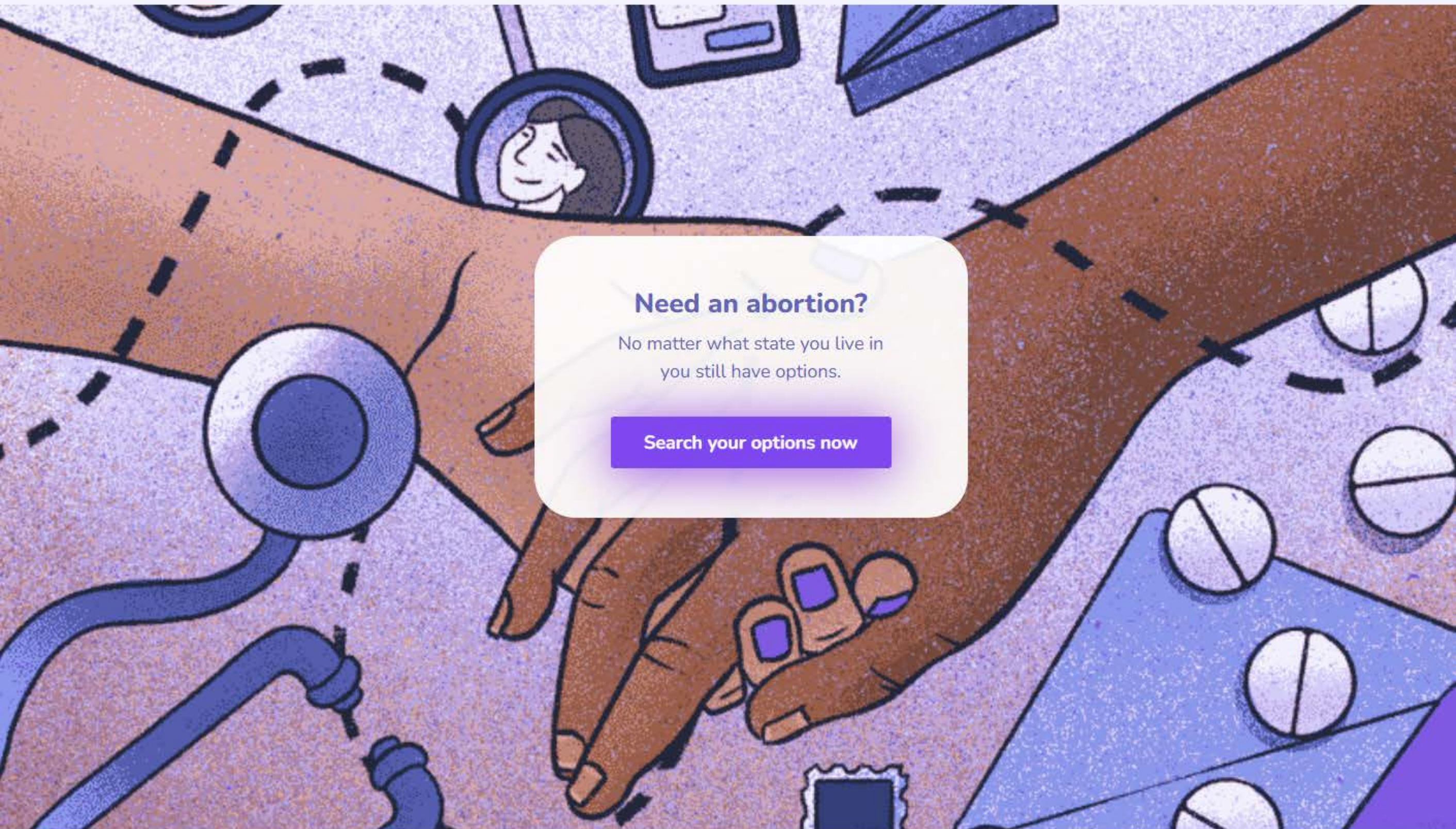
I Need an A

ineedana.com

Abortion Finder

abortionfinder.org





Need an abortion?

No matter what state you live in
you still have options.

[Search your options now](#)

Find verified abortion clinics and abortion pills by mail safely & privately

I Need An A can help you learn about all your abortion options and find the most up to date information about abortion clinics, pills by mail, state abortion laws, and support. We've designed ineedana.com to protect your privacy by not storing anything you enter when you [search your options](#) and keeping your digital footprint small.

If you are using a shared device and trying to keep your information private, we recommend you remove this site from your browser history and in the future use "incognito" or "private" browsing to look up information.

[Get more info on digital privacy](#)



Home > All states > Louisiana

Abortion Access Guide in Louisiana

Doctors have been banned from performing abortions in Louisiana, but you still have options. People in Louisiana can travel to nearby states or [order abortion pills by mail](#). I Need An A helps people compare abortion clinics, pills by mail, costs, financial support, and legal information based on their situation.



Find all your abortion options

Providers, laws, costs, and support updated daily

Search now

Your options: order pills or travel to a clinic



Order abortion pills online

Pills can cost an estimated \$150 or less and arrive in 2-5 days. Taking pills on your own is medically very safe, but may come with legal risk.

Vetted providers in Louisiana

- [The MAP / Cambridge Reproductive Health Consultants](#)
- [Southern Woven](#)
- [We Take Care of Us • Nos Cuidamos](#)
- [Abuzz](#)
- [Choices Rising](#)
- [At Home Abortion via provider in "shield law" state](#)
- [Community Networks in Louisiana](#)
- [Women On Web](#)



Travel to an out-of-state clinic

You can travel out of state to get an in-person abortion. Based on distance and clinic accessibility, these are the most practical clinics for residents of the major cities in Louisiana:

Destinations accessible from [Lafayette](#)

- 1 clinic in [Springfield, MO](#) (~10½ hr drive)
- 3 clinics in Marion-Herrin, IL (~11 hr drive)
- 2 clinics in [St Louis, MO](#) (~2 hr flight) ✈️
- 5 clinics in [Tampa Bay, FL](#) (~2½ hr flight) ✈️

Destinations accessible from [New Orleans](#)

- 1 clinic in [Springfield, MO](#) (~12 hr drive)
- 3 clinics in Marion-Herrin, IL (~10½ hr drive)

- [Aid Access](#)
- [A Safe Choice](#)
- [Community Network - AccessMA](#)
- [Abortion Pills In Private](#)
- [Her Safe Harbor](#)
- 2 clinics in [St Louis, MO](#) (~2 hr flight) ✈️
- 5 clinics in [Tampa Bay, FL](#) (~2½ hr flight) ✈️

Find all your options with search



Current Louisiana Abortion Laws

Abortion is mostly banned in Louisiana, but you still have options ❤️

Under [Louisiana Revised Statutes § 40:1061.1.3](#), providers can only provide abortion care in very limited situations, such as to prevent a serious health risk to the pregnant person.

These laws apply to providers — not the person having an abortion. In fact, the law specifically says it cannot be used to punish the person who has an abortion. In simple terms, self-managed abortion is not a crime in Louisiana.

Here are other key pieces of legal context to consider when exploring your options in Louisiana:

- Abortion pills by mail are available in every state including Louisiana. Self-managed abortion is not a crime.
- Although telehealth abortion is not permitted in Louisiana, people can still order abortion pills online. Louisiana law does not criminalize taking abortion pills, but what the law says can be different than what happens in reality.

- Traveling out of Louisiana to get an abortion in another state is not a crime. If you [decide to travel](#), you can go to another state where abortion is legal and get care there.
- Louisiana law allows abortion only in very limited situations, such as to save the life of the patient, to protect the physical health of the patient, or in the case of serious fetal anomaly.
- Even when someone qualifies for an exception, it can be very hard to find a provider who will offer care. You can find exceptions-based care information on [this map](#).

If you have questions about legal risk or your rights, call the [Repro Legal Helpline](#) at 1-844-868-2812.

Collapse additional legal info

Learn more about the laws in Louisiana at Repro Legal Helpline →

This legal information is sourced from the [Abortion Policy API](#). It was last refreshed on September 24, 2026. If you see issues, please contact us.

Frequently asked questions



How much do abortions cost in Louisiana?





What if I need help paying?



What's an in-clinic abortion like?



What happens with abortion pills?



What are the abortion laws in Louisiana?



I need help. Who can I talk to?



The most important thing to know: You're not alone.

People from all walks of life have abortions. These are some of their stories.

audio 2+ abortions +13

video self managed +8

**Amy, 46 (Cincinnati, Oh
1991/92 & New Orleans,
La 2010/11)**

 Podcast length 43:06

Listen @ The Abortion Diary

**How I Had an Abortion
at Home in Texas**

 Video length 8:54

Watch @ Press

video written +9

***One misconception
about people who get
abortions is that we're...***

 Video length 4:46

Watch @ WeTestify

See more stories



Search for all your abortion options

Learn about your abortion options, exact costs, &
support with our search tool

Search now

Find abortion options in Louisiana cities

Baton Rouge

New Orleans

Lafayette

Shreveport

Monroe

Find abortion options in other states

Alabama

Kansas

Alaska

Kentucky

Arizona

Maine

Arkansas

Maryland

California

Massachusetts

Colorado

Mexico

Connecticut

Michigan

Delaware

Minnesota

District of Columbia

Mississippi

Florida

Missouri

Georgia

Montana

Hawaii

Nebraska

Idaho

Nevada

Illinois

New Hampshire

Indiana

New Jersey

Iowa

New Mexico

New York	South Dakota
North Carolina	Tennessee
North Dakota	Texas
Ohio	Utah
Oklahoma	Vermont
Oregon	Virginia
Pennsylvania	Washington
Puerto Rico	West Virginia
Rhode Island	Wisconsin
South Carolina	Wyoming

Your safety and privacy are our top priorities

As such, we'll never ask you for personally identifiable information or store anything you've input.

If you are using a shared device and trying to keep your information private, we recommend you remove this site from your browser history. We can help you [learn how](#) to do that and other ways to reduce your digital footprint.

[Learn more about privacy](#)



About ineedana.com

Built by people who've had abortions for people who will, ineedana.com launched in 2016 as the first comprehensive and regularly updated resource for abortion seekers in the US. Since then, we've been called the "Quintessential Post-Roe Resource" by The Nation, appeared on John Oliver's Last Week Tonight, and, most importantly to us, have helped more than 3 million people learn about their options. As a small and independent non-profit project, we couldn't do it without the support of our volunteers and donors.

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Find all your abortion options

Providers, laws, costs, and support updated daily

Search now 



Frequently Asked Questions

 Search...

About our service

- How does The MAP work?
- Is this a legitimate service?
- What pills-by-mail services does The MAP provide?
- How long will it take for me to get medications?
- How much does it cost?
- How can you provide these medications so affordably?
- Why wasn't I eligible for abortion pills by mail through The MAP?
- How do I get in touch with you if I have questions?

Abortion Options

- How do abortion pills work?
- How do abortion procedures work?
- Is abortion legal in the US?

With the overturn of Roe v. Wade by the US Supreme Court in June 2022, abortion laws can be different in each state. But no matter where you live, there are still ways to get an abortion.

Even though abortion is illegal or restricted in some states, it is protected in others. Doctors and medical professionals in certain states where abortion is protected may prescribe abortion pills by mail, even if you live in a state where it is banned or restricted. It is also legal to travel to another state to get an abortion at a clinic.

Most people are not at risk of getting in legal trouble for having an abortion. In rare cases, people have faced increased risk of legal trouble if they live in a state where abortion is banned or restricted and are more than 13 weeks pregnant, have told people who can't be trusted about their plans to get an abortion or that they had an abortion, or are in a violent or controlling relationship.

If you have more legal questions about abortion or want to learn about what you can do to protect yourself, you can talk to a lawyer for free at the Repro Legal Helpline — call or text 1-844-868-2812.

- Do my abortion options depend on the state I am in?
- Do my abortion options depend on how many weeks pregnant I am?
- What are my abortion options if I'm under 16 years old?
- Who can I talk to about legal questions?



Frequently Asked Questions

 Search...

About our service

How does The MAP work?



We work with doctors in Massachusetts to prescribe FDA-approved abortion medication to patients anywhere in the US who meet eligibility for the medications and apply through our website.

You will complete the intake form to provide some basic information about you, your pregnancy, and your medical history. You will also provide contact, shipping, and payment details.

Within 1-12 hours, your intake form will be reviewed by a licensed clinician. If you are under 80 days pregnant, are 16 years of age or older, and have no medical conditions that would make taking abortion pills unsafe, they will write you a prescription. In some cases, we will ask for more information or request that you have an ultrasound before prescribing pills.

After you have been prescribed pills, we will process your payment and ship the medication to you with detailed instructions. We will send you the tracking information so you can keep track of your package.

The pills arrive in the mail, and you take them at home or wherever is comfortable for you.

We will also follow up with you after you receive the pills in the mail. We will follow up again 4-6 weeks after you receive the medication, and a clinician will contact you if you need anything.

Is this a legitimate service?



What pills-by-mail services does The MAP provide?



How long will it take for me to get medications?



How much does it cost?



How can you provide these medications so affordably?



Why wasn't I eligible for abortion pills by mail through The MAP?



How do I get in touch with you if I have questions?





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[Blog](#)

[Visit Doctor's Website](#)

[Support & Resources](#)

[Contact](#)

Medication Abortion. Discreetly Delivered.

We are **a referral network of caring and experienced medical doctors** who provide safe, private, and effective medication abortions to women nationwide. Shipped discreetly to all 50 states.



Trusted By:

 English

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WayBack Machine

https://asafechoicenetwork.com/

Go

MAY 2025

JUL 12 2026

SEP 2027

69 captures
7 Nov 2024 - 21 Sep 2026















About this capture

Privacy, confidentiality, and data security +

Abortion Shield Law +

Possible legal risks to you —

The legal risk for having an abortion depend on the state in which you live. To learn more, please go to the [Repro Legal Helpline](#) or call them at 884-868-2812. You can also learn more through the [Plan C website](#).

In-person clinics In-person abortion clinics usually offer both abortion pills and abortion procedures. To find the nearest clinic to Louisiana, use this search tool.	 Abortion clinics serving Louisiana Plan C clinic listings Find clinics in or near Louisiana for in-person care options. plancpills.org/abortion-clinic/louisiana	 Comprehensive clinic and support finder I Need an A A complete and up-to-date resource for people seeking abortion services in the US. ineedana.com/us/louisiana
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↑ [Back to top](#)

Frequently asked questions	How do people choose a provider? 
	Is this legal? Can someone get in trouble for using abortion pills in Louisiana?  • Research shows that hundreds of thousands of people in the United States have received and used pills by mail over the past few years with no legal problems. • But, in rare cases (less than 1%), people have gotten in legal trouble, even though most states, including Louisiana, don't have laws against doing your own abortion.



STATE OF CALIFORNIA

Office of the Secretary of State

STATEMENT OF INFORMATION

CORPORATION

California Secretary of State

1500 11th Street

Sacramento, California 95814

(916) 657-5448

For Office Use Only

-FILED-

File No.: BA20260123108

Date Filed: 1/16/2026

Entity Details

Corporation Name

Entity No.

Formed In

A Safe Choice Network Inc.

B20260021522

CALIFORNIA

Street Address of Principal Office of Corporation

Principal Address

455 MARKET ST STE 1940 #611906

SAN FRANCISCO, CA 94105

Mailing Address of Corporation

Mailing Address

455 MARKET ST STE 1940 #611906

SAN FRANCISCO, CA 94105

Attention

Street Address of California Office of Corporation

Street Address of California Office

455 MARKET ST STE 1940 #611906

SAN FRANCISCO, CA 94105

Officers

Officer Name	Officer Address	Position(s)
Margaret Simeone	PO BOX 2151 HEALDSBURG, CA 95448	Chief Executive Officer, Secretary, Chief Financial Officer

Additional Officers

Officer Name	Officer Address	Position	Stated Position
None Entered			

Directors

Director Name	Director Address
Margaret Simeone	PO BOX 215 HEALDSBURG, CA 95448

The number of vacancies on Board of Directors is: 0

Agent for Service of Process

California Registered Corporate Agent (1505)

UNITED STATES CORPORATION AGENTS, INC.

Registered Corporate 1505 Agent

Type of Business

Type of Business

Health and wellness

Email Notifications

Opt-in Email Notifications

No, I do NOT want to receive entity notifications via email. I prefer notifications by USPS mail.

Labor Judgment

No Officer or Director of this Corporation has an outstanding final judgment issued by the Division of Labor Standards Enforcement or a court of law, for which no appeal therefrom is pending, for the violation of any wage order or provision of the Labor Code.

Electronic Signature

☒ By signing, I affirm that the information herein is true and correct and that I am authorized by California law to sign.

Remy Coeytaux

Signature

01/16/2026

Date

B4333-9763 01/16/2026 5:10 PM Received by California Secretary of State



WATCH PARTY PACKS

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ABOUT

Access to the abortion pill, which safely and effectively ends a pregnancy up to 12 weeks, **has never been more threatened**, directly impacting the lives and rights of people all over America. In spite of being approved by the FDA more than two decades ago and being used in more than half of all abortions in the United States, misinformation about abortion medication is rampant and, in some states, access is largely withheld. Our urgent, timely documentary **PLAN C** had its **world premiere at the 2023 Sundance Film Festival** amidst the ongoing public health emergency post-Roe v. Wade. Our film follows **Francine Coeytaux**, a public health expert and the co-founder of the organization [*Plan C*](#), as **she and her team fight to expand knowledge of - and access to - the abortion pill across the United States**. The film reveals the grassroots network and pipelines Plan C built, the criticism they faced, and **the hope they have for the future**.



How Mississippi Residents Can Get Abortion Pills in 2026: 3 Private Paths

 June 26th, 2026

Navigating Mississippi's Abortion Restrictions

Mississippi was at the center of the legal case that overturned Roe v. Wade, and its trigger law now bans abortion at every stage of pregnancy. The state has even taken the position that mailing abortion medication into Mississippi could be a crime. But there is still a way forward. Shield-law providers like A Safe Choice can prescribe and ship abortion pills in Mississippi legally, and advanced provision lets you have them on hand.

 English

even need them. This guide explains the legal landscape, how medication abortion works, and how to get abortion pills in Mississippi privately and safely.

No judgment. Just the facts.

What Mississippi's Law Says Right Now

Mississippi has a near-total abortion ban. The state's trigger law, which took effect after the Supreme Court's 2022 Dobbs decision, prohibits abortion at every stage of pregnancy. The law explicitly bans the use of any medicine or drug to terminate a pregnancy, with narrow exceptions only to save the life of the pregnant person or in cases of rape where a formal charge has been filed with law enforcement.

Mississippi's attorney general has also argued that mailing abortion pills into the state could be punishable by up to five years in prison. While enforcement against out-of-state providers operating under shield laws remains legally uncertain, the practical effect is that no clinics inside Mississippi provide abortion care, and the state takes an aggressive posture toward anyone facilitating abortion within its borders.

Because in-state access is nonexistent, many Mississippians now rely on telehealth providers based in states with shield laws. These laws protect doctors who prescribe and mail abortion pills to people in Mississippi and other restricted states. It is a proven, legal pathway that thousands of people use



every year to get abortion pills in Mississippi and other banned states.

How Abortion Pills Work

Medication abortion uses two [FDA-approved medications](#): mifepristone and misoprostol.

You start with mifepristone, which blocks progesterone, the hormone your body needs to maintain a pregnancy. Then, 24 to 48 hours later, you take misoprostol. This second medication causes your uterus to contract and pass the pregnancy, similar to how a miscarriage occurs naturally.

The experience is typically compared to a heavy period. Cramping and bleeding generally last four to seven days, with lighter spotting possible after that. Nausea and diarrhea may occur for a few hours after taking misoprostol, but these effects are temporary.

The two-drug regimen is about 96 to 98 percent effective in early pregnancy. Serious complications happen in fewer than one percent of cases. Be alert for warning signs: soaking through two pads per hour for two consecutive hours, severe stomach pain that does not go away, or a high fever. If any of these occur, go to an emergency room. You can say, "I am pregnant and bleeding," and you will receive the care you need. You are not required to mention the pills.

Getting Abortion Pills in Mississippi Through A Safe Choice

A Safe Choice is a telehealth network of licensed doctors who provide medication abortion care. They partner with Optio Women's Health, an online clinic operating under California's shield law. Their physicians are legally protected when they prescribe and ship abortion pills to people in Mississippi and other states with restrictions.

The process is simple and private. Visit asafechoicenetwork.com and fill out a secure health intake form. No account is needed. The form asks about your medical history, current medications, and your last menstrual period if you know it. A licensed physician reviews your information, and if you are eligible, they prescribe the standard mifepristone and misoprostol regimen so you can get abortion pills in Mississippi without leaving your home.

The total cost is \$150. That covers the medications, the clinical review, shipping, and follow-up support. Packages are sent via USPS Priority Mail in plain, unmarked packaging and arrive within two to three business days. Nothing on the outside indicates what is inside.

You also have phone access to licensed doctors throughout the entire process. When your medications arrive, you will have clear, step-by-step written instructions to guide you.

Advanced Provision: Order Before You Need Them

Here is one of the most important things to know about A Safe Choice: you do not have to be pregnant to order. This is called advanced provision, and in a state like Mississippi, it can make all the difference.

Because Mississippi's laws make it impossible to access abortion care in-state and the state has taken an aggressive stance against mailing abortion medication, having pills already on hand means you avoid the legal gray area of shipping entirely. If you already have the pills at home, that problem goes away. You do not need a pregnancy test to order through advanced provision. Misoprostol has a shelf life of about two years, and mifepristone lasts about five years. Store them in a cool, dry, dark place, and they will be ready if and when you need them.

No pregnancy test. No account. Completely confidential.

Your Privacy Matters

A Safe Choice prioritizes your privacy. No account is required, and their processes are built to protect your health information. The packaging is completely discreet.

You can take additional steps to protect yourself. Use a private email address unconnected to your regular accounts. Delete confirmation emails after saving your tracking in



English

you share a device, clear your browsing history after visiting the site. Keep your medications somewhere secure and private.

If you need emergency medical care at any point, you do not have to tell anyone you took abortion pills. Simply tell the provider you are pregnant and bleeding. They are trained to treat complications from pregnancy loss and will take care of you.

What About the Law and Your Safety?

This is a concern for many people, so let us be direct.

Mississippi's laws are written to target providers and facilitators of abortion services, not individuals who take abortion pills.

Mississippi's statute expressly exempts the pregnant person from prosecution. No person in the U.S. has been successfully convicted of a crime solely for taking abortion pills, though a small number of people have been arrested and charged. In every documented case where charges were filed, they were later dropped. Mississippi's law expressly exempts the pregnant person from prosecution and targets those who perform or facilitate abortion, not the person taking the medication. Still, it makes sense to be thoughtful and protect your privacy.

The Repro Legal Helpline at 844-868-2812 is a free, confidential resource staffed by lawyers who specialize in these questions. If you are unsure about your situation, give them a call.



Resources That Can Help

Whether you need legal information, financial help, or emotional support, organizations are ready to stand with you.

The Repro Legal Helpline (844-868-2812) offers free, confidential, state-specific legal guidance. The All-Options Talkline (1-888-493-0092) is a non-judgmental line for anyone navigating a pregnancy decision. The Mississippi Reproductive Freedom Fund and the Yellowhammer Fund, which serves the broader Deep South region, are strong regional resources for financial assistance and practical support. The National Network of Abortion Funds can also help connect you with funding and logistics.

And of course, A Safe Choice is available at asafechoicenetwork.com or by phone at (707) 710-8866.

Frequently Asked Questions

Can I get abortion pills in Mississippi through telehealth?

Yes. Doctors in shield-law states like California can legally prescribe and mail abortion pills in Mississippi, even though no in-state clinics can provide them. Telehealth and advanced provision are the main paths for Mississippians today.

Is it legal for out-of-state doctors to send pills to Mississippi?

Doctors in shield-law states are protected in their home jurisdictions. Mississippi's attorney general has taken an aggressive stance, but the law targets providers



English

US.

For specific guidance, call the Repro Legal Helpline at 844-868-2812.

Are there any abortion clinics in Mississippi?

No. Mississippi's near-total ban means no clinics currently provide abortion care in the state. People often travel to Illinois, use a telehealth provider, or arrange to get abortion pills in Mississippi ahead of time through advanced provision.

Can I order pills before I am pregnant?

Yes. Advanced provision is available through A Safe Choice. No pregnancy test is needed. Misoprostol stays effective for about two years and mifepristone for about five years when stored properly. This is especially important in Mississippi, where having pills already on hand avoids the legal gray area of shipping after a pregnancy is confirmed.

What does it cost?

The flat fee is \$150, covering everything: medications, clinical review, USPS Priority shipping with tracking, and follow-up support.

Mississippi's near-total ban creates genuine and serious barriers. But options still exist, and you do not have to face this alone. Whether you order in advance, connect with a telehealth provider, or reach out to a local organization, people are ready to help you make the decision that is right for your life.

Contact A Safe Choice at asafechoicenetwork.com or by calling (707) 710-8866. For legal questions about your specific situation, the Repro Legal Helpline is at 844-868-2812



English

You deserve clear information, real privacy, and care that treats you with respect.

Legal information is current as of July 2, 2026. Laws can change rapidly. Readers should verify current laws and consult the Repro Legal Helpline at 844-868-2812 for personalized legal guidance.



Related Resources

For more context before ordering, read our guides to [buying abortion pills online safely](#), [mifepristone](#), and [misoprostol](#). These resources explain how the medications work and what to consider when using telehealth in Mississippi.



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[Contact Us](#)

A Safe Choice and the doctors in our network will never give or sell any of your information. We use the best and latest data security technology to ensure that whatever information you share with us stays with us.



Medication Abortion via Telehealth

Safe, private, and trusted care
from OPTIO Women's Health.



OPTIO is proud to be A Safe Choice network member.

OPTIO is a medical practice that offers **medical abortions via telehealth to people everywhere in the United States.**

If your pregnancy is less than 13 weeks along, or if you are not pregnant and want to have abortion pills for future use, we can help you.

We offer **free (optional) medical consultations with a licensed doctor (M.D.)** by telephone (telehealth) or via a confidential online form. We take great care in protecting your privacy every step of the way.

Your Choices

Stay Safe: Read the digital privacy tips

Quick Exit (esc)



We offer a streamlined and secure way to serve our patients. To begin, please **fill out this form**.



You can schedule a free telephone consultation (optional) with an OPTIO doctor by **clicking here**.



You can also ask us a question via our **secure contact form here**.

More Information:

What is a medication abortion?



What is a telehealth medication abortion?



How safe and effective is a telehealth medication abortion?



What is the price and what is included?



Is a telehealth consultation with an
OPTIO medical doctor really free?



Do I really have to talk to an OPTIO medical doctor?



How do I request a medication abortion?



How do I communicate with OPTIO medical doctors?



Stay Safe: Read the digital privacy tips

Quick Exit (esc)

What are abortion pills?



What is mifepristone?



What is misoprostol?



How is my identity and information kept safe and private?



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Payments accepted





HOME > SUPPORT AND RESOURCES

Support and Resources

Helpful websites

These organizations provide trusted information, support services, and guidance for people seeking abortion care. Find help with finding clinics, understanding your rights, and accessing medical support.

[Plan C Pills](#)

[Miscarriage and Abortion Hotline](#)

[Abortion Finder](#)

[I Need an Abortion](#)

[Repro Legal Helpline](#)

Recent News Stories

Journalism covering telehealth abortion access, legal developments, and public health research. Stay informed about policy changes affecting medication abortion access across the United States.

Thanks to Shield Laws in Five States" (*Ms. Magazine*)

"8,000 women a month get abortion pills despite their states' bans or restrictions" (*PBS*)

"Will Florida's Strict Six-Week Ban Be Bypassed by Abortion by Mail?" (*Tampa Bay Times*)

"Unanimous Supreme Court Preserves Access to Widely Used Abortion Medication" (*AP News*)

"Medication Abortion Now Accounts for More Than Half of All US Abortions" (Guttmacher Institute)

Research Articles

Peer-reviewed clinical research published in leading medical journals demonstrating the safety, effectiveness, and acceptability of telehealth medication abortion services.

Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided Via Telemedicine: A National Cohort Study (*BJOG: An International Journal of Obstetrics & Gynaecology*)

Effectiveness and Safety of Telehealth Medication Abortion in the USA (*Nature Medicine*)

Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine in the United States: A Population Based Study (*The Lancet Regional Health Americas*)

Scoping Review (*npj Digital Medicine - Nature*)

Outcomes and Safety of History-Based Screening for Medication Abortion:
A Retrospective Multicenter Cohort Study (*JAMA Internal Medicine*)

Telehealth vs In-Clinic Medication Abortion Services (*JAMA Network Open*)

Medication to Manage Abortion and Miscarriage (*The Journal of General
Internal Medicine*)

The Provision of Abortion Care via Telehealth in the United States: A Rapid
Review (*The Journal of Midwifery & Women's Health*)

Abortion Safety and Use with Normally Prescribed Mifepristone in Canada
(*The New England Journal of Medicine*)

Comparison of medication abortion outcomes at less than and greater
than 6 weeks gestation (*Contraception*)

Clinical Guidelines

Official clinical practice guidelines and recommendations from leading medical
organizations including WHO, ACOG, FDA, and NAF for medication abortion care.

World Health Organization (WHO)

American College of Obstetricians and Gynecologists (ACOG)

US Food and Drug Administration (FDA)

National Abortion Federation (NAF)

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Quick Exit (esc)

Society of Family Planning and Society for Maternal-Fetal Medicine



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Request Medication

The process to request medication abortion pills is highly confidential and secure. You're simply asked to provide some relevant personal and medical information to be reviewed by a licensed physician and pay an order fee of \$140 USD.

The \$140 fee covers the cost of:

- Medication (1 mifepristone pill + 12 misoprostol pills)
- Discreet shipping via US Postal Service Priority Mail
- Clinical support via telephone or secure messaging

Questions? Call 707-710-8866 or email doctor@optiowomenshealth.com

Cancel

Continue

You will be billed as OPTIO WOMEN'S HEALTH

Questions or issues ordering? Please call us at

 707-710-8866

What happens after you pay

Stay Safe: Read these digital privacy tips

- 2 Approved? Your order typically ships the next morning.
- 3 Not approved? You receive a full refund.
- 4 Questions later? You can reach your doctor — and your order arrives with detailed instructions written by our doctors.



OPTIO is proud to be **A Safe Choice network member.**



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Aid Access

[Get Pills Now](#)

[How to use abortion pills](#)

[Pill Access by State](#)

[FAQ](#)

[About us](#)



ES

[I need an abortion](#)

Get Abortion Pill Online in Louisiana - Order Here

You can buy an abortion pill online and get it by mail in Louisiana. The FDA has approved abortion pills by mail. Aid Acces works with U.S. based abortion providers in so called shield law states (this means that the states will protect the providers against legal action). Therefor Aid Access can provide abortion services to all 50 U.S. states including Louisiana.

Aid Access will help you order abortion pills and have them delivered to your home in New Orleans, Baton Rouge, Shreveport, Metairie, Lafayette, or anywhere else in Louisiana.

Louisiana abortion pill online orders:



X Quick Exit
(<https://www.google.com/>)

(<https://www.abuzzhealth.com>)

Need abortion care at home?

Get access today
(<https://www.abuzzhealth.com/form/>)





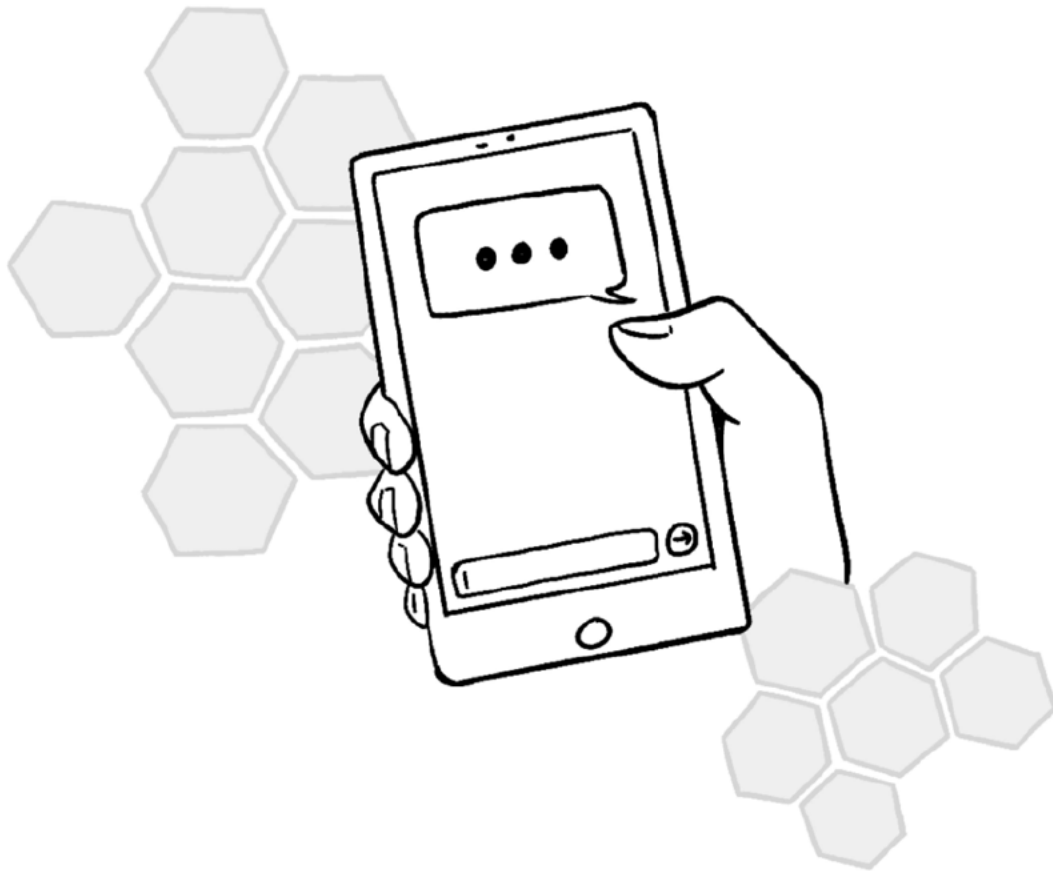
Fast, discreet shipping.

Packages arrive in 2-5 days. Medications are shipped in a plain mailing envelope.



Affordable care for everyone.

Accessing safe and affordable healthcare is a fundamental right. Services are available for \$0-145 sliding scale.



The support you need, when you need it.

An experienced medical team is here to answer your questions, provide support, and guide you through the process.

***Abuzz may be able to help
you if...***



You're less than 13 weeks pregnant.

You must be less than 13 weeks pregnant to access abortion through Abuzz. Remember that pregnancy is measured from the first day of your last menstrual period, which is around two weeks before conception.

How do I estimate the length of my pregnancy? →
(<https://www.abuzzhealth.com/pregnancy-calculator/>)

You're comfortable with virtual abortion care.

In most cases, providers do not require a phone call or video visit. After you fill in the form, a clinician will arrange payment with you and review your information. If you're approved to receive abortion pills by mail, your pills will

be shipped out in 1-2 business days.

Still have questions? Check out our FAQ

Go to the FAQ →
(<https://www.abuzzhealth.com/faqs/>)



(<https://www.abuzzhealth.com>)

Abuzz: Abortion Pill Access At Home

About Us(<https://www.abuzzhealth.com/about/>)

How it Works(<https://www.abuzzhealth.com/how-it-works/>)

FAQ(<https://www.abuzzhealth.com/faqs/>)

Terms of Use(<https://www.abuzzhealth.com/terms-of-use/>)

Privacy Policy(<https://www.abuzzhealth.com/privacy-policy/>)

Donations allow us to help all pregnant people, regardless of their ability to pay. Please consider supporting our work.

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X Quick Exit
(<https://www.google.com/>)

(<https://www.abuzzhealth.com>)

How It Works

The process is simple, confidential, and designed to meet your needs.

1. Fill in the form.

The form asks a few basic questions to help the clinician know if you are eligible to get abortion pills by mail.

You will also be asked to upload a copy of your photo ID (if you do not have one, please let us know) and sign a consent form.

Fill in the form →
(<https://www.abuzzhealth.com/form/>)

2. Check your email.

You'll get instructions for making a payment and signing into the secure portal. Follow those instructions to complete your request.

3. Review

A US-licensed clinician will review your eligibility for an at-home abortion with pills within 1-2 business days. In most cases, a phone/video call is not required. If your provider has more questions, they will contact you via the portal.

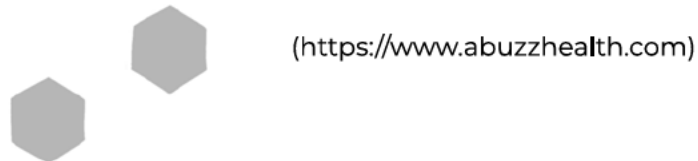


4. Receive and use abortion pills at home

Your FDA-approved medications will be sent by mail. Shipping takes 1-5 business days. Detailed instructions and support are provided. Clinicians are available to answer your questions 7 days a week.

Still have questions? Check out our FAQ

Go to the FAQ →
(<https://www.abuzzhealth.com/faqs/>)



Abuzz: Abortion Pill Access At Home

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(<https://www.abuzzhealth.com>)

Frequently Asked Questions* (<http://abuzzhealth.com/faqs#disclaimer>)

Services | *About Abortion Pills* | *Before Taking Abortion Pills* | *How to Use Abortion Pills* |
During An Abortion With Pills | *After An Abortion With Pills*

Services

I can't afford \$145. Can I still get help?

—

Yes, you can still get help! Just let your provider know what you can afford when you fill out the form.

Can I get abortion pills even if I'm not pregnant?

—

Yes, clinicians offer abortion pills "just in case" you do get pregnant. These are sometimes called "advance provision" or "pills for future use." Financial assistance is limited for this service, so there is a minimum fee of \$90.

Do I have to have a video visit or phone call?

—

In most cases, a phone or video call is not required. Everything is done through the intake form. You will receive a phone number so that you can contact the medical team for any follow up questions. We are here to support you if you choose.

What happens after I fill out the form?

—

We will connect you with a provider that is best suited to support your care. The provider will arrange payment with you and review your file. They might ask you some follow up questions. If you are eligible to receive services, they will mail you abortion pills.

How do I get started?

—

Fill in the form here. (<https://www.abuzzhealth.com/get-access-today/>)

About abortion with pills

What comes in the abortion pill kit?

—

The package contains FDA-approved medications that can be used to end a pregnancy at home.

How do the abortion pills work?

—

There are two medications used for an abortion with pills.

Mifepristone blocks a hormone the pregnancy needs to keep growing. Misoprostol causes the uterus to contract and push out the pregnancy.

How effective are abortion pills?

—

The combination of mifepristone and misoprostol has been shown to be 98% effective at ending a pregnancy.

Are abortion pills safe?

—

They are very safe – safer than Tylenol and safer than driving in a car! The risk of severe, life-threatening complications requiring hospitalization is less than 1%.

Will the abortion pills affect my ability to get pregnant in the future?

—

No, abortion pills do not affect your future fertility. You can still get pregnant again.

I have an Rh negative blood type. Will I need Rhogam if I am less than 12 weeks when I take the abortion pills? —

No, Rhogam is only needed for people with Rh negative blood *after* 12 weeks.

Do abortion pills increase the risk of infection? —

Infections from abortions are very rare. They occur in less than 2% of all abortions and usually are easily treated with antibiotics when they do occur.

How far in pregnancy can I use abortion pills? —

The clinicians we refer to will send the pills to people up to 12 weeks and 6 days pregnant. If you are 13 weeks pregnant or more, you can find services [here](#).

What is an ectopic pregnancy and how would I know if I had one? —

Ectopic (tubal) pregnancies are located outside of the uterus. The risk of having an ectopic pregnancy is very low (less than 2%), but if it bursts it is a medical emergency. The only way to know for sure if you have an ectopic pregnancy is by ultrasound. If you are pregnant and have any of the following signs of a ruptured ectopic pregnancy, you should go to the hospital right away: severe abdominal pain on one side, dizziness, lightheadedness, feeling very weak. There is a higher risk of ectopic pregnancy if you have an IUD or history of ectopic pregnancies.

Will the pills work if I have an ectopic pregnancy? —

The abortion pills will NOT work for an ectopic pregnancy. If you take abortion pills and do not have any bleeding within 24 hours after taking misoprostol, you should speak to your abortion pill provider right away. They may recommend an ultrasound to check the location of the pregnancy.

Can I use abortion pills if I have an IUD in place? —

It is very rare to become pregnant with an IUD in place. If you are pregnant with an IUD, there is a higher risk of it being an ectopic pregnancy. Ectopic pregnancies are dangerous because they can burst suddenly and cause severe internal bleeding. While an ultrasound is not required, it would show the location of the pregnancy and the IUD. You don't need to have the IUD taken out before taking abortion pills. They will still work

(unless it is an ectopic pregnancy) and a risk is that the IUD may come out with the pregnancy. Since you have become pregnant, it also means you will need to have the IUD replaced after the abortion since it is no longer working correctly.

I got an abortion pill kit for future use. How long is it good for?

—

You can store the pills for at least two years (and probably longer) in a cool, dry, dark place. It's not recommended to store them in the bathroom because the heat and humidity can make the pills less effective.

Before taking abortion pills

What should I do before taking abortion pills?

—

Before taking pills, it is helpful to do a pregnancy test to confirm you're pregnant. This avoids taking pills unnecessarily and prevents confusion. If you don't want to take a pregnancy test, you don't have to. You should also estimate how far along the pregnancy is. Pregnancies are measured starting from the first day of your last period (and not from conception or when you had sex). You can figure out how far along the pregnancy is using your last period in a [**pregnancy calculator like this one**](https://form.jotform.com/231711180285248) ([**https://form.jotform.com/231711180285248**](https://form.jotform.com/231711180285248)) or by getting an ultrasound.

What kind of pregnancy test should I use before taking the pills?

—

Almost any pregnancy test will work. Dollar store tests work great. We do not recommend using any digital (positive/negative or +/-) pregnancy tests because we have noticed many people having false positives (a positive test result when they are not actually pregnant).

Do I need to get an ultrasound before taking abortion pills?

—

No, getting an ultrasound is not required for most people. You do not need to get an ultrasound as long as your provider can figure out how far along your pregnancy is and you do not have signs of an ectopic pregnancy.

How should I get ready to take my abortion pills?

—

1. Read our information on how to take the pills, what you might see and feel, and how to identify signs of complications.
2. Have a plan for where and when you will take the pills. You will want to be in a comfortable place and have access to a bathroom for up to 12 hours after taking misoprostol (the second medicine).
3. Have a plan for how to get emergency medical care in the unlikely event that you need it. It can be good to have a support person (in-person or virtually) (<https://community.reprocare.com/>) in case you need help – especially the day you take misoprostol because this is when you'll have the most cramping/pain and bleeding.
4. Have on hand whatever you usually use to help with your periods (ex: large overnight pads, painkillers, anti-nausea medicine, heating pads, comfortable clothes, snacks, netflix/movies, etc).

How to use abortion pills

How should I take the abortion pills?

—

These instructions (<https://www.abuzzhealth.com/instructions/>) follow guidance from the World Health Organization. (<https://www.who.int/publications-detail-redirect/9789240039483>)

How do I take misoprostol?

—

Misoprostol can be taken in 3 different ways – under the tongue, in the cheek pocket, or in the vagina. All 3 ways are very effective, the one you choose mainly comes down to personal preference.

The vaginal route may have less side effects like nausea and vomiting. However, pill fragments could remain and be found during a pelvic exam.

What can I take for nausea?

—

You can take over the counter anti-nausea medicine like Unisom or Dramamine. Other things that can help with nausea include ginger tea, chewing gum, and sucking on hard candies.

What can I take for pain?

—

1. It's most effective to wait until you feel some pain before taking painkillers (but do not wait until the pain is unbearable). You can take over-the-counter painkillers like ibuprofen (Motrin/Advil) and acetaminophen (Tylenol). You can take 600-800mg ibuprofen every 6-8 hours with food. You can take 1000mg of acetaminophen every 6 hours. You can also take ibuprofen and acetaminophen together. If you do not want to use ibuprofen, you can try taking naproxen (Aleve) 550mg every 12 hours. To be more comfortable during the process, you can also try using a hot water bottle or heating pad on the belly, listening to music, having a support person, being someplace private, etc.

Why do I start with fewer misoprostol pills when I'm 12+ weeks pregnant?

—

The farther along you are, the fewer misoprostol pills you need for each dose. After 12 weeks, people should take 1 mifepristone followed by 2 misoprostol pills repeated every 3 hours until the pregnancy passes.

Why do I have extra pills and what should I do with them?

—

Extra misoprostol pills are included because some people need more medication to complete the abortion.

Please hold onto them for 1-2 months in case you need to take them.

What if I throw up after taking the abortion pills?

—

If you threw up after taking MIFEPRISTONE: As long as you kept the mifepristone down for at least 30 minutes, it will most likely be effective. If you vomited less than 30 minutes after taking mifepristone, it might not be as effective, so contact your provider for further information.

If you threw up after taking MISOPROSTOL: As long as you kept the misoprostol in your mouth for at least 20 minutes, that should be enough time for the medication to absorb and be effective. If you vomited less than 20 minutes after putting the misoprostol in your mouth, it's recommended to take anti-nausea medication, wait a few hours, and try again.

During an abortion with pills

What happens after taking the abortion pills? —

Most people don't have any symptoms after taking mifepristone. Some people might have light bleeding or nausea.

After taking misoprostol, you can expect bleeding and cramping. Other side effects of misoprostol include nausea, vomiting, headache, diarrhea, fever, and chills. These are usually temporary and go away on their own. If the fever (more than 101 degrees) continues for more than 24 hours after taking misoprostol, please contact your abortion pill provider because this can be a sign of infection.

How much bleeding and cramping will I have? —

Every person is different, and there is a range of normal bleeding and cramping. Most people have bleeding and cramping that is heavier than a period and can include blood clots the size of lemons. Some people only have light bleeding. It usually starts 4-6 hours after taking the misoprostol (the second medicine) and starts to slow down within 1 day. Some people have mild pain, and other people have very intense cramps.

What if I start bleeding/having a miscarriage before I use the abortion pills? —

Signs of a miscarriage don't always mean you had a complete miscarriage so it is recommended that you still use the abortion pills to make sure the pregnancy passes fully.

What are the side effects of misoprostol (the second medicine)? —

The side effects of misoprostol include nausea, vomiting, headache, diarrhea, fever, and chills. These are usually temporary and go away on their own. If the fever (more than 101 degrees) continues for more than 24 hours after taking misoprostol, please contact your abortion pill provider because this can be a sign of infection.

How much bleeding is too much?

—

It is normal to have heavy bleeding and blood clots. If you are soaking 2 large overnight pads per hour for 2 hours in a row (4 pads in 2 hours) that is too much bleeding. You should seek medical attention right away if this happens. Sometimes providers recommend taking 2 more misoprostol pills to slow the bleeding down while waiting for medical attention.

What are signs of a complication?

—

If you have very heavy bleeding (soaking 2 large overnight pads per hour for 2 hours in a row), fever for over 24 hours since taking misoprostol, or severe pain that is not relieved by painkillers, these are signs of severe medical complications, and you should seek medical attention right away.

Will anyone be able to tell that I took abortion pills?

—

No, there are no tests to detect that you took abortion pills by mouth. The only way for the providers to know is if you tell them or if you took the pills vaginally and they see them on an internal exam. You do not need to say that you took abortion pills.

If I have to go to the hospital, what should I say?

—

The treatment for a miscarriage and abortion are the same, so you can just say something like "I'm bleeding but it doesn't feel like my usual period. I'm afraid something is wrong" or "I'm pregnant and bleeding. I'm scared there's something wrong" and you should get the care you need.

After an abortion with pills

How do I know if the abortion pills worked?

—

Most people can tell if the pills worked by what they experience and how they feel. Some signs that the abortion pills worked can include: bleeding (light or heavy), cramping after taking the pills, passing clots and/or tissue, and no longer feeling pregnant. Pregnancy

tests can stay positive for up to 5 weeks after a successful abortion, so they are not reliable before that time. If you still feel pregnant, you should contact your abortion pill provider.

What if I have little or no bleeding after taking the abortion pills?

—

This could be a sign that the pills didn't work, so you need to talk to your abortion pill provider for further guidance.

How long will I bleed after taking abortion pills?

—

Bleeding should start to slow down after the pregnancy passes. However, light bleeding and/or spotting can continue off and on for up to 6 weeks. If you have been bleeding more than 6 weeks, contact your abortion pill provider.

What if I have vaginal odor after using the pills?

—

Your vagina needs time to adjust to the changing hormones after ending the pregnancy, so any odor changes can be normal. Burning or pain from the discharge are reasons to seek medical attention.

When can I get pregnant again after an abortion?

—

You can get pregnant as soon as 1 week after your abortion. If you want to prevent pregnancy, it is important to start birth control soon after your abortion.

When can I start birth control after my abortion?

—

You can start most methods right away. If you start within 1 week, you are protected from pregnancy right away. Here is a guide (<https://www.bedsider.org/features/1319-how-to-start-birth-control-after-an-abortion>) to starting birth control after an abortion.

When can I start exercising or return to work/school after an abortion with pills?

—

Everybody is different. Most people are able to return to normal activities the day after you finish taking misoprostol (the second medicine).

When can I have sex again after an abortion?

—

This is up to you and what feels right for your body. You can have sex again whenever you feel ready.

* Nothing on this website is to be construed as medical advice. Please consult with a trusted healthcare professional before making any medical or healthcare decisions.



(<https://www.abuzzhealth.com>)

Abuzz: Abortion Pill Access At Home

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To talk to a lawyer about your specific circumstances, questions, and needs, call [844-868-2812](tel:844-868-2812) or contact us through our [secure online form](#).
The information on this page is not legal advice. We do not sell or provide abortion pills. We cannot give medical advice.

Louisiana abortion law at a glance	+
Legal considerations for everyone	×

Heavily Restricted

- As of 2026, abortion is not against the law for pregnant people in Louisiana.
- Healthcare professionals in the state of Louisiana cannot provide abortions except to save the life or health of the pregnant person. You can learn more about emergency medical treatment under *Getting the medical care you need* on our [Legal Rights and Risk page](#).
- No matter your age, you have the constitutional right to travel to [another state](#) where abortions are still being legally provided.

Are telehealth abortion pills legal in Louisiana?

- **As of May 14, 2026, all medication abortion pills are currently available by telehealth and mail.** The Supreme Court of the United States has blocked the May 1, 2026 decision by a federal appeals court that temporarily prevented healthcare providers in all 50 states from prescribing and mailing mifepristone via telehealth. This means that all medication abortion pills will continue to be available by telehealth in other states until the appeal is over. **No matter what the final outcome of this case, using abortion pills to end your own pregnancy is not a crime in Louisiana.**
- On October 1, 2024, a new law went into effect making the FDA approved medications used for abortion care—mifepristone and misoprostol—controlled substances. It is **NOT** a crime for pregnant people to possess abortion pills for their own use. But if you are not pregnant and do not have a prescription from a doctor licensed to practice in Louisiana, then possessing abortion pills is a crime.
- If you have questions about your legal rights and risk, call [844-868-2812](tel:844-868-2812) or contact us through [our secure online form](#) to speak with a lawyer.

Legal considerations for people under 18	+
--	---

ⓘ Plan C does not sell pills or provide medical advice. This guide lists verified results of our research.

Abortion pill access: Louisiana ▾

People in Louisiana access abortion pills by mail from online clinics and providers outside of the state, despite laws that restrict in-state services.

Research in Plan C’s Guide compares verified abortion providers, mail-order costs, and delivery times for online abortion pill options in Louisiana.

[List of providers](#)

[Pregnancy calculator](#)

[How do people choose a provider?](#)

[Is this legal? Can someone get in trouble for using abortion pills in Louisiana?](#)



Forward Midwifery offers sexual & reproductive telehealth services in California, Colorado, Maryland, Massachusetts, New Mexico, Oregon, & Washington D.C.

[Learn More >](#)

- ✓ Medication Abortion (Plan C)
- ✓ Emergency Contraception
- ✓ Birth Control Counseling & Prescriptions
- ✓ Missed Period Pills
- ✓ UTI & STI Screening
- ✓ Irregular Periods
- ✓ Gender Affirming Care
- ✓ Postpartum Depression & Mood Disorders
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HEALTH, NATIONAL

Online Abortion Provider Christie Pitney of Forward Midwifery: “Fast, Convenient Care”

PUBLISHED 1/28/2022 by CARRIE N. BAKER

“Abortion and all sexual and reproductive healthcare is just healthcare,” said Christie Pitney, a midwife serving patients in California, Colorado, Oregon and Massachusetts. “It should be accessible without having to jump through all of these hoops.”



FEMINIST DAILY NEWS

Five Years Later, Girls in Afghanistan Are Still Waiting For School Doors To Open

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Domestic Violence and Gun Violence

Ectopic Pregnancy Deaths Have Nearly Doubled: Are Abortion Bans the Cause?

Popular This Week



"Overall, people feel really confident about doing it at home," telehealth abortion provider Christie Pitney told *Ms.* (Pitney's shirt reads, "Since people have been birthin', people have been abortin'" —a quote from Dr. Ghazaleh Moayed.)

(Forward Midwifery / Instagram)

As we await the fate of Roe v. Wade, Ms.'s "Online Abortion Provider" series will spotlight the wide range of new telemedicine abortion providers springing up across the country in response to the recent removal of longstanding FDA restrictions on the abortion pill mifepristone.

Christie Pitney is an advanced practice midwife with Forward Midwifery, serving patients seeking to end early pregnancies in the states of California, Colorado, Oregon and Massachusetts. Christie works with Plan C, is an Aid Access provider, volunteers

for the Miscarriage & Abortion Hotline and is part of the MYA Network of telehealth abortion providers.

Ms. spoke to Christie about how and why she began offering telehealth abortion services.

Carrie Baker: Could you tell me about your background and practice?

Christie Pitney: *I am a certified nurse midwife, and a sexual and reproductive health nurse practitioner. I had always wanted to work in abortion and reproductive health. During the pandemic, I reached out to Dr. Rebecca Gomperts of AidAccess to see how I could help. They did not have a provider for California yet so I was able to step into that role. Then I started Forward Midwifery, my private telehealth practice. I began offering telehealth abortion through Forward Midwifery and Aid Access for California in February of 2021 and then Massachusetts in May of 2021. I added Oregon in November of 2021. Through Forward Midwifery, I began serving Colorado in January of 2022.*

*@forwardmidwifery Ding Dong again. #dingdong
#medicationabortion #abortion #abortiontok
abortionmidwife #athomeabortion #plancpills #aidaccess
#myanetwork 🎵 original sound – forwardmidwifery*

Baker: Are you thinking about expanding to other states?

Christie Pitney: *I currently have pending licenses for New Mexico, D.C., New York and then potentially more as well. I want as*

many options out there as possible for folks.

Baker: How do you provide telehealth abortion care?

Pitney: As with everything, I want people to have as many options as possible. At Forward Midwifery, they have the choice of doing everything through email, online consultation, a phone call or a video call.

Baker: Can you take me through the process?

Pitney: They request an appointment time on the website and then we approve that time and send them the intake forms, including a telehealth consent form asking what state they're in and some basic medical history questions. There's a question about how they want to do the visit. I would say it's 50/50 phone call and email. Very, very few want a video call. For email care, we use a HIPAA-compliant electronic medical record system.

If it's going to be by email, then we might just send a few messages back and forth. If they have any questions, I answer them, they confirm their address, and then our requested price is \$150, but I don't want financial burdens to be a barrier for anyone. So I do a sliding scale or more like a pay-what-you-can model. If someone can't pay \$150, then I do payment plans. So they might pay 50, 50, 50, or 75 and 75. Some of them say, "I have \$10 to my name, and that's what I was going to use for groceries, I really can't afford anything." And that's okay, we're still going to make sure that they get the care that they need.

@forwardmidwifery #abortion #abortionaccess
#abortionissafe #abortionisnormal #abortionathome
#medicationabortion #telemedabortion #prochoice 🎵 Body
– Megan Thee Stallion

Baker: Are you working with funds to help make that up?

Pitney: *There was an anonymous donor who gave some funding to the pharmacy that I'm using, and so we're able to use that fund. The cost can be covered, up to \$75, which covers the cost of the medication and the shipping. But then sometimes I'm still donating the consultation time. I am also working with several of the abortions funds that help folks in the state that I provide services in. We have these funds listed on the Forward Midwifery website.*

Baker: Do you take insurance?

Pitney: *I don't at this time, but I'm working on getting credentialed so hopefully in the future I will. I'm going to start with Medicaid and then maybe eventually private insurances. I want to focus on Medicaid first to prioritize the patients with the most need.*

Baker: Do you do any patient education before you have a consult with a patient?

Pitney: *Yes, in the forms that they get right off the bat, it has patient education. So it has instructions on what to expect, on how to take the medication, on what the medications are that they're going to receive. We have a four-page typed out consent form and some infographics. We find that sending it in*

both formats is helpful because everyone has different learning styles.



Christie Pitney and her mother Merlyn Pitney serve as clinic defenders in July 2021.

(Forward Midwifery / Instagram)

Baker: If they schedule a phone appointment, what happens?

Pitney: Patients have already received the patient education prior to the phone call, so usually the phone call is answering additional questions that they might have. For some

patients, it's five minutes or less. Some patients have a little more anxiety and more questions, and I've had them go on, usually no more than about 30 to 40 minutes.

Baker: Are you able to do same day consults?

Pitney: Yes, most of the time, we are able to.

Baker: Do you offer appointments on weekends or at night?

Pitney: Right now, we aren't but my schedule will be changing soon. So it is a possibility.

Baker: What pharmacy do you use?

Pitney: Honeybee Health. I also just emailed American Mail Order Pharmacy to get connected with them as well.

Baker: How long does it take for the pills to reach the patients?

Pitney: I'm having them mailed with USPS priority shipping, so one to three days from when I send the prescription to the pharmacy.

Baker: What kind of follow up care do you provide to patients after they get their pills?

Pitney: We don't schedule any sort of follow up. We tell the patients that they can call us at any time though. I have a phone number that rings to me 24/7 and I have a clinical assistant who's available Monday through Friday, eight hours

per day. Between the two of us, they'll always be able to get a hold of someone. We also provide the Miscarriage and Abortion Hotline phone number, so they can call or text them if for some reason they can't get ahold of me. We let them know that they can do a pregnancy test about four weeks after taking their medications. But ultimately, monitoring pregnancy symptoms is the most reliable way to know that the medications were successful and that everything went well for them.

Baker: How often do people follow up with you by phone or text afterwards?

Pitney: *Rarely. Less than 10 times ever for my Forward Midwifery patients. Aid Access utilizes a help desk team so I don't always know about patient follow up unless they have a medical question.*



View this post on Instagram

A post shared by Forward Midwifery (@forwardmidwifery)

Baker: How many patients have you seen since you opened in February?

Pitney: *I have had 1,097 patients overall through November. December was my busiest month that I've had since I started. I had a total of 274 patients. And then 128 through mid-January.*

Baker: Who are your telehealth patients?

Pitney: *They are a whole range of people. I've had minors—I think the youngest that I've had was 15 years old—up to mid to late 40s. Most have had at least one child. My clinical assistant speaks Spanish so I'm able to see Spanish speaking patients.*

For a little while, I was keeping a map of where the patients were located in California. It was all over, but by far the most patients I was getting were from Los Angeles. It's a progressive state, a progressive city, with multiple abortion clinics, but there are just so many different barriers that we don't always think about to getting healthcare in general and abortion specifically. So people were still turning to telehealth.

“

My telehealth patients are a whole range of people. I've had minors—I think the youngest that I've had was 15 years old—up to mid to late 40s. Most have had at least one child.

Baker: Are many of your patients coming from out of state into the states you cover to get this service?

Pitney: I think that that is happening more now, as more and more restrictions are popping up since S.B.8 and S.B.4 in Texas. We have had 10 to 20 Texas patients in just the last few weeks.

Baker: Do you have a sense of why your patients are using telehealth?

Pitney: Yes—because they want fast, convenient care. There are often long wait times at Planned Parenthood. And I've had folks tell me that they're doing it because they have had horrible experiences going to a clinic and going past protesters, and they can't deal with that trauma again. Others felt that this was a more private way of doing things. Childcare is a huge, huge thing too. Patients also come to us because of our low price of \$150, and because we allow rent plans.

Baker: How do your patients find you?

Pitney: Plan C and social media platforms like TikTok and Instagram. I post a lot of TikTok videos to educate folks about telehealth abortion.

@forwardmidwifery Getting reported for posting informative content. #abortion #medicationabortion #abortionaccess #abortionisnormal #plancpills #myanetwork #abobo original sound – forwardmidwifery

Baker: Do you offer advance provision abortion pills?

Pitney: Yes, absolutely. I'm happy to do that for all of my states.

Baker: Do you offer missed period pills?

Pitney: We are doing that as well, yes.

Baker: How have your patients responded to telehealth abortion?

Pitney: People overall are very thankful and appreciative. Overall, people feel really confident about doing it at home.

One thing that I think is hugely important for people to know is that if you're going to do a medication abortion, whether it's in clinic or at home through telehealth, the abortion works at home no matter what. If you go to a clinic, you're going to get the [mifepristone] and take it there, but the mife

has little to no side effects, and then 24 to 48 hours later, you take that miso [misoprostol] and that's when the bleeding and cramping starts. Any bleeding, cramping, passing of the pregnancy tissue is going to happen at home, regardless of whether you get your medications at a clinic or in the mail.

@forwardmidwifery. Oops. Accidentally dropped this here again. [#abortionbyemail](#) [#abortion](#) [#21stcenturyabortion](#) [@plancpills](#) [↗ original sound – forwardmidwifery](#)

Baker: What are your motivations for offering telehealth abortion?

Pitney: *I got into it because I lived in a rural area, and it was hard for folks in my area to access that care. I lived in the Central Valley between Fresno and Bakersfield, where the closest abortion clinic was a 45-minute drive away from where I lived. Unfortunately, I wasn't able to offer abortion services at my FQHC [federally qualified health center] because of political restrictions. Many of the folks living in that area are working six or seven days a week, they have childcare needs, they don't have reliable transportation. So even though they live in California, it was still too much to get to that clinic. And so that's why I think telehealth is an amazing option for folks who need it.*

“

Any bleeding, cramping, passing of the pregnancy tissue is going

to happen at home, regardless of whether you get your medications at a clinic or in the mail.

Baker: How does it feel to be able to help people in this way?

Pitney: *It's so important. It feels great to be able to help my patients in having autonomy, independence and control of their lives.*

Baker: Have you experienced any harassment for offering telehealth abortion by anti-abortion extremists?

Pitney: *I have on social media, but no personal threats or mail.*

Baker: Was it difficult to start your telehealth abortion practice?

Pitney: *I didn't find it that difficult to get started. I got malpractice insurance, I got the electronic medical record system, I set up accounts with GenBioPro and Honeybee Health.*

It feels great to be able to help my patients in having autonomy, independence and control of

their lives.

Baker: The FDA requires providers to sign up with the mifepristone distributors Danco or GenBioPro. Is that burdensome?

Pitney: I did not find it to be burdensome. Providers might see that and think that they're on some list or that it's gonna be this huge effort to make an account, but it's really like a two-page document that you have to fill out. For someone who already has an established practice, adding telemedicine abortion is such a simple thing that can be handled in one day.

Baker: What do you do with Plan C?

Pitney: I am a consultant for Plan C. I talk to providers about starting their own telehealth practice, or connect them to existing providers like Choix and Just the Pill. When I was starting, I used Plan C's Access Delivered toolkit to start my practice. I later contributed to the second edition and now I help distribute the toolkit. Plan C asked me to come on and help other providers navigate setting up a practice. It's just so important that we have as many providers doing this work as possible. The more providers doing this work the better.



Pitney (left) and her midwifery cohort. ([Forward Midwifery / Instagram](#))

Baker: Any final thoughts?

Pitney: *Abortion and all sexual and reproductive healthcare is just healthcare. It should be accessible without having to jump through all of these hoops. While I don't think that it should be a political issue, in the U.S. it is, so that makes it important for people to be involved politically, to vote and sign petitions and contact their local politicians. I think it's important that people stay informed and get involved in whatever way they are able to. If they have money to donate, if they have time to donate, if they can share things on social media, whatever that looks like for people. It's a critical issue with Roe v. Wade most likely getting overturned. It's only going to become more important that we have as much access as possible in the states that are not going to restrict abortion.*

Explore the full collection of online abortion providers profiles:

- Dr. April Lockley Answers Your Questions About Abortion Pills: 'To Protect Each Other As Much As We Can', Ms., March 16, 2022
- Online Abortion Provider Razel Remen: 'Telemedicine Abortion Is Safe and Reliable' Ms., March 2, 2022
- Telemedicine Abortion Provider Rebecca Gomperts Gets Abortion Pills Into the Hands of Those Who Need Them: 'It's a Privilege' Ms., Feb. 23, 2022
- Telemedicine Abortion Provider Alison Case: "Helping People in Texas Access Abortion Care" Ms., Feb. 15, 2022
- Telemedicine Abortion Provider Melissa Grant: "Abortion? Yeah, We Do That." Ms., Feb. 2, 2022.
- Online Abortion Provider Christie Pitney of Forward Midwifery: "Fast, Convenient Care," Ms., Jan. 28, 2022.
- Online Abortion Provider Julie Amaon of Just the Pill Is "Making Abortion as Easy as Possible for People," Ms., Jan 26, 2022.
- Online Abortion Provider and "Activist Physician" Michele Gomez Is Expanding Early Abortion Options Into Primary Care, Ms., Jan. 19, 2022.
- Online Abortion Providers Cindy Adam and Lauren Dubey of Choix: "We're Really Excited About the Future of Abortion Care," Ms., Jan. 14, 2022.
- Telemedicine Abortion Provider Dr. Deborah Oyer Supports Patient Autonomy and Control: "No Different Than When They're in Clinic," Ms., Jan 12, 2022.
- Online Abortion Provider Robin Tucker: "I'm Trying To Remove Barriers. ... It Feels Great To Be Able To Help People This Way," Ms., Jan. 4, 2022.
- Abortion on Demand Offers Telemedicine Abortion in 20+ States and Counting: "I Didn't Know I Could Do This!" Ms., June 7, 2021.

Is It Legal to Order Abortion Pills Online?

FDA Lifts Some Abortion Pill Restrictions, Leaves Others in Place: "Ignores the Science and Smacks of Political Interference"

Abortion Pills in Your Medicine Cabinet? Advance Provision Medication to End Early Pregnancies

TAGGED: ABORTION ACCESS, ABORTION HOW-TO, ABORTION PILLS, ABORTION PROVIDERS, ACTIVISM, ANTIABORTION EXTREMISM, ANTIABORTION LAWS, CHILDCARE, HEALTHCARE, MATERNAL HEALTH, MEDICARE AND MEDICAID, MENSTRUATION AND MENSTRUAL EQUITY, ONLINE ABORTION PROVIDER (SERIES), PLANNED PARENTHOOD, REPRODUCTIVE JUSTICE, SEXUAL AND REPRODUCTIVE HEALTH, SOCIAL MEDIA, THE MS. Q&A, WOMEN'S HEALTH

ABOUT CARRIE N. BAKER

Carrie N. Baker, J.D., Ph.D., is the Sylvia Dlugasch Bauman professor of American Studies and the chair of the Program for the Study of Women and Gender at Smith College. She is a contributing editor at *Ms.* magazine. Read her latest book at *Abortion Pills: U.S. History and Politics* (Amherst College Press, December 2024). You can contact Dr. Baker at cbaker@msmagazine.com or follow her on Bluesky at [~arrienbaker.bsky.social](https://bsky.social/~arrienbaker).

For further information contact:

ACP
P.O. Box 9120
Chelsea, Massachusetts 02150-9120
617-727-3261
1-866-SAFE-ADD
Website: www.sec.state.ma.us/acp

1-866-SAFE-ADD

Address Confidentiality Program



ACP Brochure
Updated 1/19/23
English



William Francis Galvin
Secretary of the Commonwealth

Address Confidentiality Program

What is it?

The Address Confidentiality Program (ACP) provides a means by which survivors of domestic violence, sexual assault, rape, or stalking or those engaged in legally protected gender-affirming and reproductive health care services may use a confidential address to increase safety.

How does it work?

A survivor completes an ACP application with a certified Application Assistant (AA). The applicant must demonstrate that disclosure of the survivor's address threatens their safety.

Legally protected health care professionals do not need to use an Application Assistant to submit an application or demonstrate that disclosure of their address threatens their safety.

Once the ACP receives an application, it is reviewed. If accepted, the Secretary will assign a substitute address to the participant to be used as the participant's legal address in the state of MA.

What ACP is:

A mail forwarding service

A legal mechanism for suppressing the participant's address from disclosure on the public record by providing a safe mailing address

A safe address for purposes of RMV transactions

Note: the ACP does not protect from prior disclosures of addresses

What ACP is not:

Social Service Agency

Law Enforcement Agency

Witness Protection Program

Who can apply?

- 1) Survivors of domestic violence, sexual assault, rape, or stalking who:
 - live in MA
 - have recently relocated to a new address or are willing to relocate
 - have not made their new address part of any public record
 - have not updated their new address with the RMV or USPS
 - know that the perpetrator does not know new address
 - can demonstrate that disclosure of address threatens safety
- 2) Individuals who are engaged in the provision, facilitation, or promotion of legally-protected healthcare services including:
 - gender-affirming health care services
 - reproductive health care services

How do I apply?

For survivors:

- Call ACP office to be connected with an AA
- Contact a DV/SA agency in MA

For legally protected healthcare professionals:

- Visit the ACP website
- Note:** Healthcare professionals are not required to submit their application through an AA

For more information contact

Address Confidentiality Program
 PO Box 9120
 Chelsea, MA 02150
 1-866-SAFE-ADD
 617-727-3261
sec.state.ma.us/acp

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HEALTH, NATIONAL

Online Abortion Provider Robin Tucker: "I'm Trying To Remove Barriers. ... It Feels Great To Be Able To Help People This Way"

PUBLISHED 1/4/2022 by CARRIE N. BAKER

As we await the fate of Roe v. Wade, Ms.'s "Online Abortion Provider" series will spotlight the wide range of new telemedicine abortion providers springing up across the country in response to the recent removal of longstanding FDA restrictions on the abortion pill mifepristone.



FEMINIST DAILY NEWS

Five Years Later, Girls in Afghanistan Are Still Waiting For School Doors To Open

Put the Gun Down: The Intersection between

Robin Tucker is a nurse practitioner of women's health and a certified nurse midwife who offers first-trimester medication abortion by phone call, video visit or online intake forms to patients in Virginia, Maryland and Maine. She charges a sliding scale fee up to \$150.



Robin Tucker, nurse practitioner.

Her Bethesda-based Metro

Area Advanced Practice Healthcare serves "all genders, all lifestyles, all types of bodies" with reproductive and sexual health care, and offers telehealth, office visits and even house calls, with an "emphasis on harm reduction, trauma informed care and following the Health At Every Size philosophy."

Ms. spoke to Tucker about how and why she began offering telemedicine abortion services and how her patients have responded.

Co-Editor: Can you tell me about your medical background and practice?

Domestic Violence and Gun Violence

Ectopic Pregnancy Deaths Have Nearly Doubled: Are Abortion Bans the Cause?

Popular This Week



Robin Tucker: *I have independent practice licenses in D.C., Maryland and Virginia. Virginia just started allowing nurse practitioners to offer medication abortion services. I still practice part time at a hospital doing deliveries. I think it's great to be able to do births and then get back online and do an abortion case. I love that. I love that balance. It just feels like I'm really able to meet people's needs for their reproductive health.*

Baker: **How did you begin offering telemedicine abortion?**

Tucker: *I saw a post on the Reproductive Health Access Project mailing list about need for virtual abortion providers and I thought, "That's great, how do I get involved in that?" And it turns out they were specifically looking for a provider in Virginia. I was also establishing my brick-and-mortar office at the time. So, everything kind of came together at once with opening up my practice.*

I started working with Aid Access and the group Access Delivered, which is affiliated with Plan C. Before I joined Aid Access, they were doing abortions in Virginia through European doctors, who prescribed through an overseas pharmacy, so it was taking a lot longer. Once I joined, it was easier for the Virginia patients, because then they could get their meds shipped from inside the U.S. in three or four days.

“

*It's great to be able to do births
and then get back online and do*

an abortion case. I love that balance. It just feels like I'm really able to meet people's needs for their reproductive health.

Baker: Tell me about your telemedicine patients?

Tucker: I'm getting a lot of patients from Maryland and Virginia, people in rural areas who would have had to take time off work to go to a clinic in person. They come through virtually and schedule an appointment, a phone consult, or just the forms. Many are lower income and need assistance. A lot of them are in Southwestern Virginia, Southern Virginia. I get a lot of people in the military and public service occupations—really, it's everyone, but this allows me to meet people where they really are if they have limited resources.

If somebody lives out in Southwestern Virginia and has five kids and can only afford \$20 for her abortion and wants to talk to me on the phone—I'm able to help her more than if I'm in a clinic and she has to find transportation. I feel like I've been able to really help people like that.

Baker: Can you serve people from other states if they come to Virginia?

Tucker: Yes. Legally, if I'm mailing to a Virginia address, I'm doing the service in Virginia. They need to be physically in

Virginia on a computer and they have to attest in the telehealth consent form that they are completing the intake form in that state. If they're visiting family in Virginia and they want the pills shipped there, I can do that because I'm providing in the state I'm mailing to.

Baker: Aid Access has a sliding scale fee. How does it work for you as a provider?

Tucker: Patients pay what they're able to. That's part of my agreement with Aid Access as a provider and the mission of the organization. I decided to integrate that into my practice's model of care. I've had some very difficult months trying to be able to meet the needs of people who can't pay the full fee, but still trying to open a fledgling startup practice.

One month, I had almost \$3,000 of care that I gave away. So I've had a GoFundMe page to help with my patient assistance efforts. With my abortion care, I did want to keep it "need-blind."

I was able to affiliate with one of the Virginia abortion funds—the Blue Ridge Abortion Fund—so that has been extremely helpful.

Baker: How does it work with the abortion fund?

Tucker: What we worked out is we all signed a HIPAA agreement. If the patient says they need assistance in their intake forms, an additional consent form pops up that allows me to send their medical information to the abortion fund. Once they sign that, I automatically have it sent to intake at the abortion fund and they review it. Blue Ridge Abortion Fund calls the patient and talk to them. They want the patient to know that if they need care after the abortion, they can

help provide that. Then they fax my office with a pledge saying, we'll cover this amount for this patient's abortion. They usually get back to me in a few hours or within one business day. And then I bill them and they transfer funds. That's for Virginia.

In the other states, I take whatever patients can pay, and I cover it with the help of the GoFundMe or other grant funding that has been allocated through Plan C or AidAccess.

“

People say, this seems too good to be true, this just seems so easy, there has to be a catch. I just try and make it easy. I'm trying to remove barriers.

Baker: Why do your patients use telemedicine?

Tucker: *A lot of people have told me, I would have had to take off work, I would have had to find a babysitter, I would have had to do all this other stuff if I couldn't do telemedicine.*

I've had people say, this seems too good to be true, this just seems so easy, there has to be a catch. I just try and make it easy. I'm trying to remove barriers.

** of them say, thank you for making this so easy to deal ... I clicked on the button, I made an appointment, I got*

the forms. Everything was just super easy. I tailored the workflow so the phone intake form is different from the office intake form. I have a daytime receptionist, Maura, who is amazing and can talk them through the forms and process if they have questions.

Baker: Are you able to do same-day consults?



Tucker.

Tucker: Yes.

I have a different set of hours for my

medication abortion and telehealth visits hours. I keep extended hours for that because I don't have to go into the office for that. I just have it set up to where it gives me two hours lead time.

Baker: Do you have appointments at night and on weekends?

Tucker: *Yeah, I have a lot of weekend callers. And I'll do them all the way up till 8 p.m.*

Baker: How long do the calls normally take?

Tucker: *Ten or 15 minutes. Most of the time people who find my practice website have done a lot of reading. The biggest concern usually is, when am I going to get these pills?*

“

Most of the time people who find my practice website have done a lot of reading. The biggest concern usually is, when am I going to get these pills?

Baker: How long does it take for the pills to reach patients?

Tucker: Three to four days. We also offer UPS next-day air for an extra fee of \$25. But some of the rural areas don't have the capability for next day air, so UPS puts it on second-day air.

Baker: Where do the abortion pills come from?

Tucker: We use Honeybee Health pharmacy in California. They have been great. They work directly with the supplier. Once they got my information that I was approved with the medication supplier, they work with the supplier to get the inventory in and they send the prescriptions priority mail.

Baker: What kind of follow-up care do you provide after patients get their pills?

Tucker: Patients can call my main office receptionist Maura from 9 to 5. And she's great, I have gotten many compliments about how helpful she is.

After hours, I have a 24-hour answering service. They answer the phone just like my usual receptionist, ask medical screening questions and then decide to either contact me, send the patient to the hotline or route the message for routine follow-up. I work with the Miscarriage and Abortion Hotline (The M+A Hotline). There's always somebody immediately available there from 8 a.m. until 2 a.m. seven days a week.

Baker:
How
many



Metro Area Advanced Practice Healthcare.

telemedicine abortion patients have you seen so far?

Tucker: I'm averaging 95 to 100 a month, so probably 600-people so far. About half came through Aid Access.

Baker: And how are the outcomes for your telemedicine patients?

Tucker: I offer a free follow-up telehealth visit. People can make it from the same screen where they schedule their phone consult. I tell them I recommend a follow-up visit, but most people don't schedule one. I also do follow-up surveys with my patients.

Most of them are saying that it went great. I've had one person who said she went to the hospital, but she was okay. I had another person get very anxious and change her mind in the middle of the abortion. An anti-abortion crisis pregnancy center prescribed her progesterone to reverse the abortion. She contacted me afterward because she took the medication they gave her, and she ultimately had heavy bleeding and ended up in the ER for monitoring.

I assume that if I'm on the phone with someone, and they want abortion pills, it's not my role to question and ask if they are sure. I feel like that's disrespectful. I'm not an options counselor. If people have questions about what they should do, then I'll definitely help them answer them. But I'm not going to initiate a conversation about how sure they are.

“

I assume that if I'm on the phone with someone, and they want abortion pills, it's not my role to

*question and ask if they are sure.
I feel like that's disrespectful. I'm
not an options counselor.*

Baker: Do you take insurance?

Tucker: *If people have insurance that covers telehealth abortion, we can bill them for that. It's just a matter that most of the coverages don't have it. Virginia just made it so that plans on the health insurance exchange are allowed to cover abortion before, but they don't mandate that they cover it. So if the insurer wants to and if the plan wants to allow it, then they can cover it.*

Baker: Do you offer advance provision abortion pills?

Tucker: *The pharmacy we work with has decided that they will not provide advance provision for us. So if someone fills out my forms, and they say, I'm not pregnant, I just want this for the future, then I technically can't provide it through the pharmacy that we work with. But patients can come to my Bethesda office and get it. I'm happy to do advanced provision there.*

Baker: You stock pills at your office?

Tucker: *Yes, I keep a small stock, maybe like a dozen at a time. And then I'll order another dozen when I'm getting low.
'o have the ability to see people in Maryland in my
consult office. This allows me to offer this service according to*

the laws in Maryland, which allows me to see minors there or people who travel from West Virginia. The clients from West Virginia have been very grateful for this option because West Virginia has very restrictive laws about medication abortion via telemedicine).

Baker: How does it feel to be able to help people?

Tucker: *It really feels great to be able to help people this way. I approach care of my patient population like I would hope that someone would approach taking care of one of my kids. I have a 17-year-old daughter, and I have a 25-year-old, non-binary child. A lot of my patients are their ages. I approach them how I would want my child to be treated in this situation.*

“

I approach care of my patient population like I would hope that someone would approach taking care of one of my kids.

Baker: Have you experienced any harassment for offering telemedicine abortion?

Tucker: *I have not. I've been very lucky. I'm just a solo practice that just happens to do abortions. I'm providing one thing in the spectrum of reproductive health care. And I also provide*

all these other things. But my kids get kind of nervous about that. My partner gets very nervous about it.

Baker: Any final thoughts?

Tucker: *I think abortion care is an incredibly important part of reproductive health care. You can't really separate abortion care from reproductive health care. It's linked inextricably. In an ideal world, people would be able to see their regular reproductive health care provider for abortion pills. I think it really goes along with my mission of providing reproductive health care in general.*

Previous profiles:

- Abortion on Demand Offers Telemedicine Abortion in 20+ States and Counting: "I Didn't Know I Could Do This!", Ms., June 7, 2021.
- Telemedicine Abortion Provider Dr. Deborah Oyer Supports Patient Autonomy and Control: "No Different Than When They're in Clinic," Ms., Jan 12, 2022.

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Our Clinical Team

Robin "Ro" Tucker, DNP, MPH, CNM, WHNP-BC, FACNM

Founder and Clinical Director

Ro founded Roxy Clinic after years of providing abortion care at a previous practice and watching firsthand what access barriers cost patients - time, money, dignity, sometimes the procedure they wanted. She is trained as a nurse-midwife and women's health nurse practitioner, with doctoral-level education in nursing practice and a master's in public health. She is a Fellow of the American College of Nurse-Midwives - a professional recognition for sustained contributions to the field.

Her clinical work focuses on making high-quality abortion care easier to access, not harder. That means sliding-scale pricing starting at \$0, discreet packaging that doesn't tip anyone off, delivery to whatever address the patient chooses, and telehealth consultation with no in-person visit - the operational details that make care actually accessible rather than just technically available.

Roxy Clinic is built around a clinical team of board-certified, U.S.-licensed nurse practitioners and midwives with specialized training in reproductive health. Every consultation is reviewed by a licensed clinician before any medication is sent. Our providers are licensed in each state we serve.

Board-Certified

Licensed NPs & Midwives

Reproductive Health

Specialized training

Telehealth in 14 states

Licensed in each state

With telehealth abortion, doctors have to learn to trust and empower patients (https://www.northcountrypublicradio.org/2023/01/17/telehealth-abortion-doctors-have-to-learn-to-trust-and-empower-patients)

BY MARA GORDON (HTTPS://WWW.NPR.ORG/PEOPLE/729920606/MARA-GORDON) — JAN 17, 2023 1:22PM (NPR)



<https://media.npr.org/assets/img/2022/12/05/telehealthabortion-30266e6985b05dd957a2476bec7708540c62931b.jpg?s=1000>

Image: Jesse Zhang for NPR

Like many pandemic-era remote workers, Robin Tucker starts her work day sitting on her sofa with a laptop, wearing soft pants and a T-shirt. But the Washington, DC-area nurse practitioner and midwife doesn't have a typical work-from-home job. She provides abortions over the Internet, a service that has only become available in the United States in the last few years.

Her career, she says, has turned out to be very different from what she learned in midwifery school, where she'd spend long shifts in a high-intensity labor and delivery unit, helping patients give birth.

These days, her work involves reviewing patient information and electronically prescribing the two medications — mifepristone and misoprostol — that together can end an early pregnancy. Patients take the medicines at home.

Sometimes she works from hotels, airports, or public libraries. Once, she provided an abortion from a restaurant, where she was out to dinner with friends.

"I have found ways to just sort of work it into the rest of my life," she says. "If I've got to go meet a contractor at my house, I'll be doing an abortion phone consult while I'm driving."

Tucker is one of a growing number of health care providers who offer medication abortion services online. Some work for companies like Hey Jane (<https://www.heyjane.co/>) and Aid Access (<https://aidaccess.org/en/>); others, like Tucker, work in private practice. Demand for the service, they say, has exploded since the Supreme Court overturned *Roe v. Wade* and states started passing laws banning abortion.

The growth of online abortion care is driving a radical shift in the way doctors think about caring for their patients. At the same time, it's asking them to take on new legal risks on their patients' behalf.

A historical change

In the first half of the 20th century, hospitals and medical organizations were slow to recognize abortion as a legitimate part of medical care, says sociologist Carole Joffe (<https://bixbycenter.ucsf.edu/carole-joffe-phd>), who studies abortion. That's because it called into question the traditional hierarchy between doctor and patient, she says.

Typically, doctors were used to determining both the diagnosis and the treatment – the doctor tells the patient what he or she needs. But when a patient seeks an abortion, that power dynamic is upended: The patient tells the doctor that she wants to end the pregnancy, not the other way around. (In some cases, such as a fetal anomaly or an urgent medical risk to the pregnant person, a doctor might advise an abortion.)

Joffe says that many doctors found this power shift threatening.

She interviewed doctors about abortion in the pre-*Roe* era for her book *Doctors of Conscience* (<https://www.penguinrandomhouse.com/books/204166/doctors-of-conscience-by-carole-joffe/>). One doctor told her, "I don't want to be a rubber stamp," Joffe says, describing his concerns about allowing patients to request abortions.

Advocates worked for decades both to legalize the procedure and to make abortion an accepted part of mainstream medicine. As *Roe vs. Wade* became law in 1973, abortion providers actually fought to restrict abortion care to hospitals and clinics, Joffe says, as a way to help legitimize it.

They said: "Only we medical doctors can decide what are the conditions under which it should be allowed," Joffe says. "And if it should be allowed, only we should be able to do it."

These efforts were largely successful. Up until the COVID-19 pandemic, abortion mostly did take place according to the terms set by both lawmakers and the health care establishment.

That included medication abortion. The U.S. Food and Drug Administration required that patients get mifepristone directly from a clinician. This meant patients had to go see a doctor in person, usually at a clinic focused on abortion and other reproductive health services.

Then during the pandemic, the FDA relaxed some of its rules (<https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>) around mifepristone, so it could be prescribed through mail-order pharmacies. At the same time, many state medical boards and insurance companies also made it easier for patients to see their doctors via telehealth. (Earlier this month, the FDA relaxed the rules even further (<https://www.npr.org/2023/01/05/1147044290/abortion-pills-should-be-easier-to-get-that-doesnt-mean-that-they-will-be>), making mifepristone available at regular retail pharmacies.)

These changes allowed telehealth abortion to flourish, and with its growth comes another adjustment to the traditional doctor-patient hierarchy.

Also driving demand: in states where abortion was outlawed in 2022, some patients who might have sought an abortion in-person are turning to telehealth instead. As telehealth abortion grows, both clinicians and their patients have found new ways to communicate and build trust, without the traditional in-person visit.

There's a "historical reversal," Joffe says. "Now you have a generation of doctors ... who are saying ... 'You don't need us. Our job is basically to assure you, the patient, that it's safe for you to do by yourself.'"

A patient-centric experience

Telehealth abortion – which is available up to about 10 weeks gestational age in the U.S. – requires much less clinician involvement than the pre-pandemic experience of providing an early abortion. First, it omits most of the testing that is typically done in a clinic, including getting an ultrasound to establish how far along the pregnancy is, and blood tests.

Instead, patients complete an online symptom checklist that rules out rare conditions that could make medication abortion dangerous, like an ectopic pregnancy or a bleeding disorder. The patient reports when her last period was, which establishes the gestational age of the pregnancy.

At some telehealth abortion companies, clinicians provide live video visits, but others may never interact with the patient in real time. Many companies simply have clinicians review a patient's intake form, then submit an electronic prescription for abortion pills to a mail-order pharmacy.

Several companies also offer what's called advance provision of abortion pills, which means patients can buy mifepristone and misoprostol even if they aren't pregnant, to be used if needed at a future date.

Patients pay with a credit card, a cash transfer app like Venmo, or if they don't want their purchase to be tracked, with a prepaid gift card. The pills arrive a few days later.

"I really love how empowering that is, and less paternalistic," says Dr. Kristyn Brandi (<https://www.acog.org/about/leadership-and-governance/get-involved/darney-landy-fellows>), a New Jersey family planning specialist who is a spokesperson for the American College of Obstetricians and Gynecologists. "To be able to trust people and give them the opportunity to take the medicine into their own hands."

There's a growing body of research that shows much of the testing and counseling ([https://www.contraceptionjournal.org/article/S0010-7824\(20\)30108-6/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(20)30108-6/fulltext)) that patients might receive during an in-person visit is not necessary for an abortion. A study of medication abortions provided via telehealth during the pandemic found them to be just as safe and effective at ending an early pregnancy as in-person care.

(<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451>)

Of course, certain patients may need tests or an ultrasound, and the protocol telehealth providers follow is designed to identify them. For instance, if a patient has severe pelvic pain or if she doesn't know the date of her last period, the telehealth abortion provider will usually send the patient for an ultrasound close by, then have her upload the results to the telehealth platform.

And there are specific criteria that would prompt a doctor to send their patient for blood work, including a history of severe anemia.

If it isn't safe to proceed with the telehealth abortion, either because the pregnancy is too far along or because the patient has a medical condition that makes it dangerous, the provider will refer the patient to a hospital or clinic.

Brandi says she thinks her patients understand that providing accurate information about their health is essential for safe medical care.

"In the family planning community, we have the mantra of trust women, or trust patients," Brandi says. "The patients are the experts in their lived experience. They know when their last menstrual period is. They know how certain they are of that or not."

Still, many doctors are accustomed to a "trust, but verify" approach to practicing medicine, which means confirming their patients' stories with objective medical tests. This is common in many areas of medicine. Many U.S. doctors worry they order too many tests on their patients (<https://pubmed.ncbi.nlm.nih.gov/28877170/>), yet feel compelled to do so.

And even though the research shows that telehealth abortion is safe without most testing, long-established patterns of medical practice can be slow to change.

"Providers may be set in their ways and slow to adapt the evidence," Brandi says. "I think medicine takes a little bit of time to adapt to the data and the research."

Even before the Supreme Court overturned *Roe*, abortion was often under so much scrutiny that over-testing became the norm. State laws specific to abortion drive more unnecessary testing than other areas of medicine, says Brandi. Certain states mandate that patients undergo an ultrasound (<https://www.guttmacher.org/state-policy/explore/requirements-ultrasound>), for example, even though it isn't always essential. Other states require blood and urine tests (https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/o28/chapter29/chap29toc.html&d=)).

"The testing that may often happen in the clinic, as just routine care, may not actually be as needed for everybody," Brandi says. "I think that's been driven by unnecessary abortion restrictions."

Even though telehealth abortion mostly takes place in states that don't have those kinds of laws, abortion is so politically charged that doctors everywhere remain particularly cautious about avoiding errors, says Brandi.

Telehealth abortion is also pushing the old boundaries of medicine by providing only very minimal counseling. Most patients can make the decision to end a pregnancy without needing to talk it through with a doctor, telehealth abortion providers say.

But giving up that counseling – and the close emotional bond that can arise from meeting patients in person – can be challenging for some abortion providers.

When Dr. Jamie Phifer, the medical director of Abortion on Demand (<https://abortionondemand.org/about/>) brings new medical staff on board, they often need "retraining," she says.

"There's this societal assumption that when your patient needs an abortion, it's a sad thing," Phifer adds, "You need to be present and hold their hand through it."

She encourages her staff to focus on an efficient review of medical information, rather than intensive counseling.

"You don't need to bring a lot of your own baggage as a physician into the visit," she says. "That's radical trust, in a lot of ways."

Of course, changing the culture of medicine does come with its share of pushback.

Tucker, the DC-area nurse practitioner, says she's gotten a lot of "ignorant comments" about her work providing abortion pill prescriptions online.

"This is how people are getting their Paxlovid [for COVID-19 infection] (<https://aspr.hhs.gov/COVID-19/Therapeutics/Products/Paxlovid/Pages/default.aspx>), but they don't act like that's coming off the back of a pickup truck," she says.

Even as telehealth clinicians embrace a more hands-off approach to providing abortions, many of them have to worry about being held liable for a procedure that takes place in uncharted legal territory.

That's because telehealth abortion is legal in many U.S. states (<https://www.kff.org/womens-health-policy/issue-brief/the-intersection-of-state-and-federal-policies-on-access-to-medication-abortion-via-telehealth/>), but it is also outright banned in others. And when the clinician is sitting at home in one state, and the patient is in another, and the clinic itself is online, it isn't always clear what it means to have an abortion in a given state.

When the FDA changed its policy to allow abortion pills to be sent through the mail, "there was an enormous amount of confusion," says Harry Nelson (<https://www.nelsonhardiman.com/attorney/harry-nelson/>), a health care lawyer who advises on telehealth abortion. "It was a real moment of uncertainty."

Even now, Nelson says that many of the legal subtleties undergirding the provision of telehealth abortion haven't been tested in court, and therefore aren't yet clearly established. As a result, doctors have to go to extreme lengths to legally protect themselves.

Abortion on Demand, for example, uses software that can detect approximately where a patient is located while connecting with the service. A patient can do her intake visit with the company from a state where abortion is restricted. But she must travel to a state where telehealth abortion is allowed to pick up the pills, which the company verifies by asking patients to send in a copy of a plane ticket, or taking a photograph of a receipt from a gas station along with the patient's identification.

"We keep a very, very conservative practice in terms of who we can treat and where their location is," Phifer says. "There's a lot of legal nuance around that."

Doctors haven't generally needed to worry about legal risks when prescribing many other types of medication across state lines, says Nelson, like sending in a refill when a patient's on vacation in a different state.

But with abortion, these practices are under more scrutiny. "All of a sudden, these are really highly charged questions, very high-risk questions," he says.

Tucker, the DC-area nurse practitioner, has taken steps to insulate herself from legal risk. For example, she has administratively separated her telehealth abortion company from her main private practice, where she provides general reproductive health care.

It's "due to the legal climate and the increased risk for providers," Tucker says. "Not knowing 100% ... If our pills are getting forwarded somewhere, if somebody's picking them up in Virginia, and going to Oklahoma, and my name is on this prescription bottle."

Despite these challenges, telehealth abortion companies say demand continues to grow, as patients become more comfortable with the legitimacy of the services and share their experiences with their friends.

"The most common comment that we get is: 'I can't believe this is so easy,'" says Phifer of Abortion on Demand. "Every day we have people who just start crying on the video visit ... They're crying because they're so relieved."

Seeking care over the internet can be empowering for patients, says Nelson, the health care lawyer, letting them choose the timing and location of their care.

"You don't have to explain yourself," he adds. "You're just like, 'This is what I need.'"

Mara Gordon is a family physician in Camden, N.J., and a contributor to NPR. She's on Twitter at @MaraGordonMD (<https://twitter.com/maragordonmd?lang=en>).

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Heidi Kocher - Practice Concentration and Experience

Heidi Kocher has more than 20 years of experience in health care legal and compliance related issues. Her experience includes positions at a large hospital corporation, serving as a compliance officer for a sleep lab / Durable Medical Equipment (DME) company and a compliance director, chief privacy officer and interim chief compliance officer at a medical device manufacturer. In addition, Ms. Kocher has represented and advised critical access and long-term care hospitals, physician groups, home health agencies, DME companies, pharmacies (including compounding pharmacies), non-profit organizations, and licensed individuals. As a result, Ms. Kocher understands the complexities and challenges that providers large and small face in complying with increasingly varied and complex laws.

Ms. Kocher is an expert in all aspects of compliance and privacy programs, including developing and deploying policies, procedures and training. Her experience includes implementing the various requirements and aspects of a Corporate Integrity Agreement, responding to and defending audits from Medicare, Medicaid and private insurers up through the Administrative Law Judge (ALJ) level, guiding clients through voluntary self-disclosures, seeking advisory opinions from the Department of Health and Human Services (HHS), Office of Inspector General (OIG), and defending Food and Drug Administration (FDA) audits. Ms. Kocher developed criteria for and implemented an aggregate spending system, permitting a medical device manufacturer to timely report correct information under the Physician Open Payments Acts (also known as the Physician Payments Sunshine Act). In addition, Ms. Kocher is experienced in developing and implementing a compliance program to address Foreign Corrupt Practices Act (FCPA) requirements, including Eucomed guidelines. Ms. Kocher also has significant reimbursement experience, addressing coverage policy issues, challenging denials, recoupments, and loss of billing privileges, obtaining HCPCS codes, and other reimbursement related issues.

In an acknowledgement of her experience, Ms. Kocher was recently appointed a lecturer in the University of Texas at Dallas' Bioengineering Department graduate program. Her course helps bioengineering and medical device entrepreneurs identify and navigate risks in commercializing and marketing new and innovative products. Additionally, Ms. Kocher is a highly sought national speaker on compliance and regulatory issues.

Ms. Kocher speaks fluent Spanish and German, and conversational French.



DEPARTMENT OF CONSUMER & REGULATORY AFFAIRS

District of Columbia Government

Corporations Division

Articles of Organization for Domestic Limited Liability Company

One or more persons acting as the organizers under the provisions of the Title 29 of D.C. Code (Business Organizations Act) adopt the following Articles of Organization:

First: Company name:

Forward Midwifery PLLC

Second: The street address of the initial principal office:

1331 H Street, NW

Washington, District of Columbia 2005

Third: Registered agent's name and address in the District of Columbia:

Christy Pitney, CNM

1331 H Street, NW

Washington, District of Columbia 20005

Fourth: The company will have one or more series that is treated as a separate entity which limits the debts, obligations, and other liabilities to the assets of a particular series as provided in the operating agreement as authorized by § 29-802.06: No

Answer 4A & 4B if answered "Yes"**Fourth A:** The limited liability company has at least one member: YES**Fourth B:** The date on which a person or persons became the company's initial member or members: 4/8/2022**Fifth:** Effective Date: 4/8/2022**Sixth:** Miscellaneous Provisions:

Midwifery and healthcare services

Seventh: Organizers Name & Address:

Name	Address
Heidi Kocher	P.O. Box 864391, Plano, Texas 75086-4391

Eighth: Organizers executing this form:

No information provided.

If you sign this form you agree that anyone who makes a false statement can be punished by criminal penalties of a fine up to \$1000, imprisonment up to 180 days, or both, under DCOC § 22-2405;

Amount Paid: \$99.00**Date:** 4/14/2022 10:54 AM**E-Signed**



— Our policy on AI-assisted content

We're going to be more direct about this than most sites:

We use AI tools in our content workflow. Specifically, AI tools are sometimes used to help find information, to help put together initial drafts, and to help structure long-form articles.

What AI tools never do:

- **AI does not write final clinical content.** Every AI-assisted draft is read in full by the clinical reviewer, edited for accuracy, and rewritten where the AI produced phrasing that was imprecise, outdated, or wrong.
- **AI does not generate clinical recommendations, dosing, or protocols.** Those come from the medical bodies listed above and from the clinical reviewer's training.
- **AI does not publish anything without human clinical review.** There is no "automated" content pipeline.
- **AI does not review or approve other AI-generated content.** Review is always human, always clinical.

This is part of why we publish less frequently than larger sites with paid editorial staff. Reviewing AI-assisted drafts carefully takes longer than approving content written by colleagues we trust, and we do not cut corners on the review.

We're explicit about this for a reason: increasingly, medical content on the internet is being generated by AI tools without human review, and patients have no way to tell the difference. Our position is that disclosure is more honest than denial.



**Southern
Woven**

Case 2:26-cv-03836

Document 1-41

Filed 09/30/26

Page 2 of 2 PageID #: 301

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Works

Learn

Resources

FAQs

**Start
Consultation**

 ES

**Safe
Exit**

Just Between Us

**Safe Abortion pill access
For Southerners By Southerners**

Get Pills Now

How It Works

For Southerners, By Southerners

Southern Woven was founded by someone who knows what it's like to grow up in a place where the choices feel like they're being made for you, not by you.



FROM A SOUTHERN WOVEN FOUNDER

I grew up in Louisiana and still have family there. I've lived in the South, moved through it, and watched it from the inside as a place that the rest of the country tends to talk about without listening to. The South is not one thing. It's not the caricature on cable news, and it's not the bumper sticker version on a bag of grits in an airport gift shop. It's people — most of them working harder than anyone gives them credit for, raising kids in places where the nearest hospital is an hour away, navigating health systems that were never designed with them in mind.

Southern Woven exists because I watched choices get taken away from those people, little by little, by elected officials who had more of those choices to begin with.

Why Southern Woven exists

Poverty in the South is not abstract. It's the deciding factor in whether someone can take a day off work to drive six hours to a clinic, whether they can afford a hotel near it, whether they can afford the procedure once they get there, and whether they can afford the time off when they get home. The states with the most restrictive abortion laws are also, by no coincidence, the states with the deepest poverty, the worst maternal health outcomes, and the fewest doctors. People in these states started out with fewer options than the lawmakers who voted to take more away.

Southern Woven was built on the idea that the people most affected by these laws are the ones best positioned to make decisions about their own lives — and that the rest of us should be making it easier for them to do that, not harder. Telehealth is the way we do that. Mail is the way we do that. A sliding scale that doesn't ask anyone to prove they're poor is the way we do that.

What we want is a world where people are treated as competent adults, capable of managing their own health and making their own decisions about their own bodies.

Most of what Southern Woven does is just removing the obstacles other people have placed between patients and that basic respect.

How we work

Southern Woven connects people with licensed clinicians who provide asynchronous telehealth medication abortion care. The model is simple on purpose: someone fills out a confidential intake, a licensed clinician reviews it, FDA-approved medications are mailed in discreet packaging, and support is available throughout the process. Most patients never need a phone call or a video visit. The whole thing can happen on someone's phone, in the spare moments between work and family.

Everything published on this site — clinical content, patient guidance, state-specific information — is reviewed by a credentialed clinician before it goes live. That review is the slowest part of how we work, and we're fine with that. Care this consequential should not be moving fast.



Working alongside the community

Abortion access in the South works because of an ecosystem of community organizations — abortion funds, mutual aid networks, miscarriage management providers, transgender health organizations, and reproductive justice groups doing the work that institutional medicine has historically failed to do. Southern Woven is one piece of that ecosystem. We're not trying to be the whole thing.

That means we refer out frequently. If you can't access care through Southern Woven for any reason — geography, eligibility, timing — there's a good chance another organization can help, and we'll point you in the right direction. Abortion funds can often cover costs we can't reduce further. Local mutual aid networks can help with transportation, childcare, and other practical needs. Specialized providers can offer in-person care, procedural care, or care past the gestational range we serve.

These organizations do work Southern Woven cannot do. They show up in places we cannot show up. We try to be useful to the ecosystem rather than competing with it.

A model built on trust

The sliding scale is \$0 to \$145. Nobody is turned away for inability to pay, and we don't ask for documentation of income, hardship, or anything else.

This is intentional. The medical system historically has treated patients as suspects — people who might be lying about their symptoms, exaggerating their pain, gaming the system for free care. That suspicion costs more than the care itself, in both money and in the dignity of the people seeking it. We start from the opposite assumption: that the person filling out the intake form knows their own life better than we do, including what they can pay.

The same logic runs through our clinical model. The intake asks people to share their medical history, the date of their last period, their current health. Our review process trusts that information. We don't require ultrasounds for most patients because the evidence shows we don't need to — last menstrual period and symptoms are sufficient for the vast majority of cases. We trust people to tell us about their own bodies, and that trust is part of the care.

That trust extends to information, too. We tell patients the actual failure rates of medication abortion, the actual risks of complications, the actual things that might go wrong. The medications we use have been in use for decades and have a long safety record — safer than many things people take without a second thought. But "very safe" is not "perfectly safe," and pretending otherwise would be a different kind of disrespect. Patients deserve real numbers, not reassurance.

Not every source claiming to help patients takes this approach. Some withhold information, distort what they share, or promote interventions that medical evidence does not support. Southern Woven takes the opposite approach: give people the full picture, including the parts that are uncomfortable, and trust that they're still the best person to make the decision for their own life.

About our clinical care

Clinical care at Southern Woven is overseen by a Certified Nurse Midwife with more than a dozen state licenses and clinical experience going back to 2010 across labor and delivery, women's health, and complex gynecology. Every clinical document published on this site is reviewed against current standards from the American College of Obstetricians and Gynecologists (ACOG), the World Health Organization (WHO), the National Abortion Federation (NAF), and the Society of Family Planning (SFP).

The medical review page describes our clinical standards and review process in detail.

What we are, and what we're not

Southern Woven does one specific kind of work — telehealth medication abortion care for early pregnancy. We're not a full reproductive healthcare provider. We're not a birth center. We're not an emergency service. If you're past 13 weeks of pregnancy, if you need a procedural abortion, if you're navigating a complex medical situation that needs in-person care, we'll point you toward the providers and organizations who can help.

What we can do, we do well. And what we can't, we try to make sure you can find somewhere else.

One thing worth being clear about: Southern Woven is the platform. The care comes from your Southern Woven clinician, a licensed provider who reviews your intake, decides whether medication abortion is appropriate for you, and writes the prescription. This website does not practice medicine and does not make that decision. It connects you to the person who does.

Start a Consultation

About Our Clinical Care

For legal questions about your specific situation, the [If/When/How Repro Legal Helpline](#) (844-868-2812) is free and confidential and is the right first call.



Safe, private, and accessible reproductive healthcare delivered with compassion

Services

- Clinical Consultation



Get Started Today

We're here to support you through every step of your reproductive health journey

Where You Are

We're where you need us to be



Serving the South

Safe and discreet delivery to your door



We're where you are!

We're here to help — start a consultation to see if we can serve you.

Our Mission

Southern Woven expands access to medication abortion in the South by connecting people with licensed telehealth clinicians. We believe everyone deserves access to safe, affordable abortion care regardless of their ability to pay.

How Your Donation Helps

Every donation directly supports:

- People who cannot afford the full cost of medication
- Reducing barriers to accessing timely abortion care
- Ensuring no one is turned away due to cost

About Our Fiscal Sponsor

We partner with CE Repro Fund, our fiscal sponsor, to process donations securely and transparently. CE Repro Fund is a 501(c)(3) nonprofit organization.

100% of your donation goes directly to supporting abortion access through Southern Woven.

Your donation is tax-deductible to the extent allowed by law.

Ready to Make a Difference?

Click the button below to make a secure donation through our fiscal sponsor, CE Repro Fund.

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FAQs

Is Southern Woven Legit? Here's What You Should Know

 Southern Woven Medical Team  April 10, 2026  5 min read

Is Southern Woven Legit?

If you searched "is Southern Woven legit," we get it. That's a smart question to ask before trusting any online healthcare provider, especially for something this personal.

The short answer: **yes**. Southern Woven is a real telehealth service staffed by licensed clinicians who prescribe FDA-approved medications for abortion and [missed period pills](#). Our availability varies by state and can change over time; when you begin a consultation, we'll tell you right away if we're able to serve you where you are. Our care is confidential, affordable, and medically supervised.

But you shouldn't just take our word for it. Here's how to verify us yourself.

Who We Are

Southern Woven is a telehealth medication abortion service. We connect people with licensed healthcare providers who can prescribe FDA-approved medications used safely by millions of people worldwide for over 30 years.

[Start Consultation](#)

Our care is available on a **\$0–145 sliding scale** because we believe cost should never be the reason someone can't access healthcare.

How to Verify Us

Don't just trust us. Check us yourself:

Check Our Referral Partners

Southern Woven is a referral partner of some of the most trusted organizations in the reproductive health space:

- **Plan C** (plancpills.org). The leading resource for information about accessing abortion pills in every state. Plan C links directly to our consultation page.
- **AbortionFinder.org**. A verified directory of abortion services. AbortionFinder also links to Southern Woven.
- **INeedAnA.com**. A trusted search tool for finding abortion services. Southern Woven is listed as a verified provider.

These organizations vet providers before listing them. If they trust us enough to send people our way, that's a meaningful signal.

Look at What We Actually Do

Here's what happens when you start a consultation with Southern Woven:

1. **You fill out a health questionnaire.** We ask about your medical history, current medications, allergies, and timing. This is how real medicine works.
2. **A licensed clinician reviews your case.** Not an algorithm or a chatbot. A real healthcare provider looks at your information and makes a medical decision, usually within one business day.
3. **If approved, your medications ship.** FDA-approved medications, sent in plain, discreet packaging with no branding on the outside.

[Start Consultation](#)

Check Our Privacy Protections

All care through Southern Woven is:

- **HIPAA-protected:** your information is encrypted and confidential
- **Discreetly shipped:** plain packaging, no indication of contents
- **Legally protected:** our providers operate under [shield laws](#) in their home states

For tips on protecting your own digital privacy, see our [digital privacy guide](#).

Why People Ask This Question

We understand why you're cautious. Here's what's going on:

There are a lot of options out there, and it's hard to know who's who. Some sites are telehealth clinics, some are community organizations, and some are anti-abortion organizations pretending to be healthcare providers. When you're searching for help at a stressful time, it's hard to sort through it all.

Telehealth for abortion is still relatively new. Even though medication abortion has been around for decades, getting it through telehealth, especially across state lines, is a newer model. It makes sense to want reassurance that it's real.

The name might be unfamiliar. We're not a massive corporation with a Super Bowl ad. We're a focused service built specifically to reach people in the communities that need us most. Being small doesn't mean being illegitimate. It means being intentional.

For a broader guide to evaluating any online abortion service, check out our checklist: [How to Tell If an Online Abortion Service Is Legit](#).

What We Don't Do

Transparency goes both ways. Here's what we're upfront about:

Start Consultation

- We do **not** provide legal advice. For legal questions, we always refer to the **If/When/How Repro Legal Helpline** at **844-868-2812**
- We do **not** claim that accessing care through telemedicine is "legal" in every state. What we say is that people across all 50 states are safely accessing care, and that shield laws protect the providers who prescribe

We'd rather be honest than oversell. You deserve a provider who tells you the truth.

Real Care, Real People

We know that searching for abortion care online can feel isolating and stressful. We built Southern Woven because we believe that everyone deserves access to safe, compassionate reproductive healthcare.

If you have questions before starting a consultation, you can reach us:

- **Email:** hello@southernwoven.com
- **Phone:** 845-THE-PILL
- **Consultation:** [Start here](#)

We're real. We're here. And we're on your side.

This information is for educational purposes and is not a substitute for medical advice. Content reviewed by the Southern Woven Medical Team.

Last updated: September 2, 2026 **Last medically reviewed:** April 10, 2026 Southern Woven Medical Team

This is educational content only and is not medical or legal advice. Medication abortion regimens may vary, and the right plan for you depends on your specific situation. For care decisions, talk to your provider. For legal questions, contact [If/When/How](#) at 844-868-2812.

Start Consultation



Southern Woven Healthcare

Donate to Southern Woven

Powered by the CERepro Fund (a licensed 501(c)(3) nonprofit)

Why Southern Woven?

Southern Woven is a community-driven organization that creates safe, dignified pathways for people in the South to access essential reproductive health services and related counseling. By weaving together local clinics, tele-medicine providers, and grassroots outreach, Southern Woven ensures that:

- **Everyone gets timely, confidential care**, even if they live in an area where care is difficult to access.
- **Financial barriers are lowered** through a sliding-scale model that covers medication, clinical support, and after-care.

Your contribution helps keep that safety net intact.

CE Repro is a funding partner who ensures that your donation goes to Southern Woven, while still allowing you to make a tax deductible donation.

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hello@cerepro.org

Choose amount

One-time

Monthly

Quarterly

\$5

Pay to ship one package of abortion pills to a patient in need.

\$15

Provide one dose of Misoprostol (the second medicine in the abortion kit) for a patient in need.

\$25

Provide one hour of administrative support.

\$44

Provide one mifepristone pill to a patient in need.

\$88

Provide 2 mifepristone to help two patients in need.

\$150

Fund a medication abortion service from start to finish with Roxy clinic, which includes medications, clinical support, and after care.

\$300

Fund 2 full services

\$450

Help even more patients!

\$ Other

USD

- ☐ Add note/comment
- ☐ Give in honor/memory

Continue

Midwife and doula supported **medication** **abortion** in all 50 states

[START HERE](#)

How it works:

Complete an online intake form

We'll ask about your medical history to confirm your eligibility.

A U.S. licensed provider will review your history and contact you to coordinate your care.

Select a price and complete your payment

We offer a range of price options using a sliding-scale, 'pay-what-you-can' model.

We trust you to consider your ability to pay and select a payment amount that fits your situation.

Receive your treatment by mail

We provide care in all U.S. states, Guam, Puerto Rico and APO addresses.

In most cases, you will receive your treatment by mail within 2 - 3 business days.

Message with our team for ongoing support

Our accompaniment team provides 24/7 support via secure messaging.

You can keep in touch with us as much or as little as you like before, during and after your treatment.

The legal context of abortion care is different in every state and policies are changing frequently.

Find up-to-date information about the laws and recommended security practices when receiving abortion care via telehealth in your state [here](#).

About our care

Who are the providers?

We Take Care of Us connects you with Certified Nurse Midwives (CNMs) specializing in whole-person, trauma-informed reproductive healthcare care. All CNMs are U.S. licensed providers. The CNMs we help connect you with focus on health promotion, wellness care, gynecologic and family planning services.

What is telehealth?



How much does care cost?



I can't afford an abortion. Is financial assistance available?



Do you take insurance?



Is support available if I have questions?



Complete this form to determine your medical eligibility to receive care for medication abortion, miscarriage management or menstrual regulation.

This form should take about 5 - 7 minutes to complete.

How it works:

First:

We'll ask questions about your medical history to check that you are eligible according to guidelines set by the FDA and World Health Organization. You'll find out immediately if you are eligible for care with one of our affiliated U.S. licensed providers.

Next:

If you are eligible and you wish to continue, we will:

- Collect the following person details:
 - Full name
 - Contact info (this is where a provider from our team will reach you)
 - Shipping address (where your medication will be mailed)
- Request a signature from you consenting to our services
- Provide you with information about our pay-what-you-can pricing model
- Collect and process your payment

All information you provide is confidential.

While each person's care is different, you can expect your provider to contact you about your care plan within 1-2 business days of completing this form.

How much it costs:

We use a pay-what-you-can pricing model. We understand that everyone's situation is different. We offer a range of price options to account for these differences.

Once your eligibility is approved, you will see a detailed description of your pay-what-you-can price options. We trust that you will honestly consider your ability to pay and select a price that fits your situation.

[Back](#)[Next](#)

STEP 1

Complete the request form and provide all the required information



GET STARTED

1. Share the details of your pregnancy and medical history.
2. Upload a clear picture of your government-issued ID card.
3. The total cost is \$150. However, we offer financial assistance for those who cannot afford the full amount. Please note that funding is limited and may be exhausted.

If you are unable to cover the cost of the medications, please let us know. We can help connect you with a funding agency.

If you have any questions text (707)200-8291

STEP 2

Complete the required consent forms



After submission, you will receive a communication—either a text message or an email—containing a link to create your secure patient portal account.

Once your request form has been reviewed, you will need to log into the patient portal to sign all necessary consent forms. Please note that all forms must be fully completed and submitted through the portal before you can receive care.

STEP 3

You have been approved to receive care!



Once our healthcare provider has determined that no additional preliminary steps are required, we will notify you via the secure communication portal when you have been medically cleared to receive the service.

To ensure the prompt delivery of your medications following medical clearance, please confirm your current mailing address with us as soon as possible.

STEP 4

Prepare to receive your medications!!



We will send you a message via the secure communication portal containing the following information:

- Detailed instructions on how to take the medications.
- A guide on what to expect during the medication abortion process.
 - Advice on how to manage your symptoms.
- Tracking details for your package.

Please note that the package will arrive in an unmarked box to protect your privacy, and you should expect delivery within 3–5 days.

HOME

ABORTION PILL

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CHOICES RISING

Choices Rising is a virtual clinic offering medication abortion (abortion pill) you can take at home.

Who and What We Are...

Based out of California, Choices Rising was founded in 2022 by a team of licensed healthcare professionals with a vision of using telemedicine to expand access for all people who seek safe and affordable abortion care from the privacy of their own homes.

Our small team has over 50 years of combined reproductive healthcare experience. Our board-certified physicians and registered nurse are here to educate, advise, and support you while providing access to the FDA-approved medications for safe in-home abortion treatment.

Our mission is to provide the highest quality, non-judgemental medical care to women who seek early pregnancy intervention. Our goal is to enable you to be an autonomous participant in your own healthcare decisions.

We are committed to your health and well-being. We are unequivocally, steadfastly committed to your freedom of choice!!

We work with our patients as advisors, collaborators, and partners in helping you all make the best decisions for yourselves.

What we value most...

- Respect
- Dignity
- Compassion
- Integrity
- Accessibility
- Expertise
- Love

We're a proud member of the Abortion Care Network (ACN).

— How will state specific laws affect my pregnancy options?

Depending on how far along your pregnancy is, you may have different abortion options available to you—some of this depends on the laws in your state.

It's important to try to have the abortion as soon as possible if that's what you choose.

To find out more about what is legal in your state and where to go if you are at a later stage in your pregnancy and want an abortion, visit [Ineedana.com](https://www.ineedana.com).

The [Guttmacher Institute](#) also provides a state-by-state breakdown of current Abortion Laws – see [An Overview of Abortion Laws](#). All links can be found on our Resources page, too.

— Will I need to have a video consultation?

Louisiana



OR

Choose Policy

Abortion Policies

Abortion Data

Abortion Policies in Louisiana

MOST RESTRICTIVE

States have constructed a web of abortion laws and regulations that restrict or support whether, when and under what circumstances providers can offer abortion care and a pregnant individual can obtain an abortion. While a state's abortion policies affect all people seeking care, they are particularly significant for individuals who find it difficult or outright impossible to access care when forced to navigate around abortion bans and restrictions. This includes people already facing barriers due to factors like their race, income, age or gender identity.

Abortion policies currently in effect in Louisiana include the following:

- Abortion is completely banned with very limited exceptions. People can still access abortion care via telehealth from states with shield laws or by traveling to another state.
- State constitution explicitly excludes abortion rights
- Patients forced to make two trips—one for in-person counseling and another at least 24 hours later for the abortion
- Patients forced to get an ultrasound even if medically unnecessary
- State Medicaid coverage of abortion care is banned except in very limited circumstances
- Private health insurance coverage of abortion (specific to insurance purchased on health exchanges) is banned except in very limited circumstances
- Medication abortion can only be provided after in-person visit because state requires pills to be dispensed in person. People can still access abortion care via telehealth from states with shield laws.
- Targeted regulations are in force that single out abortion care unnecessarily; many are designed to shutter abortion clinics without basis in medical standards
- Parental consent is required for a minor's abortion
- Only physicians can provide abortions and not other qualified health care professionals
- Abortion reporting required

LOS ANGELES BUSINESS JOURNAL

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HEALTH CARE

Abortion Activists

BY HOWARD FINE

JULY 10, 2023



Team: Honeybee Health co-founders Peter Wang and Jessica Nouhavandi.

When **Jessica Nouhavandi** and **Peter Wang** founded online pharmacy **Honeybee Health Inc.** in late 2017, they didn't imagine that six years later their Culver City company would be on the front lines in the nation's abortion wars.

But now, as one of the nation's leading providers of online mail-order medication abortion pills, Honeybee Health has taken center stage in the effort to ensure that as many women as possible have access to medication abortions, even as anti-abortion activists are pushing to outlaw the pills entirely.

The company has filed an amicus brief siding with the defendant, the Food and Drug Administration, in a lawsuit filed by anti-abortion groups aiming to overturn the FDA's 2000 approval of mifepristone – the first pill in the two-pill medication regimen – and subsequent policies to expand access to that drug. A decision from the Fifth U.S. Circuit Court of Appeals in this landmark case is pending.

Honeybee Health is also working with abortion rights activists to move legislation in Sacramento granting a liability shield to medication and surgical abortion providers in California who make treatment or pills available to residents of states where abortion is now outlawed.

And, as the public face of Honeybee Health, Nouhavandi has emerged as a leading national spokeswoman for efforts to increase access to medication abortions, which, according to several reports, now comprise roughly half of intentional pregnancy terminations.

"This is a matter of health care and shouldn't be a political issue," Nouhavandi said. "But it is a political issue and so I have gotten involved."



As a result
personal security when she travels.

Generic medication focus

This wasn't in Nouhavandi's business plan when she and Wang started their business in 2017 and launched online operations around the beginning of 2019.

Nouhavandi and Wang had intended their online pharmacy business to help patients without health insurance obtain affordable generic medications. The business model was simple: obtain large quantities of hundreds of commonly prescribed generic medications and sell those medications at steep discounts of up to 80% from prevailing market rates to uninsured patients.

And for the company's first two full years selling online – 2019 and 2020 – it grew wildly fast. For the three-year period ending in 2020, revenues grew more than 19,000% to \$5.2 million, making Honeybee Health by far the top company on the Business Journal's Fastest Growing Private Companies list.

But then the pandemic hit and changed things overnight.

The pandemic forced the immediate shutdown of most abortion clinics – even those primarily dispensing medication abortions – in spring 2020. Clinic operators immediately reached out to online pharmacy operators to try to convince them to mail the two-pill regimen for medication abortions – mifepristone and misoprostol – to patients once clinicians had prescribed them through telehealth sessions.

But at the time, there was no clear guidance from the FDA on whether this practice was even legal. When the agency approved mifepristone in 2000, it explicitly said it had to be prescribed by a clinician following an in-person patient visit. The FDA didn't outright ban mail-order sales, but nearly all pharmacy operators interpreted it that way and chose not to heed the calls from clinic operators to provide the pills via online mail order.

All except Nouhavandi and Wang's Honeybee Health, which began providing the pills in the late spring of 2020.

"We were pioneers in this gray area," Nouhavandi said.

This move was welcomed by women's reproductive health rights activists.

"Honeybee was the first to actually look at the restrictions and say, 'Hey wait a moment, they don't mention anything about mailing,'" said **Francine Coeytaux**, co-founder and now strategic advisor to Plan C Pills, a nonprofit campaign whose fiscal sponsor is Washington D.C.-based National Women's Health Network. "It was pushing the interpretation. She (Nouhavandi) stepped up and started doing this."

At that time, Honeybee kept quiet about its online sales of abortion pills, choosing not to mention it for a previous Business Journal story in late 2021. Nouhavandi said recently this was an intentional policy aimed at avoiding a political outcry as Honeybee, along with other medication providers, attempted to convince the FDA to suspend its in-person requirement for the dispensing of mifepristone during the pandemic emergency.

The FDA paused its in-person clinic requirement in May 2020, a move that was upheld by a judge in July of that year. After some back-and-forth over the next year, the suspension was made permanent in late 2021.

That suspension cleared the way for Honeybee Health to sell mifepristone legally. Because of its head start, Honeybee quickly became one of the nation's largest providers of online medication abortion pills. By mid-2021, sales of medication abortion pills comprised roughly one-third of Honeybee's overall revenue, which was about \$15 million for that entire year.

Dobbs decision

But Nouhavandi and Wang knew that this would not be the end of their difficulties in selling abortion pills. The other shoe dropped a year ago, when the United States Supreme Court, in its landmark ruling in *Dobbs vs. Jackson Women's Health Organization*, overturned the 1973 *Roe vs. Wade* decision that legalized abortion nationwide and essentially left abortion rules up to individual states.

In the mo

states including in their language bans on medication abortions. And activists in many of those states have since set their sites on outlawing the sale of abortion pills nationwide.

“We now have a cadre of lawyers on staff just to track all this legislation and all the court battles now going on,” Nouhavandi said. “It’s a state-by-state battle right now.”

Unlike Honeybee’s previous stance in pushing the envelope, Nouhavandi said the company is observing the abortion bans enacted in the 24 states and is not selling abortion pills to individual patients or medical providers in those states with complete bans. “In most of those states, we sell other generic medications that have nothing to do with abortions and we don’t want to jeopardize our licenses to sell those medications in those states,” she said.

But in the remaining states, Honeybee Health is welcomed.

“We first learned about Honeybee Health through others in the abortion space as the pioneering first pharmacy willing to ship mifepristone,” said **Kiki Freedman**, chief executive of **Hey Jane**, a New York-based virtual clinic offering telemedicine abortion care.

“We had previously been mailing (pills) from doctors’ offices, and their (Honeybee’s) entry into the market allowed us to massively streamline our operations and reach more patients,” Freedman added.

Nouhavandi added that in the last couple years Honeybee has packaged the sale of abortion pills with other related reproductive health products, including pregnancy tests, anti-nausea medications and contraception.

In the meantime, Honeybee Health in January of this year became the first online pharmacy certified by the FDA to sell mifepristone on an ongoing basis, subject to meeting and maintaining certain safety requirements. (The other medication abortion pill, misoprostol, has long been FDA-approved for other uses, such as controlling gastric ulcers and is therefore readily available. The FDA has also approved misoprostol for use in terminating abortions, but only when paired with mifepristone as part of a two-pill regimen.)

B-to-B Focus

The abortion pill business line and the pandemic also combined to open up another unanticipated market for Honeybee Health: Physician practices, telehealth providers and virtual care partners – “anybody who provides some or all of their care online,” as Nouhavandi put it – as markets for the rest of their generic medication products.

As recently as two years ago, 80% to 90% of Honeybee’s business was direct-to-patient, with most of those patients being uninsured. But that has now started to change.

“Virtual care was something that was foreign to most people before the pandemic,” Nouhavandi said. “But once they started using it, people like the privacy, convenience and speed. That’s the future of providing health care.”

The goal, she said, is to become the online pharmacy of choice, particularly for telehealth providers with lots of uninsured patients. To help with this effort, Nouhavandi said Honeybee intends to launch another funding round later this year.

“We are looking to sign up more and more telehealth providers,” she said.

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The Brief

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HEALTH

Abortion drugs

Bill would allow doctors to prescribe anonymously

By Patrick Adams | NPR

Published September 10, 2025 11:00 AM



Medication abortion with the two-drug regime of mifepristone and misoprostol is the most common form of abortion in the U.S.
(Natalie Behring / Getty Images)

A California bill that would allow health care providers to anonymously mail abortion drugs could soon become law, marking the latest effort by a blue state to safeguard access to medication abortion.

The two-drug regimen of mifepristone and misoprostol is used in more than 60% of abortions in the U.S., and roughly a quarter of abortions are now done via telehealth, according to the Society of Family Planning.

Under the measure, which the legislature is considering this week, doctors, pharmacists and others authorized to prescribe the drugs to end a pregnancy could leave their name off the prescription label.

Abortion rights advocates say the measure adds to protections already on the books under the state's existing shield law, one of a handful nationwide that protects doctors who mail

abortion pills out of state by shielding them from extradition and other legal actions from states with abortion bans.

According to recent studies, shield laws have expanded abortion access – roughly 12,000 abortions a month are provided under the laws, the vast majority to patients living in the nearly two dozen states that ban or severely restrict the procedure.

Now, as legal attacks against telehealth providers put shield laws to the test, some states have moved to strengthen the laws by allowing providers to prescribe anonymously, reducing their risk of legal or individual harassment. To date, five states — New York, Maine, Massachusetts, Vermont, and Washington — have passed these laws, while a similar bill in Pennsylvania is currently in committee.

"We've now had a solid two years of shield law provision, and like a lot of things, with real-world experience, we've identified areas [of the law] that can be strengthened or made more explicit," said Dr. Angel Foster, a co-founder of the Massachusetts Medication Abortion Access Project, a clinic near Boston that mails pills to patients in states with abortion bans. Massachusetts passed its bill allowing anonymous prescribing of abortion pills in early August.

Recent legal attacks against doctors in New York and California, have put shield laws to the test. So far, they've worked as intended, says Greer Donley, a law professor at the University of Pittsburgh who has advised legislators across the country on crafting shield laws. "But it's clear that anti-abortion advocates are going to be looking very hard for additional cases they can bring."

Removing the name of the provider from the label on the package adds another layer of protection, she says. "It makes it a lot harder to find the person you're trying to target." And protecting doctors can ensure that patients have access to abortions.

Opponents of abortion counter that shield laws have turned those states into safe havens for criminal activity.

"So-called shield laws are yet another tactic abortion activists use to exploit the FDA's reckless mail-order abortion scheme," said Erik Baptist, senior counsel for Alliance Defending Freedom, the Christian legal advocacy group that led the fight to overturn Roe v. Wade in 2022. "These shield laws are designed to obstruct other states from protecting unborn babies and their mothers against the dangers of abortion drugs."

California's key role in abortion access

If California passes this law, it could shape access to medication abortion for patients across the country, reproductive health advocates say. That's because California-based pharmacies have come to play a pivotal role in the distribution of abortion pills nationwide.

Few shield law providers mail mifepristone themselves, with most relying instead on pharmacies in California.

"We're really the main hub for mailing abortion pills," said Jessica Nouhavandi, lead pharmacist and co-founder of the online pharmacy Honeybee Health, which was the first U.S.-based online pharmacy to ship abortion pills directly to patients and remains the nation's largest distributor of mailed abortion pills. "Almost everything comes out of California, and mainly from Honeybee."

One reason for that is the sheer amount of work required to dispense mifepristone, which is tightly regulated by the Food and Administration under special rules known as a Risk Evaluation and Mitigation Strategy, or REMS.

"The REMS really requires providers to be clinicians but also pharmacists," said Anna Fiastro, a researcher in family medicine at the University of Washington and a co-founder of Access, Delivered, a UW-affiliated research initiative that works to advance telehealth medication abortion services across the U.S. "On top of their clinical duties, providers have to order, stock and store the medication, which are all steps they're not taking to prescribe other medications."

The California bill, AB 260, would remove not only the name of the prescribing clinician, but also that of the patient receiving the medication and the pharmacy that mails it, effectively extending California's protections to providers across the country.

"We're being asked to carry out standard-of-care medicine under the constant threat of legal harassment," Nouhavandi said. "This bill doesn't just protect providers legally — it's a statement that we're not alone. And that matters, because access to care only exists if there are people still willing to provide it."

Legal attacks target telehealth providers

Recent legal attacks against a New York-based physician, Margaret Carpenter, have underscored the reality of those threats. In February, a Texas judge ruled against Carpenter in a civil suit brought by attorney general Ken Paxton, ordering her to stop prescribing and sending abortion pills to patients in Texas and imposing a penalty of more than \$100,000.

Then, in January, Carpenter was indicted by a grand jury in Louisiana for allegedly prescribing abortion pills to a pregnant minor and charged with criminal abortion by



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from hundreds of studies and clinical trials and 24 years of approved use has shown that the pills are safe and effective, whether dispensed in person or via telemedicine.

On Feb. 11, Landry signed an extradition warrant for Carpenter, though New York's Democratic governor Kathy Hochul has said she won't extradite Carpenter, citing New York's "strict shield laws that anticipate this very situation." Experts say both of the cases are likely to end up in front of the Supreme Court.

Still, advocates say the updates to California's law can't come soon enough.

"This is really, really urgent," said a New York-based physician who spoke on the condition of anonymity due to the threat of legal actions. The physician is one of a handful of U.S. providers working on behalf of the Europe-based nonprofit Aid Access, the largest organization of shield law providers.

"We're prescribing 12,000 pills a month to people all over the country," they said. "We need to get our names off these labels so that we don't have to live in fear."

And that may be the real goal of cases like Carpenter's, says Farah Diaz-Tello, senior counsel and legal director at reproductive health advocacy group If/When/How: to scare and intimidate people in the hope that they'll be too afraid of possible legal action and give up.

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CLIMATE & ENVIRONMENT

Hurricane Polo

Coastal erosion and flooding possible in SoCal



Lucas Brady Woods covers the weather and disasters, among other climate and science topics.

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Nos. 25A1207, 25A1208

IN THE
Supreme Court of the United States

DANCO LABORATORIES, LLC,
Applicant,
v.
LOUISIANA, *et al.*,
Respondents.

GENBIOPRO, INC.,
Applicant,
v.
LOUISIANA, *et al.*,
Respondents.

ON APPLICATIONS TO STAY THE JUDGMENT OF THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

**BRIEF OF *AMICUS CURIAE* HONEYBEE HEALTH, INC.
IN SUPPORT OF APPLICATIONS BY DANCO AND
GENBIOPRO TO STAY OR VACATE THE
FIFTH CIRCUIT'S STAY PENDING APPEAL**

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TABLE OF CONTENTS

	<u>Page</u>
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT.....	1
ARGUMENT	3
I. Mail-Order Pharmacies Benefit Patients’ Health and Autonomy.	3
II. Obtaining Mifepristone by Telehealth and Mail-Order Pharmacies Is Safe and Effective.....	7
III. The In-Person Dispensing Requirement for Mifepristone Seriously Harms Patients and Mail-Order Pharmacies.	12
A. Eliminating access to mifepristone by mail harms patients.	12
B. Prohibiting mail-order dispensing of mifepristone inflicts serious harm on mail-order pharmacies.....	17
CONCLUSION.....	20

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INTEREST OF AMICUS CURIAE¹

Amicus curiae Honeybee Health, Inc. (“Honeybee”) is a mail-order pharmacy run by a board-certified pharmacist with more than twenty years of experience. Honeybee was the first mail-order pharmacy in the United States to dispense mifepristone by mail after the U.S. Food and Drug Administration (“FDA”) lifted the in-person dispensing requirement for mifepristone. Honeybee dispenses the highest volume of mifepristone by mail of any U.S. mail-order pharmacy. Honeybee only dispenses mifepristone by mail in jurisdictions whose laws permit it to do so (currently thirty-one states and the District of Columbia) and does not ship mifepristone to Louisiana. It has safely dispensed hundreds of thousands of orders of mifepristone to date.

Honeybee submits this brief to highlight: (1) the role that telehealth and mail-order pharmacies play in providing patients with access to high-quality and low-cost healthcare and medications; (2) the many studies showing the safety and efficacy of using medication, including mifepristone, dispensed by mail-order pharmacies; and (3) the harms that the in-person dispensing requirement will impose on patients and mail-order pharmacies.

SUMMARY OF ARGUMENT

Telehealth and mail-order pharmacies play a vital role in ensuring that patients have access to safe and effective healthcare and medication. Medications

¹ No counsel for any party authored this brief in whole or in part or made any monetary contribution to its preparation and submission.

have been delivered to patients by mail for more than 100 years, and in recent years, use of mail-order pharmacies in the United States has increased dramatically. Research has shown that the use of telehealth and mail-order pharmacies is safe and effective and benefits patients by improving health outcomes, providing cost savings, and promoting patient privacy and autonomy.

Access to mail-order pharmacies promotes individual patients' ability to obtain high-quality and affordable healthcare in the manner that is most appropriate for them. That is true for mifepristone, which is an essential part of the recommended and most commonly used medication abortion regimen in the United States. Numerous studies have shown that prescribing mifepristone by telehealth and using mail-order pharmacies to dispense it is safe and effective, with an extraordinarily low rate of serious adverse outcomes. Research also underscores that this model is a safe and effective way of providing patients with timely access to abortion care. Thus, substantial scientific evidence supports the FDA's decision to lift the in-person dispensing requirement for mifepristone. The Fifth Circuit's decision disregards this scientific evidence.

Reinstating the in-person dispensing requirement eliminates access to mifepristone by mail even in states where abortion is legal. This imposes severe harm on patients who rely on mail-order pharmacies to obtain this medication. This harm falls hardest on patients who face difficulties accessing in-person healthcare and brick-and-mortar pharmacies. The in-person dispensing requirement also seriously harms mail-order pharmacies, like Honeybee, that have relied on the FDA's

determination that dispensing mifepristone by mail is safe and effective. The in-person dispensing requirement eliminates a significant portion of Honeybee's business and jeopardizes the viability of mail-order pharmacies more broadly.

ARGUMENT

I. Mail-Order Pharmacies Benefit Patients' Health and Autonomy.

Telehealth, telemedicine, and mail-order pharmacies play a vital role in ensuring that patients have access to safe and effective healthcare and medication, including mifepristone.² Decades of experience have shown that telemedicine is safe and effective, and provides patients with important benefits, including cost-savings and increased healthcare access.³ Research has also demonstrated that telehealth and telemedicine is as effective as in-person care,⁴ and may be more effective in some circumstances.⁵

² Although the terms "telehealth" and "telemedicine" are often used interchangeably, "telehealth" refers broadly to "the use of telecommunications technology in health care delivery, information, and education," including pharmacy services, whereas "telemedicine" "refers specifically to clinical services." Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, 17 J. Nurse Prac. 218, 218 (2021).

³ Victor C. Ezeamii et al., *Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care*, 16 Cureus e63881 (2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11298029/>.

⁴ E.g., Carly McCord et al., *Comparison of in-person vs. telebehavioral health outcomes from rural populations across America*, 22 BMC Psychiatry 778 (2022); Joseph Ford & Markus Reuber, *Comparisons of Communication in Medical Face-To-Face and Teleconsultations: A Systemic Review and Narrative Synthesis*, 39 Health Comm'n 1012, 1012, 1017 (2023).

⁵ E.g., Derek J. Baughman et al., *Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System*, 5 JAMA Network Open e223367 (2022),

Mail-order pharmacies like Honeybee play an integral role in the telehealth ecosystem. Between 1996 and 2018, use of mail-order pharmacies in the United States increased by approximately fifty percent.⁶ An estimated 200,000,000 prescriptions are delivered by mail annually.⁷ Like brick-and-mortar pharmacies, mail-order pharmacies are subject to regulation by state pharmacy boards and must comply with FDA regulations as to the medications that they dispense.⁸

Substantial scientific evidence confirms the safety, efficacy, and benefits of using mail-order pharmacies.⁹ For example, research has shown that patients who use mail-order pharmacies often exhibit better adherence to their medication

<https://pubmed.ncbi.nlm.nih.gov/36156147/>; Christopher M. Jones et al., *Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic*, 79 JAMA Psychiatry 981, 981, 991 (2022).

⁶ Duy Do & Pascal Geldsetzer, *Trends in Mail-Order Pharmacy Use in the U.S. From 1996 to 2018: An Analysis of the Medical Expenditure Panel Survey*, 61 Am. J. Preventative Med. e63, e69 (2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8319048/>.

⁷ Adam W. Gaffney et al., *Health Needs and Functional Disability Among Mail-Order Pharmacy Users in the US*, 181 JAMA Internal Med. 554, 555 (2021).

⁸ See, e.g., 21 C.F.R. § 1304.40; *Locate a State-Licensed Online Pharmacy*, U.S. Food & Drug Admin., <https://www.fda.gov/drugs/besaferx-your-source-online-pharmacy-information/locate-state-licensed-online-pharmacy> (last visited May 2, 2026).

⁹ E.g., Junyi Ma & Li Wang, *Characteristics of Mail-Order Pharmacy Users: Results from the Medical Expenditures Panel Survey*, 33 J. Pharm. Prac. 293, 293 (2018); Phil Schwab et al., *A Retrospective Database Study Comparing Diabetes-Related Medication Adherence and Health Outcomes for Mail-Order Versus Community Pharmacy*, 25 J. Managed Care & Specialty Pharm. 332, 332, 337–39 (2019); Daniel Grossman et al., *Mail-order pharmacy dispensing of mifepristone for medication abortion after in-person clinical assessment*, 107 Contraception 36, 36 (2021). See also Julie A. Schmittiel et al., *The Safety and Effectiveness of Mail Order Pharmacy Use in Diabetes Patients*, 19 Am. J. Managed Care 882, 884, 886 (2013) (finding that use of mail-order pharmacies “may be associated with improved health outcomes”).

regimens, which in turn can lead to better health outcomes.¹⁰ For example, a 2018 study showed that stroke patients who had been prescribed anticoagulant, antiplatelet, anti-glycemic, antihypertensive, and/or lipid-lowering medications were more likely to adhere to their medication regimen if they used a mail-order pharmacy, rather than a brick-and-mortar pharmacy.¹¹ Similarly, a 2019 study found greater medication adherence among patients with type 2 diabetes mellitus who used mail-order pharmacies.¹²

Additionally, data show that using mail-order pharmacies provides significant cost savings.¹³ For example, a study published in 2010 found that patients with diabetes who switched from retail pharmacies to mail-order pharmacies “trended toward lower total and diabetes-related medical costs over time.”¹⁴ And a 2020 study found that “overall health-care costs including medication costs, inpatient costs, and

¹⁰ *E.g.*, Ma & Wang, *supra* note 9, at 293; Schmittdiel et al., *supra* note 9, at 882, 885.

¹¹ William P. Neil et al., *Mail order pharmacy use and adherence to secondary prevention drugs among stroke patients*, 390 J. Neurological Scis. 117, 118–19 (2018).

¹² Schwab et al., *supra* note 9, at 332, 339; *see also* Bharathi Ramachandran et al., *A Randomized Encouragement Trial to Increase Mail Order Pharmacy Use and Medication Adherence in Patients with Diabetes*, 36 J. Gen. Internal Med. 154, 154, 158–60 (2020) (finding that mail-order pharmacy use improved adherence to a key class of diabetes medications); Joan M. Neuner et al., *Medication delivery factors and adjuvant endocrine therapy adherence in breast cancer*, 197 Breast Cancer Rsch. Treatment 223, 223 (2023) (“Mail order users had higher adherence in both commercial and Medicare-insured cohorts [of breast cancer patients].”)

¹³ *See* Ma & Wang, *supra* note 9, at 293; *see also* Julie A. Schmittdiel et al., *Opportunities to encourage mail order pharmacy delivery service use for diabetes prescriptions: a qualitative study*, 19 BMC Health Serv. Rsch. 422 (2019).

¹⁴ Scott Devine et al., *A comparison of diabetes medication adherence and healthcare costs in patients using mail order pharmacy and retail pharmacy*, 13 J. Med. Econ. 203, 203 (2010).

outpatients costs, are . . . lower for mail-order pharmacy users.”¹⁵ These cost savings are particularly important at a time when many patients find that healthcare costs are spiraling out of control.¹⁶

Telehealth and mail-order pharmacies also increase the availability of healthcare for many patients, particularly those who live in remote areas, lack access to transportation, or have disabilities that make travel difficult. For these patients, mail-order pharmacies make it possible to obtain medication that otherwise would be

¹⁵ Ma & Wang, *supra* note 9, at 293.

¹⁶ Recent polling shows that “[j]ust under half of U.S. adults say it is difficult to afford health care costs,” with one-third saying “they have skipped or postponed getting health care they needed because of cost” in the past 12 months and one in four saying they “have not filled a prescription . . . because of the cost.” Grace Sparks et al., *Americans’ Challenges with Health Care Costs*, KFF (Apr. 30, 2026), <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>. Moreover, “[h]ealth care costs remain at the top of the list of people’s financial worries, with nearly two-thirds (64%) saying they are at least somewhat worried about affording the cost of health care.” *Id.*

difficult, if not impossible, to obtain.¹⁷ And patients who use telehealth and mail-order pharmacies cite increased privacy as a further benefit.¹⁸

II. Obtaining Mifepristone by Telehealth and Mail-Order Pharmacies Is Safe and Effective.

Mail-order pharmacies like Honeybee play a vital role in providing patients with safe and effective access to mifepristone by mail.¹⁹ Medication abortions now account for nearly two-thirds of abortions provided nationwide.²⁰ Mifepristone is an

¹⁷ See Ezeamii et al., *supra* note 3 (“Telemedicine can eliminate the need for long-distance travel for patients in rural or underserved areas, reducing the time and costs associated with accessing healthcare.”); Natalie Lawson et al., *Disability and telehealth since the COVID-19 pandemic*, Ctr. Health & Rsch. Transformation (Aug. 29, 2022), <https://chrt.org/wp-content/uploads/2022/08/RRTC-Telehealth-Aug-2022-1.pdf> (explaining that telehealth can benefit people with disabilities by, inter alia, lessening the need to coordinate transportation, increasing access to specialists, and supporting independence); Pankajkumar A. Anawade et al., *A Comprehensive Review on Exploring the Impact of Telemedicine on Healthcare Accessibility*, 16 *Cureus* e55996 (2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11009553/> (“[T]elemedicine extends healthcare reach to remote and underserved areas while enhancing temporal accessibility with round-the-clock availability.”)

¹⁸ *E.g.*, Leah R. Koenig et al., *Patient Acceptability of Telehealth Medication Abortion Care in the United States, 2021-2022: A Cohort Study*, 114 *Am. J. Pub. Health* 241, 246 (2024) (reporting that 76% of patients who obtained abortion care through telehealth cited increased privacy as a benefit); *see also* Yam B. Limbu & Bruce A. Huhmann, *What influences consumers’ online medication purchase intentions and behavior? A scoping review*, 15 *Frontiers in Pharmacology* 1356059 (2024), <https://doi.org/10.3389/fphar.2024.1356059> (“[C]onsumers’ perceptions of privacy can influence their decision to buy some prescription medicines online . . .”).

¹⁹ *See, e.g.*, Abigail Adams, *Meet the Pharmacist Expanding Access to Abortion Pills Across the U.S.*, *TIME* (June 13, 2022), <https://time.com/6183395/abortion-pills-honeybee-health-online-pharmacy/>.

²⁰ *See* Isaac Maddow-Zimet et al., *Abortion in the United States*, Guttmacher Inst. (Mar. 2026), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>.

essential part of the recommended²¹ and most commonly used²² medication abortion regimen.

In evaluating Plaintiffs' likelihood of success on the merits, the Fifth Circuit failed to consider the abundance of scientific evidence demonstrating that dispensing mifepristone by mail is safe, effective, and beneficial to patients. During the COVID-19 crisis, the FDA determined that mifepristone can safely be dispensed by mail-order pharmacies in order to minimize burdens on patients, without jeopardizing patients' health.²³ As Applicants Danco Laboratories, LLC, and GenBioPro, Inc. explain in detail in their applications to this Court, that initial nonenforcement determination was supported by robust scientific evidence, and even more compelling evidence supported the FDA's December 2021 decision to lift the in-person dispensing requirement²⁴ and its 2023 formalization of that decision.²⁵ Thus, mifepristone has

²¹ Am. Coll. Obstetricians & Gynecologists, *Medication Abortion Up to 70 Days of Gestation*, Practice Bulletin No. 225 (Oct. 2020, *reaff'd* 2023), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation>.

²² *The Availability and Use of Medication Abortion*, KFF (Mar. 20, 2024), <https://www.kff.org/womens-health-policy/the-availability-and-use-of-medication-abortion/> (“The most common medication abortion regimen in the United States involves . . . mifepristone.”).

²³ In implementing risk evaluation and mitigation strategies with respect to drugs like mifepristone, the FDA is required to “minimize the burden on the health care delivery system” and ensure that access to the drug is not “unduly burdensome on patient access to the drug.” 21 U.S.C. § 355-1(f)(2)(C)– (D).

²⁴ See U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research, REMS Modification Rationale Review, at 4 (Dec. 16, 2021).

²⁵ See U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research, Application No. 020687Orig1s020 Summary Review (Jan. 3, 2023); *see also* Memorandum on

been available to patients through telehealth and mail-order pharmacies since the height of the COVID-19 pandemic.

Research from before and after the FDA's decision confirms the safety, efficacy, and benefits of dispensing mifepristone by mail. For example:

- A 2024 study reviewing over 4,500 medication abortions prescribed via telehealth and obtained by mail-order pharmacy found that 97.7% of patients completed the abortion without further intervention, with a serious adverse event rate of only 0.25%.²⁶ This study looked at both synchronous and asynchronous models of telehealth care and found no difference in safety or effectiveness.²⁷
- A study analyzing data for nearly 4,000 patients who visited either in-person or telehealth clinics and obtained abortion medication through either in-person or mail-order dispensing concluded that there was no statistically significant difference in the safety or efficacy of medication abortion when the patient received the medications by mail, rather than in person.²⁸

Further Efforts To Protect Access to Reproductive Healthcare Services, 88 Fed. Reg. 4895 (Jan. 22, 2023).

²⁶ Ushma D. Upadhyay et al., *Effectiveness and safety of telehealth medication abortion in the USA*, 30 Nature Med. 1191, 1191 (2024).

²⁷ *Id.* at 1192.

²⁸ See Ushma D. Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA Internal Med. 482, 487 (2022).

- In a study of over 500 patients who obtained telehealth abortion care and abortion medication dispensed by mail, telehealth abortion care and abortion medication dispensed in person, or in-person care, researchers concluded that medication abortion through telehealth and mail-order dispensing has similar efficacy rates to in-person care, with “low rates of [adverse events] overall.”²⁹
- A 2024 study of 1600 patients who obtained abortion care by telehealth and obtained abortion medication from a mail-order pharmacy found that “nearly all [patients] were very satisfied with telehealth abortion,” including because this model ensures more privacy and is less expensive and faster than traveling to a clinic.³⁰
- A meta-analysis of 21 studies published between 2011 and 2022 determined that there are no differences in the safety, effectiveness, and patient satisfaction between telemedicine medication abortion and in-person abortion care.³¹ The study also found that the wait time to receive abortion medication was around 4.2 days shorter for those who used telemedicine as opposed to those who received in-person care.³²

²⁹ Lauren J. Ralph et al., *Comparison of No-Test Telehealth and In-Person Medication Abortion*, 332 JAMA 898, 901, 903 (2024).

³⁰ Koenig et al., *supra* note 18, at 248.

³¹ Leonardo Cely-Andrade et al., *Telemedicine for the provision of medication abortion to pregnant people at up to twelve weeks of pregnancy: a systematic literature review and meta-analysis*, 21 Reprod. Health 136 (2024).

³² *Id.* at 18.

Other research underscores that telehealth is a safe and effective way for patients to obtain timely access to abortion care. For example, studies confirm that telehealth medication abortion “[is] as effective, timelier, and potentially more accessible than in-clinic care,” with telehealth patients “receiv[ing] care more quickly” and seeking care earlier in pregnancy than patients who receive in-clinic care.³³ Researchers have also found that mailing mifepristone for patients’ in-home use “[does] not significantly prolong [the] time from patients’ first contact with the clinic to mifepristone ingestion or increase pregnancy duration at mifepristone ingestion.”³⁴ Moreover, pregnant persons who take mifepristone at home are no more likely than patients who take mifepristone at a health clinic to call a provider’s office or make an unplanned medical visit than those who receive in-person care.³⁵

Even when patients obtain mifepristone and misoprostol in person at a clinic, they complete the two-drug regimen at home. Thus, even before the FDA lifted the in-person dispensing requirement, nearly all medication abortions “occur[red] largely

³³ Silpa Srinivasulu et al., *Telehealth Medication Abortion in Primary Care: A Comparison to Unusual in-Clinic Care*, 37 J. Am. Bd. Fam. Med. 295, 299 (2024). *See also, e.g.*, Cely-Andrade et al., *supra* note 31; Amanda Cleeve et al., *The use of telemedicine services for medical abortion*, 6 Cochrane Database of Systematic Revs. CD013764 (2025), <https://pmc.ncbi.nlm.nih.gov/articles/PMC12135146/>.

³⁴ Leah R. Koenig et al., *Mailing abortion pills does not delay care: A cohort study comparing mailed to in-person dispensing of abortion medications in the United States*, 121 Contraception 109962 (2023), <https://doi.org/10.1016/j.contraception.2023.109962>.

³⁵ Yael Swica et al., *Acceptability of home use of mifepristone for medical abortion*, 88 Contraception 122 (2012); *see also, e.g.*, Grossman et al., *supra* note 9, at 39 (finding that of the few adverse events reported by patients who had under-gone medication abortion at home, “none . . . would have been avoided by dispensing medications in person rather than with the mail-order pharmacy”).

in nonclinical settings.”³⁶ In other words, “there is no medical reason for mifepristone to be dispensed in clinics.”³⁷

III. The In-Person Dispensing Requirement for Mifepristone Seriously Harms Patients and Mail-Order Pharmacies.

The in-person dispensing requirement for mifepristone seriously harms patients and mail-order pharmacies like Honeybee. If mifepristone is unavailable to patients by mail, it will effectively deny some pregnant persons access to this safe and effective abortion medication altogether, even in states where abortion is legal and protected by the state constitution. It also prevents mail-order pharmacies like Honeybee from dispensing this important medication in accordance with FDA regulations in states where it is permissible to do so under applicable state law. The Fifth Circuit’s Order failed to take these harms into account.

A. Eliminating access to mifepristone by mail harms patients.

Eliminating access to mifepristone by mail imposes severe harm on patients who rely on mail-order pharmacies for access to this medication, like the patients Honeybee serves.

The harms of restricted access to mifepristone fall hardest on patients who face barriers to accessing in-person healthcare and brick-and-mortar pharmacies, such as those who live in rural areas, are unable to travel, or have limited financial

³⁶ Nat’l Acad. of Sci., Eng’g & Med., *The Safety and Quality of Abortion Care in the United States* 56 (2018).

³⁷ Erica Chong et al., *Expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic*, 104 *Contraception* 43, 43 (2021).

resources.³⁸ Requiring mifepristone to be dispensed in person also harms survivors of sexual violence or other trauma who may need the greater privacy and autonomy that mail-order pharmacies provide.³⁹ For all these patients, being able to obtain mifepristone from a mail-order pharmacy can mean the difference between obtaining desired medical care and having to forgo it. *See, e.g., Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1139 (9th Cir. 2009) (“There is a general public interest in ensuring that all citizens have timely access to lawfully prescribed medications.”); *see also* 21 U.S.C. § 355-1(f)(2)(C) (requiring REMS elements to “not be unduly burdensome on patient access to the drug”).

³⁸ *See, e.g.,* Ma & Wang, *supra* note 9, at 293 (noting that many patients use mail-order pharmacies because they “live far away from a local pharmacy or have difficulty making the trip”); Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR Pub. Health Surveillance e45671 (2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC10664017/> (finding that telehealth reduced travel barriers and made it possible to obtain timely abortion care, particularly among patients who already face barriers to care); Nat’l Acads. of Sci., Eng’g & Med., *supra* note 36, at 58, 78 (“Financial burdens and difficulty obtaining insurance are frequently cited by women as reasons for delay in obtaining an abortion.”); Jill Barr-Walker et al., *Experiences Of Women Who Travel for Abortion: A Mixed Methods Systematic Review*, 14 PLoS ONE. e0209991 (2019), <https://doi.org/10.1371/journal.pone.0209991> (explaining that studies find burdens related to travel can negatively impact reproductive choices).

³⁹ *See* Elizabeth C. Romanis et al., *Safeguarding and Teleconsultation For Abortion*, 398 Lancet 555, 556 (2021) (“Many women in situations of intimate partner or family violence are prevented from attending a clinic in the first place.”); *see also* Koenig et al., *supra* note 18, at 248 (“Most patients also reported choosing telehealth for greater privacy[.]”); Emily M. Godfrey et al., *Patient Perspectives Regarding Clinician Communication During Telemedicine Compared With In-Clinic Abortion*, 141 Obstetrics & Gynecology 1139, 1143 (2023) (noting that telemedicine allowed patients to “talk more freely and openly”).

Limiting access to abortion has dire consequences for maternal and infant health. As discussed *supra* in Section II, accessing mifepristone through telehealth and mail-order pharmacies is safe and effective. Indeed, medication abortion carries far less risk for American women than childbirth. In 2017, the New England Journal of Medicine published an expert commentary observing that the maternal mortality rate for women having live births in the United States was 14 times higher than the associated fatality rate for medication abortions using mifepristone.⁴⁰ More recent data establish that lifting the in-person dispensing requirement has not altered the safety of the mifepristone regimen, which remains significantly safer than continued pregnancy and birth; indeed, deaths among mifepristone users are virtually non-existent.⁴¹ We also know that denying access to abortion threatens women’s lives.

⁴⁰ Mifeprex REMS Study Grp., *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376 N. Engl. J. Med. 790, 791 (2017); *see also* Nat’l Acads. of Sci., Eng’g & Med., *supra* note 36, at 74–76.

⁴¹ Daniel Grossman & Sarah Raifman, *Analysis of Medication Abortion Risk and the FDA Report “Mifepristone US Post-Marketing Adverse Events Summary Through 12/31/2024”*, Advancing New Standards in Reprod. Health (May 15, 2025), https://www.ansirh.org/sites/default/files/2025-05/Issue%20Brief%20MAB%20SAEs-May2025%20Final_0.pdf; *see also* Upadhyay et al., *supra* note 26, at 1191; Nat’l Acads. of Sci., Eng’g & Med., *supra* note 36, at 74–76. *See generally supra* Section II (discussing safety of dispensing mifepristone by mail).

Studies conducted both in the United States⁴² and abroad⁴³ have demonstrated a strong correlation between abortion restrictions and maternal mortality. Additional studies demonstrate that abortion restrictions are correlated with increased infant mortality rates.⁴⁴

Furthermore, restricting access to mifepristone will exacerbate health disparities across racial and income lines. Due to structural inequalities, Black Americans, for instance, are more likely to seek abortions than white Americans, and are more likely to be denied access to abortion due to restrictions and bans.⁴⁵ Black Americans also face higher incidences of maternal mortality and pregnancy complications, creating greater risk of experiencing adverse health outcomes when

⁴² *E.g.*, Amanda Jean Stevenson, *The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant*, 58 *Demography* 2019, 2019, 2023 (2021) (“Overall, estimated pregnancy-related deaths would increase for the total population by 7% in the first year of a [total abortion] ban and by 21% in subsequent years.”); Dovile Vilda et al., *State Abortion Policies and Maternal Death in the United States, 2015–2018*, 111 *Am. J. Pub. Health* 1696, 1699 (2021) (finding maternal mortality rates “were significantly higher . . . in states with the largest number of abortion restrictions”).

⁴³ *E.g.*, Ngo Valery Ngo et al., *Reproductive Health Policy Saga: Restrictive Abortion Laws in Low- and Middle-Income Countries (LMICs), Unnecessary Cause of Maternal Mortality*, 45 *Health Care for Women Int’l* 5 (2021).

⁴⁴ *E.g.*, Alison Gemmill et al., *US Abortion Bans and Infant Mortality*, 333 *JAMA* 1315 (2025); Parvati Singh & Maria F. Gallo, *National Trends in Infant Mortality in the US After Dobbs*, 178 *JAMA Pediatrics* 1364 (2024); Roman Pabayo et al., *Laws Restricting Access to Abortion Services and Infant Mortality Risk in the United States*, 17 *Int’l J. Env’t Rsch. Pub. Health* 3773 (2020).

⁴⁵ Latoya Hill et al., *What are the Implications of the Dobbs Ruling for Racial Disparities?*, KFF (Apr. 24, 2024), <https://www.kff.org/womens-health-policy/what-are-the-implications-of-the-dobbs-ruling-for-racial-disparities>.

access to abortion care is denied.⁴⁶ In short, the harms of restricting access to mifepristone will fall hardest on vulnerable communities who already face significant barriers to accessing healthcare.

Moreover, mifepristone has important medical uses in addition to its FDA-approved use as a part of a medication abortion regimen. For example, mifepristone has been effectively used for medical resolution of miscarriage, with a significantly higher success rate than other regimens.⁴⁷ Scientific studies also demonstrate that mifepristone is effective for managing and treating uterine leiomyomas,⁴⁸ for treating one type of brain tumor, and for treating endometriosis.⁴⁹ Depriving patients of access to mifepristone dispensed by mail will also harm patients who need mifepristone for reasons unrelated to abortion care.

⁴⁶ *E.g.*, Andreea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multi-State Analysis, 2008-2010*, 210 Am. J. Obstetrics & Gynecology 435.e1 (2014), <https://doi.org/10.1016/j.ajog.2013.11.039>; Anna Kheyfets et al., *The Impact of Hostile Abortion Legislation on the United States Maternal Mortality Crisis: A Call for Increased Abortion Education*, 11 Frontiers Pub. Health 1291668 (2023), <https://doi.org/10.3389/fpubh.2023.1291668>.

⁴⁷ Courtney Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 N. Eng. J. Med. 2161, 2161, 2167–69 (2018); Lisa Wu et al., *ExPAND Mifepristone: Medical Management of Miscarriage and Abortion in FQHCs*, 21 Annals Fam. Med. 468 (2023).

⁴⁸ See Blake M. Autry & Roopma Wadhwa, *Mifepristone*, StatPearls (Feb. 28, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK557612>.

⁴⁹ See Mifepristone (Mifeprex), Nat'l Libr. Med. (Feb. 15, 2026), <https://medlineplus.gov/druginfo/meds/a600042.html#ho>.

B. Prohibiting mail-order dispensing of mifepristone inflicts serious harm on mail-order pharmacies.

The Court should also consider the injury that reinstating the in-person dispensing requirement imposes on mail-order pharmacies such as Honeybee. Honeybee has relied heavily on the FDA’s determination that dispensing mifepristone by mail is safe and effective. Reinstating the in-person dispensing requirement causes significant and irreparable harm to Honeybee’s and other mail-order pharmacies’ business. The threat of existential harm to a company’s business merits considerable weight. *See, e.g., Doran v. Salem Inn, Inc.*, 422 U.S. 922, 932 (1975); *hiQ Labs, Inc. v. LinkedIn Corp.*, 31 F.4th 1180, 1188 (9th Cir. 2022); *Atwood Turnkey Drilling, Inc. v. Petroleo Brasileiro, S.A.*, 875 F.2d 1174, 1179 (5th Cir. 1989), *cert. denied*, 493 U.S. 1075 (1990); *John B. Hull, Inc. v. Waterbury Petrol.*, 588 F.2d 24, 28–29 (2nd Cir. 1978), *cert. denied*, 440 U.S. 960 (1979).

Dispensing mifepristone by mail accounts for about a quarter of Honeybee’s overall business. Thus, Honeybee’s business depends on its ability to dispense mifepristone to patients by mail in accordance with the FDA’s evidence-based regulations that permit it to do so. Under the regulatory regime the FDA has created, Honeybee has dispensed hundreds of thousands of mifepristone prescriptions by mail to patients in jurisdictions that permit it to do so.⁵⁰ Honeybee has been able to

⁵⁰ Honeybee is licensed by every board of pharmacy in each state to which it sends medication and only ships mifepristone to states that permit it to do so. Honeybee has implemented a system whereby specific medications have “Shipping Rules,” which define the states in which those medications are permitted to be shipped. In Honeybee’s system, mifepristone is only shipped to states that have permitted the use of such medication via applicable state laws and regulations.

dispense mifepristone at lower costs than other pharmacies, and it has serves some patients who may not otherwise be able to access the medication easily or at all. For example, Honeybee often serves patients who do not live near clinics or cannot afford the costs of in-person care and associated travel. Reinstating the in-person dispensing requirement for mifepristone eliminates a substantial portion of Honeybee's business and prevents it from providing a safe, essential, and effective medication to patients.

Honeybee has invested substantial time and resources to ensure that its dispensing of mifepristone complies with state and federal laws. Patients may utilize Honeybee's services only after they have received a prescription for mifepristone from a healthcare provider. And when filling prescriptions for mifepristone, the Honeybee team adheres to the FDA's REMS requirements,⁵¹ e.g., by: completing a Pharmacy Agreement Form; confirming that Honeybee has the requisite Prescriber Agreement with the prescribing provider on file; recording the lot number for the medication, and sharing that information on the patient's dashboard; and ensuring each patient receives their mifepristone prescription within four days.⁵² When Honeybee mails the medication, it provides the tracking number to the patient and the patient's healthcare provider, and notifies the patient once the shipping carrier has marked

⁵¹ See *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. Food & Drug Admin. (Apr. 8, 2026), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation#TheMifepristoneREMSProgram>.

⁵² Through its relationship with GenBioPro, Honeybee also completes annual audit questionnaires to ensure REMS compliance.

the order as delivered. If a shipment is delayed, the Honeybee team works with the patient's healthcare provider to ensure the patient receives the medication within the timeframe required by applicable regulations. Thus, Honeybee has devoted significant resources to developing systems and processes that comply with the FDA's evidence-based regulations, and reinstating the in-person dispensing requirement would cause Honeybee substantial harm.

Critically, reinstating the in-person dispensing requirement creates instability and uncertainty for mail-order pharmacies even outside the context of mifepristone. As set forth above, mail-order pharmacies invest substantial time and resources and develop considerable business interests based on the FDA's evidence-based determination to eliminate a restriction on mail-order dispensing. The Fifth Circuit's Order opens the door to similar challenges to countless other medications that mail-order pharmacies dispense, thereby threatening to destabilize other aspects of mail-order pharmacies' business. When the FDA makes an evidence-based determination regarding the safety and efficacy of dispensing a particular medication by mail, mail-order pharmacies need to be able to rely on the stability of that determination absent credible scientific evidence to the contrary. The Fifth Circuit's Order creates uncertainty that undermines the business model of mail-order pharmacies writ large. It also undermines the legitimacy of the mail-order dispensing model overall, despite ample research that mail-order dispensing is safe, effective, and beneficial to patients.⁵³

⁵³ See *supra* Sections I, II.

Like other mail-order pharmacies, Honeybee's business depends on its ability to dispense safe and effective medications, such as mifepristone, by mail in compliance with applicable federal and state laws. And Honeybee's practices present a paradigm for what mail-order pharmacies can offer: its technology and fulfillment processes ensure that the patients and their providers remain informed and connected, while its virtual services give patients the opportunity to realize greater privacy in receiving quality healthcare at a lower cost. Reinstating the in-person dispensing requirement for mifepristone seriously jeopardizes the viability of mail-order pharmacies like Honeybee and the benefits that they provide to patients.

CONCLUSION

For the foregoing reasons, Honeybee respectfully asks that this Court stay or vacate the Fifth Circuit's ruling.

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Respectfully submitted,

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Risking Everything to Offer Abortions Across State Lines

Doctors and midwives in blue states are working to get abortion pills into red states — setting the stage for a historic legal clash.



By Emily Bazelon

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When Linda Prine learned she was pregnant in 1970, she was a first-year college student in Wisconsin, where abortion was largely illegal. The doctor who gave her the news saw the look on Prine's face and handed her a slip of paper with a phone number. Prine waited until other students in her dorm left for class to call from a phone in the hallway. The woman she spoke to gave her the names of psychiatrists and told her to persuade them that she would be suicidal if she were to have a baby. Prine followed the instructions and was able to get an appointment for an abortion at the university hospital.

The night before, she checked into a room on the maternity ward with seven other women. A few of them, in their second trimester, were given large injections of saline into their uteruses, a means of inducing labor. Nurses refused to give them pain medication, and the women went into labor through the night, crying, as Prine and the other patients held their hands and wiped their brows.

The suffering of that night stayed with her, and after college, Prine became a labor organizer and a nurse. At her 10th high school reunion, she ran into an ex-boyfriend who had become a doctor. Prine decided that if he could do it, so could she. By the late 1980s — a decade and a half after *Roe v. Wade* made abortion legal — she was a resident in family medicine in New York, and her program offered training in surgical abortions, which was (and still is) unusual for that specialty. "I didn't realize how lucky I was," Prine told me recently over the phone. "They were training us to be activists as much as doctors."

When she became a physician, Prine worked at a primary-care center. If patients in her practice needed an abortion, she referred them to a stand-alone Planned Parenthood clinic, where she also worked. Outsourcing the procedure made little sense to Prine. "We did maternity care," she says. "We delivered babies. Why wouldn't we do abortions, which were so much less complicated? It seemed like we were swallowing the stigma." In 2000, she included surgical abortions as part of her regular practice and received funding in part to create a protocol for other primary-care clinicians to incorporate them as well.

That same year, the Food and Drug Administration approved a combination of two pills — mifepristone and misoprostol — for medication abortions, and Prine saw another way to make abortion care more accessible. She offered her primary-care practice as a site for clinical trials, run by other researchers, who found that it was safe and effective to give women the pills and send them home to miscarry, with backup care. "It was just

so much easier to integrate taking care of people with pills than with a surgical procedure in a busy primary-care office,” she says. “Anybody in primary care can do a pill — doctors, advanced-practice nurses, physician assistants. It takes about one hour of training to learn what you need to learn.”

But to her frustration, the F.D.A. erected barriers by requiring providers to obtain a special certification to dispense the pills and by placing a warning on mifepristone about life-threatening effects, citing safety risks to women (from the rare event of an incomplete abortion or a serious infection). The rules also mandated that providers see patients and give them the pills in person — blocking the path for medication abortion through telemedicine. And yet evidence mounted that it was safe and effective for patients to consult with doctors over phone or video when they were prescribed the pills, rather than having to go to a clinic. So abortion rights advocates including Prine pushed the F.D.A. to lift the rules preventing telemedicine abortions. Abortion opponents saw a threat that could put abortion, self-managed at home, in women’s hands, and they campaigned to prevent it. Beginning in 2011, 19 conservative states made it illegal to provide a medication abortion without seeing a patient in person, adding their own rules and penalties alongside the F.D.A.’s requirement of an in-person visit.

To providers like Prine, finding ways to increase access in red states became imperative when Texas imposed restrictions on abortion clinics in 2013 that led more than half of them to close. Prine started flying to New Mexico once a month to be the abortion provider at a clinic in Las Cruces, near the Texas border. As clinics continued to shut down in conservative parts of the country, she decided it was time to adopt more radical tactics. In 2019, Prine called Rebecca Gomperts, a Dutch physician and international activist, who, like her, saw abortion pills as the future.

More than a decade earlier, Gomperts started an online help desk, Women on Web, for people in countries where abortion was illegal or unavailable. In 2018, she expanded to the United States, starting a new telemedicine service called Aid Access, in response to pleas from women in states where clinics were closing and doctors were barred from offering telemedicine abortions. Gomperts used her Austrian medical license and prescribed pills to be mailed by a distributor in India — thus operating, she has found, beyond the reach of U.S. authorities.

Prine asked Gomperts how she could help, and with another doctor, she created the Miscarriage and Abortion Hotline, to answer questions from Aid Access patients and anyone else ending a pregnancy at home. A dozen doctors volunteered for hotline shifts. A year later, the pandemic began. Flights from India were grounded, and Aid Access’s supply of pills could not get to the United States. Gomperts appealed to clinicians in the United States for help. In July 2020, a federal judge eased the way by suspending the in-person requirement for medication abortion in light of the pandemic. A small group of doctors, including Prine, began supplying pills to Aid Access patients in states where they legally could. In the chaotic early months of the pandemic, the providers shipped pills themselves. “Handwriting the mailing labels was time consuming, so I got a labeling machine,” says Erika Bliss, a 53-year-old family-medicine doctor in Washington State. “I had a table in my office with 70 packages at a time ready to go.” When flights from India resumed, Gomperts and her network of American providers became the only telemedicine abortion service to publicly serve the whole country.

On June 24, when the Supreme Court overturned *Roe v. Wade*, Prine was in the car as her phone blew up with calls directed from a clinic in a blue state. She talked to dozens of women whose appointments for an abortion had just been canceled in Texas, Louisiana and Oklahoma. “People were a mess, so upset and angry, crying,” she says.



“Make the pills affordable and ensure that the most vulnerable people have access to them,” says Rebecca Gomperts, a Dutch physician who began prescribing abortion pills online in 2006 to women in places where they are illegal or unavailable. Alana Paterson for The New York Times

When the landscape settles, abortion is likely to be illegal or severely restricted in at least 20 states — where just two years ago, in 2020, about 250,000 people had abortions. It is clear that clinicians in those states will face imminent prosecution if they continue to provide abortions. What is much less clear is what happens if providers in blue states offer telemedicine abortions to women in states where that’s against the law. These clinicians, too, could be arrested or sued or lose their medical licenses. To protect themselves, they may have to give up traveling to certain parts of the country — and it’s still no guarantee.

In the face of so much uncertainty and an invigorated anti-abortion movement, large organizations and most clinicians are loath to gamble. But Aid Access providers think that the end of Roe calls for doctors to take bold action. Their answer is to mail many more pills to women who otherwise may be forced to carry pregnancies they don’t want.

Sitting in her office in New York, hundreds of miles from states that could go after her, Prine, at 71, was close to retirement and willing to take chances. “I don’t want younger physicians to be embroiled in lawsuits or criminally charged,” she said. “I’m the one that should happen to. Doctors like me who are at the end of our

careers, we should be the ones to step up.”

The court’s decision overturning Roe last June, Dobbs v. Jackson Women’s Health Organization, polarized the public while opening the door to a new threat — a direct clash among the states over abortion law. In jettisoning the single national standard Roe established, the court invited states to pass or enforce their own laws, which could be diametrically opposed to those of neighboring states. “In some states, voters may believe that the abortion right should be even more extensive” than Roe, Justice Samuel A. Alito Jr. wrote for the majority. “Voters in other states may wish to impose tight restrictions based on their belief that abortion destroys an ‘unborn human being.’”

Alito didn’t discuss what would happen if the new regime wound up pitting states against one another. Yet those tensions seem inevitable. Some advocates are turning to states to either end abortion — by treating it as a felony, including murder — or to safeguard it as a fundamental human right. “In a post-Roe country, states will attempt to impose their local abortion policies as widely as possible, even across state lines, and will battle one another over these choices,” three law professors, David S. Cohen of Drexel University, Greer Donley of the University of Pittsburgh and Rachel Rebouché, the dean of Temple University’s law school, wrote in a draft article for The Columbia Law Review in February. “In other words, the interjurisdictional abortion wars are coming.”

Cohen, Donley and Rebouché laid out legal strategies that could benefit an organization like Aid Access as it serves women seeking abortions in newly restricted states. The most promising, in their telling, were abortion shield laws — protections that states in favor of abortion access could offer their providers. Pro-access states can “promise that their law-enforcement agencies won’t investigate” a local provider who is accused by another state of helping a woman there have an abortion, Cohen told me. In civil as well as criminal cases, “their courts won’t recognize an anti-abortion state’s subpoena or a summons. They won’t extradite you.” A pro-access state could also try to protect providers from losing their medical licenses and prevent malpractice-insurance carriers from raising rates or dropping policies based on an out-of-state lawsuit.

State shield laws for abortion undermine basic premises of interstate cooperation. One state effectively throws a wrench into the enforcement of another state’s laws. Cohen, Donley and Rebouché argue that shield laws are a means for the abortion rights movement to “pivot from defense to offense.”

In March, Cohen testified before a committee of the Connecticut Legislature on behalf of the first abortion shield law. The bill, which passed in late April, said that Connecticut would not cooperate if Texas, for example, tried to prosecute or sue a Connecticut health care provider who performed an abortion for a patient who traveled to the state for the procedure.

Cohen saw Connecticut’s shield law as an important first step. But it didn’t address the scenario that he and providers like Prine think matters most: helping women for whom travel is out of reach. A quarter of women of childbearing age in the United States currently live — or will soon live — at least 200 miles from an abortion clinic. That distance tends to pose an insurmountable obstacle for a significant number of people, research shows, especially if they have low incomes. A trip out of state can easily run to \$2,000 or more and often requires lining up a place to stay and child care (most people who get abortions have children). If the burden of travel delays an abortion into the second trimester, the cost and strain rise.

A pro-access state could try to help more women by passing a shield law that covers providers who live within its borders and prescribe pills through telemedicine across state lines. But legally speaking, this is far more disruptive to state relations than protecting providers when patients travel to see them. “The whole model for telehealth law and policy is that telemedicine takes place where the patient is,” Rebouché says.

Article IV of the Constitution, which addresses the relationships among states, says that if a person charged with a crime in one state flees to another, she must be “delivered up,” or extradited, to the first state. If a doctor from Connecticut, for example, went to Texas, performed an illegal abortion there and then went home, Connecticut would have to send that doctor to Texas for prosecution. But courts have held in the past that if the person never set foot in the state that is prosecuting her, then she didn’t flee, and her state of residence has no constitutional obligation to extradite her. (For example, three suspects in an Ohio murder who were living in North Carolina successfully fought their extradition to Ohio in 1979 by saying they weren’t there when the crime was committed.) States often permit or require extradition even without an act of flight. Cohen, Donley and Rebouché argue that pro-access states could make an exception for providers of telemedicine abortions.

But there’s a catch. If a provider travels outside her home state while Texas has a warrant for her arrest, another state without a shield law could follow the customary practice of interstate cooperation — and extradite her to Texas. In addition, if an abortion provider in a pro-access state like Connecticut is *sued* in Texas rather than prosecuted, Article IV requires the states to help enforce a civil judgment. Connecticut would probably be obligated to comply in collecting damages, for example, if a family member of a woman who had an abortion won a lawsuit for the wrongful death of a fetus. To deter these sorts of suits, Cohen, Donley and Rebouché suggest that states that want to shield their abortion providers could authorize them to countersue for interfering with legally protected health care. “If you’re hoping for a \$1 million judgment in Alabama, but you know New York will let someone try to get it back from you, maybe you don’t sue in the first place,” Cohen says.

The closest historical analogy, however imperfect, for the coming clash may be the conflict between Southern and Northern states over fugitive slave laws in the 19th century. “There are genuinely significant differences between slavery and abortion, morally and legally,” says Jamal Greene, a law professor at Columbia University. “But it’s a reasonable starting point for understanding why it’s a problem, in a nation that wants to hold itself together, when individual states are allowed to make policy about basic rights that people feel extremely strongly about, on both sides.”

Tensions among the states can become corrosive. The framers of the Constitution gave enslavers the power to recapture enslaved people who escaped to free states. As the cause of abolition gained support, some free states passed personal liberty laws that protected Black people from kidnapping. In 1842, in *Prigg v. Pennsylvania*, the Supreme Court weighed in on the side of the South, striking down the conviction in Pennsylvania of a slave catcher for kidnapping a mother and her children.

Seizures of formerly enslaved people increased in the wake of the court’s ruling, but so did the resistance in free states, where people rejected the rule imposed by *Prigg*. The case “could easily be called the worst Supreme Court decision ever issued,” Greene wrote in *The Harvard Law Review* in 2011. The ongoing state-on-state clashes were one of many factors that contributed to the dissolution of the Union and the Civil War.

Today, with Republicans in power in states with abortion bans and Democrats in control of states with shield laws, partisan division could fuel the fight. Eventually, a case is likely to make its way to the Supreme Court, but Prigg shows that may not be the last word. “No legal rule says who has to stand down,” Greene says. “There could just be eternal conflict.”

Last December, when the Supreme Court heard the arguments in Dobbs, abortion rights groups rushed to get a response underway in states where they had political power. They offered an array of proposals, including state constitutional amendments enshrining the right to an abortion and funding for out-of-state patients.

The effort took on new urgency when a draft of Justice Alito’s opinion in Dobbs leaked to Politico in the beginning of May. Prine received a call from Shelley Mayer, a Democratic state senator in Westchester County and a supporter of abortion rights, who was also thinking about whether New York could pass a law that would allow providers to help women in other states who weren’t able to travel hundreds of miles for abortions.

Prine knew that to pass, a bill needed support from medical and abortion rights groups. It became clear that some were more open than others to the legal uncertainty of a telemedicine shield law. The Center for Reproductive Rights, a global legal group, which had already been researching how states could ensure access to abortion as widely as possible, came on board. “The risk is real, but the need is incredibly great, and we need to protect providers as best we can so they can help meet it,” says Elisabeth Smith, the center’s director for state policy. The New York State Academy of Family Physicians passed a resolution in favor of a telemedicine shield bill and set up meetings with other lawmakers. Reproductive Health Access Project, a group Prine helped found (and retired from in 2020), supported a petition drive for telemedicine and other abortion rights proposals.

But some abortion rights groups — the New York Civil Liberties Union and Planned Parenthood in New York — did not put their weight behind a telemedicine shield proposal. “We think it’s high legal risk,” Katharine Bodde, a lawyer for the N.Y.C.L.U., told me. “You don’t want to send providers false assurances that they are totally protected by the law” when an anti-abortion state still might try to sue or prosecute them. She was also concerned about “various consequences beyond our ability to reduce that risk.” For example, she says, a state like Alabama could retaliate by shielding Alabama therapists who use telemedicine to provide conversion therapy for L.G.B.T. patients in New York, where it’s illegal.

One reason the N.Y.C.L.U. and other groups didn’t use their political capital to push for telemedicine shield laws was that they had a different legislative priority: amending the State Constitution to broadly protect the right to birth control and abortion and prevent discrimination on the basis of pregnancy, as well as several other categories. (Passing an amendment is a multiyear process in New York; the first stage passed in a special legislative session on July 1.)

To Prine, the caution about legal risk was frustrating and familiar. “I just want to scream, ‘This is a public health emergency!’” she texted me at one point. Three years ago, when she started the Miscarriage and Abortion Hotline to help Gomperts, she heard similar arguments from some lawyers who supported abortion rights. “They said: You’ll get sued for malpractice. You’ll lose your licenses. You’ll face charges.” She went ahead anyway and never faced those dire consequences. The hotline has since become an essential resource for people who end their pregnancies at home. “These people who say ‘bad things will happen to providers’ — let us decide for ourselves. If we want to stick our necks out, what is the point of holding us back if it might benefit people who need abortions?”

But Prine and her allies couldn't muster enough support for a telemedicine shield proposal in New York. Instead, alongside Connecticut, California, Delaware, New Jersey, and New Mexico, New York passed a law that covers abortion providers when patients travel to the state.

In July, the kind of telemedicine shield law that Prine wanted advanced in a single state: Massachusetts. Cynthia Friedman, a state senator from the Boston suburbs, attached it to a bill that included the state's annual budget. Without using the word "telemedicine," Friedman sought to reduce risks to her state's health care providers from out-of-state charges and lawsuits "regardless of the patient's location" if they performed abortions that complied with Massachusetts law.

Prine watched with some envy as a broad progressive coalition, including reproductive rights, racial justice, labor and L.G.B.T. advocates, united behind Friedman's bill. It also included protection for providers of gender-affirming medical treatment. "We said, We can try to strengthen protections in our state as much as we can," says Carol Rose, the executive director of the A.C.L.U. of Massachusetts, which in contrast to the N.Y.C.L.U. helped draft the telemedicine shield provision with the state attorney general's office. Attorney General Maura Healey, a Democrat who is running for governor, said in a statement to me, "We cannot allow our agencies and institutions to become complicit in other states' efforts to block access to critical health care."

As the bill worked its way through the Legislature, the implicit protection for telemedicine received little press coverage, which was fine with the bill's supporters. It passed the State House 136 to 17 at the end of June and passed 40 to 0 in the State Senate. All that remained was the signature of Gov. Charlie Baker, a Republican who favors abortion rights. On July 29, Baker signed the bill into law. (Through a staff member, he declined to comment on why he supported a telemedicine abortion shield law.)

The Massachusetts law gave Prine and the other Aid Access providers momentum. They hoped it would set a new standard for other states to follow.

In August, Prine and Gomperts spent the weekend at a rented house outside Toronto with a group of doctors and midwives who work for Aid Access. Though some of the providers were friends or colleagues before they joined, this was the first time they were all meeting in person, after months of working over email and video chats.

There were seven Americans in the group, between the ages of 32 and 74. They saw reproductive health as endangered in the United States, and that propelled them. Erika Bliss in Washington State and another doctor in the Hudson Valley (who asked me not to name her for security reasons) had practices that included end-of-life care. Ruchi Kaul integrated Eastern and Western medicine in her primary-care practice in New Jersey. Christie Pitney and Robin Tucker were nurse midwives from the Washington, D.C., area. Razel Remen, a family-medicine doctor in Michigan, credited her activism to the progressive talk radio she listened to with her mother while growing up in Brooklyn. Suzanne Poppema, a 74-year-old reproductive rights leader in Washington State, joked that when people warned her she could lose her medical license, she told them that she was retired and didn't care.

"Imagine a very large number of providers prescribing from states with shield laws," says Razel Remen, a doctor in Michigan who works with Aid Access. "It would be really hard to go against all of us." Alana Paterson for The New York Times

The providers left their shoes at the door, took turns cooking meals and talked about how to get more abortion pills into women's hands in red states. They knew that Aid Access was singularly willing to do so. Since the lifting of the F.D.A. requirement of an in-person visit for prescribing mifepristone — a change the Biden administration made permanent in late 2021 — several start-ups had entered the telemedicine abortion market. They included nonprofit ventures (Just the Pill, Carafem) and private companies, like Abortion on Demand, Choix and Hey Jane, which has raised more than \$3 million in venture capital funding. Like Aid Access, the start-ups asked patients to fill out an intake form about their medical history and date of pregnancy, which a medical professional reviewed. But the start-ups offered more limited services. Most provided pills through the 10th week of pregnancy; Aid Access offers them through the 12th week, which studies have shown to be safe. Most notable, the start-ups didn't write prescriptions for pills in states with bans.

After Dobbs, queries to Aid Access tripled to about 3,600 a month from about 1,200, roughly two-thirds of them from women in states with abortion bans. A Mexican nonprofit, Las Libres, has started providing abortion pills to women in the United States. Individuals also send them privately. And it is possible to order pills straight

from a foreign drug distributor. (Neither Las Libres nor foreign distributors include a medical screening.)

For the Aid Access providers, who wanted to build trust with women and reach more of them, the main challenge was delivery times, which were affected by the patchwork of state laws. When Gomperts prescribed pills to people in states where abortion is illegal, they sometimes had to wait two or three weeks for the packages to arrive from India. Patients in states where telemedicine abortion is legal, by contrast, obtained prescriptions from the U.S. providers and received pills in just a few days from a California-based mail-order pharmacy, Honeybee Health.

On the Sunday afternoon of their weekend gathering near Toronto, the providers sat in a living room with burgundy marbled wallpaper and spoke with Francine Coeytaux, a longtime ally of Prine and Gomperts's and a founder and director of Plan C, which promotes access to self-managed abortions with pills. She floated an idea: What if the U.S. providers said they were prescribing pills for miscarriage management rather than abortion? That would allow the prescriptions to fall outside the scope of abortion bans, which meant an American pharmacy might fill them, speeding up delivery times.

The suggestion exposed an internal tension that the women in the room felt. They were desperate to figure out ways to continue doing what they had always done: provide abortions for women who needed them. And they knew that medically speaking, there was little distinction between abortion and miscarriage. "But that doesn't work for us legally," said the doctor from the Hudson Valley. "Two years ago, we were talking about how we might lose our licenses. The stakes have changed." In more than a dozen states, providing an abortion was now a felony. The punishment included a prison term ranging from two to 99 years. "We're talking about serious criminal charges."

"Those are life-changing consequences," Coeytaux acknowledged.

"We should be thinking first about a legal way to do this," the Hudson Valley doctor said.

There were already a couple of ways for women in states with abortion bans to receive pills without shipping from India. They could rely on mail-forwarding companies, which allow them to give an address in one state and receive a package in another. Aid Access also encouraged people to order pills in advance of being pregnant and stock them (as they might do with emergency contraception). But these options were a little complicated.

The best solution, from the perspective of most of the group's members, would be for more states to pass laws like the one in Massachusetts to shield telemedicine abortion. "Imagine a very large number of providers prescribing from states with shield laws," Remen said. She thought of all the clinicians in the country who supported abortion rights banding together, and her eyes widened with possibility. "It would be really hard to go against all of us. It would challenge the validity of the laws in the red states. It would look terrible for the U.S."

In such a scenario, the providers thought a U.S. pharmacy in a state with a shield law would fill the orders, cutting delivery times. And they saw another benefit. Poppema leaned forward. "The more people who are doing it, the harder it would be to find us," she said.

It's next to impossible to imagine doctors at larger, more established reproductive rights organizations debating risk in the way the Aid Access providers did. Gomperts, whom I wrote about in 2014 for the magazine, created the organization to "make the pills affordable and ensure that the most vulnerable people have access

to them,” she says. Aid Access asks for a fee of \$105 to \$150 (less than other telemedicine ventures) and accepts less or nothing from people who say they can’t afford to pay. The service is small and independent; Gomperts consults with the other providers and has final say.

“I had a table in my office with 70 packages at a time ready to go,” says Erika Bliss, a 53-year-old family-medicine doctor in Washington State who mailed abortion pills from her office in the beginning of the pandemic. Alana Paterson for The New York Times

Big institutions, by contrast, have lawyers who steer them toward strict legal compliance. For major groups that support abortion access, the history of abortion rights in the United States has created an exceptional basis for caution. Around the time of Roe in 1973, abortion care was anchored firmly in hospitals, which accounted for about 80 percent of the country’s abortion facilities. But as protesters, and the threat of violence, appeared, many doctors and medical institutions distanced themselves from the procedure. Today only 3 percent of abortions take place in hospitals and doctor’s offices. Planned Parenthood performs 37 percent of abortions, and independent clinics account for 58 percent, according to a 2021 report by the Abortion Care Network.

Segregated from the medical establishment, abortion providers can’t rely on that broad base of political and financial support. Instead, two organizations have become pillars of U.S. reproductive health care, giving them power and influence — but also making them prime targets for lawsuits and other legal attacks. Planned Parenthood, a \$2.5 billion nonprofit corporation, has affiliates with about 600 local and regional health centers. “For many patients of reproductive age, Planned Parenthood providers are their only source of health care,” a spokeswoman for the organization says. National Abortion Federation, which provides training and sets

standards for hundreds of clinics, runs the biggest abortion fund in the country, helping to pay for tens of thousands of procedures at its member clinics. “If we were not here, I can’t imagine what that would do to people looking for care,” Veronica Jones, N.A.F.’s chief operating officer, says.

Most brick-and-mortar clinics don’t offer telemedicine abortions, according to a 2021 study by the Abortion Care Network. Amid the legal uncertainty created by Dobbs, a few Planned Parenthood clinics and N.A.F. have put in place policies that underscore their full compliance with the new state bans and that have the effect of making it harder to get a medication abortion. The Planned Parenthood affiliate that provides medication abortions in Minnesota, Iowa and Nebraska told patients from states with bans that they could not pick up the medication and then return home. Instead, they had to take the full dose of the pills at a Planned Parenthood clinic, available only up to nine weeks of pregnancy.

The two-dose policy can mean patients who are traveling have to extend their trips for days. N.A.F. also didn’t want to take any chances. In August, the federation said that all its member clinics must attest that patients from states with abortion bans will take both doses of pills before going home in order to receive funding from N.A.F., The Washington Post reported. The change caused an uproar among some abortion providers. About 20 clinic directors signed a letter asking N.A.F. to reconsider, saying it would hurt the low-income patients, disproportionately Black and Indigenous people and other people of color, who most need their help. “Many patients will have to acquiesce to forced birth even if generous funding is available,” the letter said. It called on N.A.F. to “lead the way at this time in our field” so that other funds and providers can expand their services “rather than further restrict and contract from a place of fear.”

The reason for the two-dose policy, Jones told me, was concern about the legal liability of employees who staff N.A.F.’s patient hotline. “We needed to protect our staff and protect our organization,” she says. “But this has been so hard.” To respond to the directors’ concerns, the federation said it was considering alternative funding models.

Prine didn’t expect large organizations like Planned Parenthood to send pills into hostile states, but she wanted their political support for shield laws that would reduce the risk, she hoped, for providers who wanted to do so on their own. She and her allies see risk aversion, if it’s imposed throughout the abortion rights movement, as a losing strategy. In an August article in The Stanford Law Review, Cohen, Donley and Rebouché argued that abortion rights advocates should expect internal tumult in the wake of Dobbs. “People who care about the same ultimate goal of restoring abortion access will have principled, intense disagreements,” they write. “There are benefits to taking calculated risks that break new ground, even if otherwise allied people disagree.”

Abortion opponents are figuring out their own legal strategy. They are relying, for their own purposes, on the reluctance of abortion rights organizations to take chances. Last year, after Texas passed a law permitting anyone to sue an abortion provider (or someone who “aided and abetted” one), clinics in the state stopped procedures after six weeks of pregnancy, even though few suits were actually filed. “The second-largest state in the union essentially banned abortion, before Dobbs, and folks in Texas just continued their lives,” says Peter Breen, vice president and senior counsel for the Thomas More Society, a conservative law firm that often represents anti-abortion clients.

Breen, who advises Republican state legislators, is urging them to try to stop abortion clinics in blue states from treating out-of-state patients either in person or through telemedicine. He claims enforcing such laws won’t require surveilling women’s online searches or prosecuting them. Putting a stop to the flow of pills inside

the United States, in his view, will largely be a matter of bringing a few lawsuits and winning damages against abortion providers in states like Massachusetts or New York. “We recommend civil enforcement,” he says of his advice to legislators. “Put a stop to the illegal activity. It’s cleaner and easier.”

Breen doesn’t anticipate acts of mass civil disobedience by doctors or other medical professionals. They aren’t inclined in that direction, he surmises, and the abortion rights movement’s lawyers will stop them anyway. “Licensed professionals are not in the business of violating the law,” he says. “You have too much to lose.”

Other abortion opponents see potential political controversy in using lawsuits to crack down on providers who prescribe abortion pills across state lines. “If you want to have a regime that actually is effective in reducing abortion, you’re going to have to do something like that,” says Jonathan Mitchell, a former Texas solicitor general who drafted the state’s 2021 law broadly permitting private lawsuits. “But I don’t know if there’s the political will to do that.” The initial answer may depend on the lesson Republicans take from the November elections.

Abortion opponents have other legal tactics in mind as well. A model bill for the states, for example, proposed by the National Right to Life Committee and introduced in South Carolina over the summer, would make it a crime to give “information to a pregnant woman or someone seeking the information on her behalf” about “self-administered abortions or the means to obtain an illegal abortion.”

Such a law seems to violate the right to free speech. Still, over their weekend outside Toronto, the providers worried about a chilling effect at a moment when it’s crucial, from their point of view, to educate the public about abortion pills. Only about half of American adults have ever even heard of a medication abortion, according to a survey by the Kaiser Family Foundation last year. In July, a new health education nonprofit called Mayday Health put up three billboards in Mississippi, where abortion is banned, with the message “Pregnant? You still have a choice” and the link to its website, which shares information about ordering abortion pills online with a prescription. When the state attorney general sent Mayday a subpoena, the group put up more billboards.

In September, abortion opponents made another move. Twenty-two Republican state lawmakers in Utah wrote a letter to N.A.F. citing two arcane federal statutes enacted in 1873. Known as the Comstock laws, they sweepingly make it a crime to use the mail or other “interstate carriers” to send any drug, “article” or “thing” that produces an abortion. The statutes (which also make it a crime to send “indecent” publications through the mail) were challenged when Margaret Sanger opened the country’s first birth-control clinic in 1916 and haven’t been enforced since the 1960s. “We will do everything in our power,” the Utah lawmakers wrote, “to ensure that the U.S. attorney in the next Republican administration holds N.A.F. and its members accountable for every criminal act they commit in violation of these federal statutes.” In response to the letter, Jones said that N.A.F. was “supporting our members in Utah.”

Perhaps the hardest question for leaders in favor of abortion rights is how to evaluate the legal risk for *patients* who break their states’ abortion laws by taking abortion pills. No state explicitly makes it a crime to receive the pills through the mail. Only South Carolina and Nevada criminalize self-managed abortions. But since 2000, police officers and prosecutors have used other criminal laws in at least 61 cases to investigate or arrest people for supposed self-managed abortions, according to If/When/How, an abortion legal advocacy group.

In other words, though criminal enforcement is rare, it's not unheard-of. And post-Dobbs, it could rise. Black, Latina and rural white women with low incomes are more likely targets, according to National Advocates for Pregnant Women, which tracks pregnancy-related cases. "Abortion rights activists should not be minimizing the legal risk, especially for those who are already criminalized," says Jamila Perritt, president and chief executive of Physicians for Reproductive Health. "We know that sourcing pills outside the medical system has resulted in prosecution."

The Aid Access providers think their patients can weigh the risks and benefits. "People have a right to make choices about what's best for their own lives," Remen says. More than half of Aid Access patients are women of color, and more than 60 percent have children at the time of their abortions. Remen sees informing pregnant people of their full range of options as a tenet of reproductive justice, a Black-led movement that began in the mid-1990s and focuses on people from vulnerable communities. Reproductive justice places access to abortion in the context of "the human right to maintain personal bodily autonomy, have children, not have children and parent the children we have," as the organization SisterSong puts it.

One of the abortion-access movement's insights is that marginalized people have always had to go outside the law to be free. "We should talk about self-managing an abortion in every space we go in," says Marsha Jones, a reproductive-justice leader who helped found and runs the Afiya Center in Dallas. The organization, which assists Black women and trans people with H.I.V. and AIDS, offered abortion aid until Dobbs and continues to provide pregnancy and birthing services. "We provide you with the information you need to understand and make decisions for your bodies. Otherwise, we're the people taking the rights away."

In the second week of September, Prine participated in a webinar on state shield laws organized by one of the other Aid Access providers, Christie Pitney. About 60 providers from across the country appeared on Zoom, introducing themselves in the chat.

David Cohen explained how shield laws work, laying out the protections they can and cannot provide. A month earlier, during their weekend outside Toronto, some Aid Access providers joked about taking a last trip to Florida because they knew going out of state could become risky for them. Now the providers had a serious question: How do arrest warrants work — do you know if a state puts one out for you? (Answer: You might not.)

The group was also curious about the politics of the telemedicine abortion shield laws: Why hadn't states like California passed one yet? (Answer: small lobbying effort.) One provider pushing for such a shield law in California is Daniel Grossman, an obstetrician-gynecologist and the lead researcher of two large studies, published by Obstetrics and Gynecology in 2011 and 2017, that helped establish the safety of telemedicine abortions in the United States. This year, The Lancet published a study of about 3,000 Aid Access patients, which found that only 1 percent of them reported seeking treatment for a serious complication. "Telemedicine alone is not a solution to our access crisis," says Grossman, a professor at the University of California, San Francisco. "But we need someone or a group of people to do it in a big way publicly, so they can really make a difference for access. It's just frustrating to not be able to help patients in these places ourselves."

When Massachusetts made a state telemedicine abortion shield law a reality, the political ground began to shift in some other states. "Our view is that what Massachusetts accomplished" is "doable in New York," Donna Lieberman, the N.Y.C.L.U.'s executive director, told me in September, though she wasn't ready to sign off without seeing the details. Prine, who had been trying to connect with the N.Y.C.L.U. for months, finally heard

back about a meeting for late October. “We are asking questions about the mechanics of potential legislation,” a spokeswoman for Planned Parenthood in New York wrote in an email. “We are not opposed to the broader concept of telemedicine shield laws.”

With help from five or six providers in Massachusetts who are willing to test the state’s telemedicine shield law, Gomperts thinks Aid Access could multiply the number of women it serves. Providers could join the network rather than hang out a shingle on their own. Aid Access has found a malpractice carrier who would cover them, one of the doctors says. At the end of September, a founder of Honeybee Health, Jessica Nouhavandi, told me she was exploring setting up a legally separate pharmacy in Massachusetts so that her company could also take advantage of the state’s shield law.

As doctors and nurse practitioners in Massachusetts considered doing telemedicine abortions across state lines, they wrestled with a sobering personal decision, something like sailing into uncharted waters on an untested boat, when everyone is telling you there’s no guarantee it won’t sink. “It’s hard,” a provider in Massachusetts told me. “It’s scary.”

She was thinking about her “abortion heroes” — the doctors and activists who helped women end their pregnancies before Roe. But she was also thinking about her children. What if they traveled to a Southern state and got hurt and needed her? Was she ready to say she wouldn’t go to see them? “It’s keeping me up at night. I’m here. I could do it.” But she was hesitating. Before Dobbs, when she was doing her job, “there was the risk of stalking or harassment. But not being thrown in jail. Now it’s a different world. How much do I want to risk, and what could I lose?”

The ultimate goal, for advocates like Prine and Gomperts, has always been to make the abortion pills readily available. To that end, Gomperts is planning to start an international research project to test mifepristone as a form of birth control. The more uses, the more accessible the medication could become. In the meantime, advocates on all sides expect legal clashes and are gaming out the political implications. The Supreme Court blamed Roe for enmeshing the courts in the country’s abortion fight, but Dobbs could set red and blue states against each other in ways that make the previous era seem peaceful. So much is unknown and unsettled. “Are they really going to round up doctors in blue states and bring them to sit in a Texas jail?” Prine asked. “We have to do this and see if that’s really what it’s come to.”

Emily Bazelon is a staff writer for the magazine and the Truman Capote fellow for creative writing and law at Yale Law School. Her 2019 book, “Charged,” won the Los Angeles Times Book Prize in the current-interest category.

Corrected on Oct. 5, 2022: An earlier version of this article misstated the dates of publication for two articles. David S. Cohen, Greer Donley and Rachel Rebouché wrote an August article for The Stanford Law Review; it is not upcoming. And they published a draft article in February for The Columbia Law Review; it is upcoming for official publication.

Corrected on Oct. 7, 2022: An earlier version of this article referred imprecisely to the medication abortion policy of the Planned Parenthood affiliate in Minnesota, Iowa and Nebraska. Patients who travel to those states from states with abortion bans must receive the full dose of abortion medication at a Planned Parenthood clinic; they do not need to take the medication over 48 hours.

We acknowledge mistakes in our reporting with corrections. If you spot an error, please let us know at corrections@nytimes.com. Learn more.

A version of this article appears in print on , Page 26 of the Sunday Magazine with the headline: Abortion Pills Are Medication Contraband

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About Us

A Safe Choice helps people nationwide access telehealth medication abortions. This network of caring, compassionate doctors informs people of their options and provides medication through a simple, yet safe and effective process. From the privacy of your own home, our network doctors offer a free consultation, or you may order pills securely online without engaging with a doctor. Packages are delivered within 1-4 days via US Postal Service or UPS

A woman-owned business, A Safe Choice is dedicated to the values that align with those of a compassionate doctor who offered care to our Founder. She was a mother of two children with a demanding career when she was diagnosed with a nonviable pregnancy in her second trimester. She remembers how grateful she was for the comfort and help provided by her physician during this uncertain time in her life. He helped her feel secure and reassured that all would be well.

The overall goal of A Safe Choice is to provide the best patient service while broadening the field of abortion accessibility.



About medication abortion

Who is eligible for medication abortion?



Is medication abortion safe?



Is medication abortion effective?



Is it legal to take abortion pills where I live?



There are no laws directly criminalizing the ingestion of abortion pills in any state, however there can be legal risk associated with abortion care. To find out more about what is legal in your state and where to go if you are at a later stage in your pregnancy and want an abortion, visit [ineedana.com](https://www.ineedana.com), call the [National Abortion Federation hotline](https://www.nationalabortionfederation.org/hotline), or visit [If/When/How](#).

Are abortion pills FDA approved?



EXIT



Living In Alabama and Safely Ordering Abortion Pills Online

 November 13th, 2025

If you're searching for information about abortion care, know that you're not alone in this journey. Many people seek reliable details during challenging times, and it's important to have access to clear, compassionate guidance. Abortion pills, also known as medication abortion, involve taking safe, FDA-approved medications to end a pregnancy privately at home. These pills—mifepristone and misoprostol—work together to gently stop the pregnancy process.

While Alabama has implemented a near-total abortion ban under the Human Life Protection Act, there are people explore to access medication abortion c



English

s in

networks like A Safe Choice offer telehealth-facilitated services to residents in restrictive states, including advanced provision of pills in anticipation of future need.

This article aims to help you understand your rights, options, and how abortion pills work, all within Alabama's legal environment. We'll explain how telehealth and mail delivery may function, what risks and protections you should know, and how A Safe Choice's network works in states with abortion bans. We'll also cover advanced provision (ordering pills ahead of time) and your privacy rights. This information is for educational purposes and does not constitute legal advice.

If you have questions about state law, call the Repro Legal Helpline at 844-868-2812. If you want abortion pills sent to your address, A Safe Choice's network can assist — their contact is (707) 710-8866 and their website is <https://asafechoicenetwork.com/>.

Current Alabama Abortion Laws

After the U.S. Supreme Court overturned *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization* (June 2022), states gained greater authority to regulate or ban abortion. As of now, Alabama enforces one of the strictest bans on abortion in the country through the Human Life Protection Act (HB 314).

The Human Life Protection Act and Its Scope

- The Human Life Protection Act makes performing an abortion a **Class A felony** for providers, with penalties ranging from 10 years to life in prison. It is in



English

note that the penalties target providers and not people who use the medications.

- Attempting to provide a banned abortion as a healthcare provider is classified as a Class C felony.
- The law allows a narrow exception if a pregnancy poses a serious health risk to the person (not merely emotional or mental health).
- It does not include exceptions for rape or incest.
- Abortions to treat ectopic pregnancies or to prevent death are typically allowed under medical emergency exceptions, though such cases are legally delicate.

Because of this law, healthcare providers who are licensed in Alabama do not offer abortion services, including medication or procedural abortion care under most circumstances.

Telehealth, Mail, and Criminal Liability

- The state's Attorney General has stated that individuals who use abortion pills—even those prescribed remotely—can be prosecuted under Alabama law.
- However, the law specifically exempts pregnant individuals (patients) from criminal or civil liability; Alabama law is written so that doctors face criminal penalties, but patients are not criminalized.

Legal Updates on Travel and Assistance

- In April 2025, a federal judge ruled that Alabama cannot prosecute individuals or organizations who help residents travel to another state for abortion care, as this violates constitutional rights to free speech and interstate travel.



- This ruling protects groups like abortion funds or transportation organizers from legal risk under Alabama law for aiding travel.

Repro Legal Helpline & Shield Law Protections

If you want state-specific legal advice, contact the **Repro Legal Helpline** at 844-868-2812. They provide support to people in restrictive states. Also, providers in certain states that enact “shield laws” are protected from being prosecuted when prescribing abortion pills to someone in a restrictive state. These shield laws allow clinicians to treat out-of-state patients without fear of prosecution. ([KFF](#)) In practice, this means some doctors in states with shield laws may provide telehealth medication abortions to Alabama residents.

How Abortion Pills Work

This section is medically factual and consistent across states.

Abortion pills (medication abortion) use a two-step regimen of mifepristone followed by misoprostol.

1. **Mifepristone:** This pill blocks progesterone, a hormone needed to sustain a pregnancy. Without progesterone, the lining of the uterus begins to break down.
2. **Misoprostol:** Taken 24–48 hours later, this medication causes uterine contractions that expel the pregnancy tissue, much like a miscarriage.

Effectiveness and safety

- Taken within the first 10 weeks (70 days) of pregnancy, the regimen is 96–98% effective at ending pregnancy.
- Serious complications (such as infection requiring hospitalization or blood transfusion) occur in about 0.2% of cases.
- Most people experience cramping and bleeding, which is expected and part of the process.

Because abortion pills are timed for early pregnancy, they must be taken before the end of the 12th week of pregnancy (in other words, during the first trimester). The process works the same regardless of what state you're in.

Getting Abortion Pills Online in Alabama

Because Alabama enforces on healthcare providers licensed in Alabama a near-total ban on abortion, navigating online access there involves heightened legal risk and caution. Below is an overview of how options like A Safe Choice's network may apply, along with key considerations.

How A Safe Choice Network Works (in restrictive states)

A Safe Choice is a network of licensed clinicians providing telehealth-guided medication abortion services and advanced provision of pills. Even in restrictive states, people in need of an abortion can order, receive, and take medication abortion pills mailed to them by providers in shield-law states.

When using A Safe Choice from Alabama or similarly banned states, here's how it typically functions:

- You complete a secure, online consultation form, which includes a payment of \$150.
- A doctor who is licensed in a shield-law state such as California reviews the information you provide on the online consultation form.
- If the doctor determines that you are not eligible for a medication abortion, your payment is refunded in full.
- If the doctor determines that it is safe for you to have a medication abortion, the medications are shipped directly to you via the US Postal Service Priority Mail.
- No account creation is required, and advanced provision (ordering before pregnancy) is available if you are not currently pregnant.

What to Watch Out For in Alabama

- **Legal risk to providers:** Doctors who send abortion pills into Alabama may risk prosecution unless shielded by a protective law in their own state.
- **Counterfeit or unsafe pills:** Avoid unverified online pharmacies or services that claim to deliver to Alabama—these could send fake or incorrect drugs. Check to see if the provider is listed on reputable websites such as www.abortionfinder.org and www.plancpill.org
- **Timing:** Because abortion pills only work during the first trimester (the first 13 weeks) of pregnancy, delays in ordering or shipping are risky.
- **Discretion:** Discreet packaging, no labels referencing abortion, and anonymity in interactions are especially crucial.

About A Safe Choice

A Safe Choice is a network of licensed physicians (MDs) committed to offering safe, private, and accessible telehealth medication abortion services across states, including those with legal restrictions.

Key features of A Safe Choice:

- You pay a flat **\$150 total** for both mifepristone and misoprostol (no hidden fees). This fee includes shipping via USPS Priority Mail and free telehealth access to a California-based doctor.
- Shipping is via 2–3 day USPS Priority Mail.
- Advanced provision is available—meaning you can order pills ahead of time before pregnancy without needing a pregnancy test.
- No account creation is required.
- The service is designed to be discreet: packaging is neutral and non-descriptive, and all interactions are confidential.
- A Safe Choice supports people in states with bans or restrictions by utilizing shield-law providers.
- Their mission is rooted in reproductive justice, aiming to expand safe access to abortion care, especially in areas affected by bans or severe restrictions.

The Process with A Safe Choice

Here's a step-by-step look at how the process typically works — even in states with bans like Alabama — using the A Safe Choice network:



English

1. Ordering the Medication

You begin by completing a secure, online consultation form to request the medications from a doctor in the A Safe Choice Network. To complete the order, you make a payment of \$150 via credit card or debit card as part of the online consultation form.

2. Eligibility Review by Provider

A doctor licensed to practice medicine in California reviews your information. They confirm whether you meet medical eligibility and evaluate risks.

3. Prescription

If approved, the clinician writes a prescription for mifepristone and misoprostol. Because Alabama law prohibits mailing abortion pills, the provider may either rely on advanced provision (you already have pills) or mail from a protected jurisdiction under shield protections.

4. Payment & Shipping

If approved, the doctor mails the medication abortion pills to the address you provided on the the consultation form. The medications are shipped

discreetly via USPS Priority Mail (usually 2–3 day delivery). Tracking is provided.

5. Taking the Medication

You take (swallow) mifepristone pill first. You then wait 24 to 48 hours to give the mifepristone time to block the effects of the hormone progesterone on the pregnancy. After you waited 24 to 48 hours, you place 4 misoprostol pills in your mouth (under your tongue or between your tongue and cheeks) and let the pills dissolve in your mouth. You'll receive clear instructions on what to do



English

to

expect (e.g., cramping, bleeding, timing, side effects, who to call if you have questions, etc.).

Follow-Up

Most people do not need formal follow up. Once you begin to experience menstrual-like bleeding and cramping, you can feel confident that the process worked. You can call the doctor in the A Safe Choice Network who sent you the medications, or you can call the Miscarriage and Abortion Hotline at 1-833-246-2632 if you have questions.

6. Support & Guidance

Throughout the process, A Safe Choice Network doctor will be available via phone or secure messaging to answer questions, offer support, and troubleshoot issues.

Advanced Provision: Order Before You Need Them

Advanced provision means obtaining abortion pills before you become pregnant or early in pregnancy—so you have them on hand when you need them. This is especially valuable in states like Alabama that make it challenging to obtain medication abortion pills on short notice.

Why advanced provision matters in Alabama

- **Preempts delays:** In emergencies or crisis pregnancies, waiting for the delivery of medications may push you past safe gestational limits.
- **Increases autonomy:** You control timing and can act quickly if needed.

Key details about advanced provision

- You don't have to be currently pregnant to order medication abortion pills via advanced provision.
- The medication is the same: mifepristone + misoprostol.
- Pills have about 2 years' shelf life, so you can store them for future use.
- Packaging is discreet and doesn't mention abortion.
- Cost is \$150 (same as regular service).
- No account or login needed.

How to use advanced provision

1. When you're confident you might need the pills, order them through A Safe Choice.
2. Store them in a cool, dry place as instructed. By cool, we mean typical room temperature (not higher than 75 degrees).
3. If you later become pregnant and decide to use them and you are still within the gestational window, contact the prescribing clinician to discuss your current circumstances to make sure it is safe and appropriate for you to take the medications at that time.
4. Follow the standard dosing instructions (mifepristone first, then misoprostol 24–48 hours later).
5. Follow up and monitor for complications.

In Alabama's restrictive climate, advanced provision serves as a crucial safety net for people who may face increased barriers to obtaining abortion pills in a timely or legal way.

Your Rights and Privacy

Your privacy and rights matter, especially in states with restrictive laws. Below are key protections and best practices to maintain your confidentiality and safety.

Confidentiality & Discretion

- A Safe Choice uses neutral, discreet packaging that does not reference abortion.
- You are not required to create an account or include personal identifiers beyond what is medically necessary.
- Communications with providers are kept private and confidential under medical privacy standards.
- Providers in shield-law states may have additional legal protections to prevent forced disclosure.

Legal Protections

- Alabama law does not criminalize patients receiving an abortion, but providers may face prosecution.
- The 2025 federal ruling prevents Alabama from prosecuting individuals and organizations for aiding travel to out-of-state abortion services.
- Be cautious about sharing your pill use in recorded formats, social media, or public posts—documentation or admissions could be misused.

Risk Mitigation Tips

- Use a secure, private email address when corresponding with providers.
- Request and maintain tracking numbers discreetly.
- Store pills in a safe, private place.



- Avoid discussions in spaces where others might overhear or retrieve digital logs.
- If you travel out-of-state for abortion care, plan discreetly (transportation, lodging, funding) and avoid indicating abortion explicitly.

By being mindful of privacy and legal environments, you can better protect yourself while accessing care.

Support and Resources

Here are trusted national and Alabama-specific organizations you can reach out to for help, information, or support:

National Resources

- Repro Legal Helpline: 844-868-2812 (legal counseling and rights support)
- All-Options Talkline: 1-888-493-0092 (pregnancy decision support)
- Plan C (information about getting abortion pills by mail): <https://www.plancpills.org/>
- Alabama-Specific & Regional Support
 - Yellowhammer Fund: Assists Alabama residents with funds and resources for abortion care and travel
 - West Alabama Women's Center: Provides reproductive health services and may offer referrals or logistical support
 - Her Choice Birmingham: Offers pregnancy options counseling in Alabama and may provide referral information



If you're in Alabama and want legal or practical support, combining national networks with local organizations often yields the most comprehensive help.

You can always start with A Safe Choice's support line at (707) 710-8866 and their website: <https://asafechoicenetwork.com/>.

Frequently Asked Questions

Here are common questions people ask when considering abortion pills online in Alabama, with answers grounded in medical facts and Alabama's legal context.

Is it legal to get abortion pills in Alabama?

It is not legal for healthcare providers licensed in Alabama to prescribe abortion pills, but it is legal for doctors licensed in some states such as California to mail abortion pills to people who live in Alabama. According to Wikipedia, people who use medication abortion pills are exempt from criminal liability.

Can I order abortion pills online to Alabama?

Yes. Although Alabama laws ban mail delivery of abortion pills, laws in some other states (such as California) make it clearly legal to mail medication abortion pills to people in Alabama and other states with abortion bans or restrictions.

Could I be prosecuted for having abortion pills in Alabama?

The current law does not criminalize patients receiving abortion care. The risk lies primarily with providers or distributors.

However, the legal environment is volatile, so legal risk cannot be ruled out entirely. ([Wikipedia](#))

What is the window when abortion pills work?

Medication abortion is FDA-approved. They can safely and effectively be taken up until 12 weeks and 6 days after the first day of your last menstrual period.

Why is advanced provision useful in Alabama?

Having pills in advance means you can act immediately when needed. It sidesteps potential shipping delays.

How much do these services cost?

In the A Safe Choice model, the cost is \$150 total, including both mifepristone and misoprostol, as well as shipping via USPS Priority Mail and telehealth access to a California-based doctor.

How fast do pills arrive?

When mailing is legal, it's generally a 2–3 day USPS Priority Mail shipment.

What if something goes wrong — heavy bleeding, fever, incomplete abortion?

Seek immediate medical care. You can go to an emergency department (you do not need to mention abortion). You can tell staff you are pregnant and bleeding. Most hospitals treat complications regardless of cause.

Can I travel to another state for care?



English

Yes — it is legal to travel to obtain abortion care, and a 2025 ruling bars Alabama from prosecuting people or organizations who assist in travel. ([Reuters](#))

Final Thoughts

Living under Alabama’s near-total abortion ban can feel isolating and oppressive. Despite the challenges, many people find ways to access safe medication abortion care through creative, discreet, and supportive networks like A Safe Choice. Understanding the laws, being thoughtful about privacy, and seeking supportive resources are essential steps in protecting yourself.

If you’re considering abortion pills, starting with reliable channels is critical. Use A Safe Choice via <https://asafechoicenetwork.com/> or call (707) 710-8866. For legal questions, contact the Repro Legal Helpline at 844-868-2812. You’re not alone — support exists even under restrictive laws.

No matter your path, make informed choices that feel right for you. You deserve care, compassion, and dignity.

Legal information is current as of November 18, 2025. Laws can change rapidly. Readers should verify current laws and consult the Repro Legal Helpline at 844-868-2812 for personalized legal guidance.

Related Resources

For more context before ordering, read our guides to [buying abortion pills online safely](#), [mifepristone](#), and [misoprostol](#). These resources explain how the medications work and what to consider when using telehealth in Alabama.



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[Contact Us](#)

A Safe Choice and the doctors in our network will never give or sell any of your information. We use the best and latest data security technology to ensure that whatever information you share with us stays with us.

EXHIBIT 61



Are abortion pills safe?

Yes—abortion pills are very safe. In fact, they're:

- Safer than taking regular Tylenol
- Safer than driving a car
- Safer than getting your tonsils removed
- **Many times safer than carrying a pregnancy to term**

The facts:

- Used safely in the US for over 20 years
- Serious complications happen in less than 1% of cases
- Considered very safe by medical standards

EXHIBIT 62

About medication abortion

Who is eligible for medication abortion?



Is medication abortion safe?



Yes. Medication abortion is extremely safe. For every 100 people, about 99 will have a completely uncomplicated experience. Abortion medications have a better safety record than many common over-the-counter medications, including Tylenol.

Is medication abortion effective?



Is it legal to take abortion pills where I live?



Are abortion pills FDA approved?



EXIT

EXHIBIT 63

ABORTION PILL (MEDICATION ABORTION)

Get the FDA-approved abortion pill prescribed by licensed abortion providers and delivered discreetly to your door a few days after your initial request.

How does the abortion pill work?

1. The first medicine you take is mifepristone, which blocks the pregnancy hormone (progesterone) and stops the pregnancy from growing.
2. 24-48 hours later you take a second medicine, called misoprostol which causes cramping and bleeding to empty the uterus.
3. You can expect bleeding like a heavy period.
4. Taken together, these two pills work up to 98 out of 100 times to end an early pregnancy.
5. After you take mifepristone (the first medication), you must complete the abortion. If treatment with medication does not work the first time, you may have the option to repeat the medicines or you will need an in-clinic procedural abortion.

Are medication abortions safe?

1. Medication abortion ("abortion pill") is one of the SAFEST medical procedures.
2. Complications occur in less than 0.4% of patients.
3. Side effects such as fever, chills, nausea, vomiting, or diarrhea are common for up to 24 hours after taking the second medication (misoprostol).

What are the risks?

1. Complications are rare and most are not serious.
2. The most common complication is a continued pregnancy. If the pregnancy continues after taking the abortion pill, you may be able to take more medicine or you will need to have an abortion procedure.
3. Serious risks, such as heavy bleeding and infection, are very rare.

What is included with the cost?

- Initial evaluation
- Abortion medications (misoprostol and mifepristone)
- Free shipping
- Aftercare instructions
- Follow-up message after 2 and 4 weeks

There is no need to have a Telehealth consultation. Communication happens via the secure communication portal.

See if you can get [abortion funding](#) – financial assistance to pay for the abortion pill, travel, or more.

Who is not eligible for abortion pill

Not eligible if one of the following applies:

- Have a pregnancy that is more than 12 weeks (measured from the first day of your period)
- Currently have an IUD (intrauterine device) in place.
- Have been told by your healthcare provider that you have a pregnancy outside the uterus (ectopic pregnancy)
- Have problems with your adrenal glands (chronic adrenal failure)
- Take blood thinners
- Have a bleeding disorder
- Have porphyria (a rare disorder that affects the skin and internal organs)
- Take certain steroid medications
- Are allergic to mifepristone or misoprostol or medicines that contain misoprostol such as Cytotec or Arthrotec.

EXHIBIT 64

**Abortion pills
have a
better safety
record than
Tylenol.**



**WE TAKE
CARE OF US**



we_take_care_of_us • Follow



we_take_care_of_us 105w

Did you know? Abortion pills have a better safety record than Tylenol. 💊 ✨
When it comes to reproductive health, we have to look at the facts.
Together, we ensure access to safe, reliable options.

[#WeTakeCareOfUs](#) [#AbortionIsHealthcare](#)
[#ReproductiveJustice](#)



No comments yet.

Start the conversation.



20



September 20, 2024

[Log in](#) to like or comment.

EXHIBIT 65

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use MIFEPREX safely and effectively. See full prescribing information for MIFEPREX.

MIFEPREX® (mifepristone) tablets, for oral use
Initial U.S. Approval: 2000

WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING

See full prescribing information for complete boxed warning. Serious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions, including following MIFEPREX use.

- Atypical Presentation of Infection. Patients with serious bacterial infections and sepsis can present without fever, bacteremia or significant findings on pelvic examination. A high index of suspicion is needed to rule out serious infection and sepsis. (5.1)
- Bleeding. Prolonged heavy bleeding may be a sign of incomplete abortion or other complications and prompt medical or surgical intervention may be needed. (5.2)

MIFEPREX is only available through a restricted program called the mifepristone REMS Program (5.3). Before prescribing MIFEPREX, inform the patient about these risks. Ensure the patient knows whom to call and what to do if they experience sustained fever, severe abdominal pain, prolonged heavy bleeding, or syncope, or if they experience abdominal pain or discomfort or general malaise for more than 24 hours after taking misoprostol.

INDICATIONS AND USAGE

MIFEPREX is a progestin antagonist indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. (1)

DOSAGE AND ADMINISTRATION

- 200 mg MIFEPREX on Day 1, followed 24-48 hours after MIFEPREX dosing by 800 mcg buccal misoprostol. (2.1)
- Instruct the patient what to do if significant adverse reactions occur. (2.2)
- Follow-up is needed to confirm complete termination of pregnancy. (2.3)

DOSAGE FORMS AND STRENGTHS

Tablets containing 200 mg of mifepristone each, supplied as 1 tablet on one blister card (3)

CONTRAINDICATIONS

- Confirmed/suspected ectopic pregnancy or undiagnosed adnexal mass (4)
- Chronic adrenal failure (4)
- Concurrent long-term corticosteroid therapy (4)
- History of allergy to mifepristone, misoprostol, or other prostaglandins (4)
- Hemorrhagic disorders or concurrent anticoagulant therapy (4)
- Inherited porphyria (4)
- Intrauterine device (IUD) in place (4)

WARNINGS AND PRECAUTIONS

- Ectopic pregnancy: Exclude before treatment. (5.4)
- Rhesus immunization: Prevention needed as for surgical abortion. (5.5)

ADVERSE REACTIONS

Most common adverse reactions (>15%) are nausea, weakness, fever/chills, vomiting, headache, diarrhea, and dizziness. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Danco Laboratories, LLC at 1-877-432-7596 or medicaldirector@earlyoptionpill.com or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- CYP3A4 inducers can lower mifepristone concentrations. (7.1)
- CYP3A4 inhibitors can increase mifepristone concentrations. Use with caution. (7.2)
- CYP3A4 substrate concentrations can be increased. Caution with coadministration of substrates with narrow therapeutic margin. (7.3)

USE IN SPECIFIC POPULATIONS

- Pregnancy: Risk of fetal malformations in ongoing pregnancy if not terminated is unknown. (8.1)

See 17 for PATIENT COUNSELING INFORMATION, Medication Guide.

Revised: 01/2023

FULL PRESCRIBING INFORMATION: CONTENTS*

WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING

1 INDICATIONS AND USAGE

2 DOSAGE AND ADMINISTRATION

- 2.1 Dosing Regimen
- 2.2 Patient Management Following Misoprostol Administration
- 2.3 Post-treatment Assessment: Day 7 to 14
- 2.4 Contact for Consultation

3 DOSAGE FORMS AND STRENGTHS

4 CONTRAINDICATIONS

5 WARNINGS AND PRECAUTIONS

- 5.1 Infections and Sepsis
- 5.2 Uterine Bleeding
- 5.3 Mifepristone REMS Program
- 5.4 Ectopic Pregnancy
- 5.5 Rhesus Immunization

6 ADVERSE REACTIONS

- 6.1 Clinical Trials Experience
- 6.2 Postmarketing Experience

7 DRUG INTERACTIONS

- 7.1 Drugs that May Reduce MIFEPREX Exposure (Effect of CYP 3A4 Inducers on MIFEPREX)

- 7.2 Drugs that May Increase Exposure (Effect of CYP 3A4 Inhibitors on MIFEPREX)

- 7.3 Effects of MIFEPREX on Other Drugs (Effect of MIFEPREX on CYP 3A4 Substrates)

8 USE IN SPECIFIC POPULATIONS

- 8.1 Pregnancy
- 8.2 Lactation
- 8.4 Pediatric Use

10 OVERDOSAGE

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY

- 12.1 Mechanism of Action
- 12.2 Pharmacodynamics
- 12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY

- 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

14 CLINICAL STUDIES

16 HOW SUPPLIED/STORAGE AND HANDLING

17 PATIENT COUNSELING INFORMATION

*Sections or subsections omitted from the full prescribing information are not listed.

FULL PRESCRIBING INFORMATION

WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING

Serious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions, including following MIFEPREX use. No causal relationship between the use of MIFEPREX and misoprostol and these events has been established.

- **Atypical Presentation of Infection.** Patients with serious bacterial infections (e.g., *Clostridium sordellii*) and sepsis can present without fever, bacteremia, or significant findings on pelvic examination following an abortion. Very rarely, deaths have been reported in patients who presented without fever, with or without abdominal pain, but with leukocytosis with a marked left shift, tachycardia, hemoconcentration, and general malaise. A high index of suspicion is needed to rule out serious infection and sepsis [see *Warnings and Precautions (5.1)*].
- **Bleeding.** Prolonged heavy bleeding may be a sign of incomplete abortion or other complications and prompt medical or surgical intervention may be needed. Advise patients to seek immediate medical attention if they experience prolonged heavy vaginal bleeding [see *Warnings and Precautions (5.2)*].

Because of the risks of serious complications described above, MIFEPREX is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the mifepristone REMS Program [see *Warnings and Precautions (5.3)*].

Before prescribing MIFEPREX, inform the patient about the risk of these serious events. Ensure that the patient knows whom to call and what to do, including going to an Emergency Room if none of the provided contacts are reachable, if they experience sustained fever, severe abdominal pain, prolonged heavy bleeding, or syncope, or if they experience abdominal pain or discomfort, or general malaise (including weakness, nausea, vomiting, or diarrhea) for more than 24 hours after taking misoprostol.

1 INDICATIONS AND USAGE

MIFEPREX is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.

2 DOSAGE AND ADMINISTRATION

2.1 Dosing Regimen

For purposes of this treatment, pregnancy is dated from the first day of the last menstrual period. The duration of pregnancy may be determined from menstrual history and clinical examination. Assess the pregnancy by ultrasonographic scan if the duration of pregnancy is uncertain or if ectopic pregnancy is suspected.

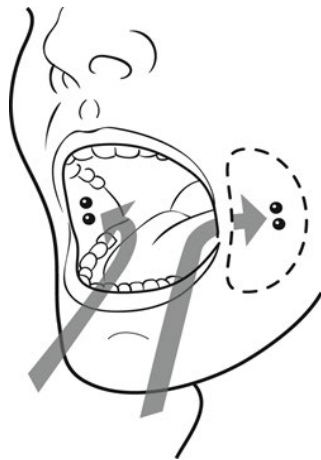
Remove any intrauterine device ("IUD") before treatment with MIFEPREX begins [see *Contraindications (4)*].

The dosing regimen for MIFEPREX and misoprostol is:

- MIFEPREX 200 mg orally + misoprostol 800 mcg buccally
 - *Day One: MIFEPREX Administration*
One 200 mg tablet of MIFEPREX is taken in a single oral dose.
 - *Day Two or Three: Misoprostol Administration* (minimum 24-hour interval between MIFEPREX and misoprostol)
Four 200 mcg tablets (total dose 800 mcg) of misoprostol are taken by the buccal route.

Tell the patient to place two 200 mcg misoprostol tablets in each cheek pouch (the area between the cheek and gums) for 30 minutes and then swallow any remnants with water or another liquid (see Figure 1).

Figure 1



2 pills between cheek and gum on left side + 2 pills between cheek and gum on right side

Patients taking MIFEPREX must take misoprostol within 24 to 48 hours after taking MIFEPREX. The effectiveness of the regimen may be lower if misoprostol is administered less than 24 hours or more than 48 hours after mifepristone administration.

Because most women will expel the pregnancy within 2 to 24 hours of taking misoprostol [see *Clinical Studies* (14)], discuss with the patient an appropriate location for them to be when taking the misoprostol, taking into account that expulsion could begin within 2 hours of administration.

2.2 Patient Management Following Misoprostol Administration

During the period immediately following the administration of misoprostol, the patient may need medication for cramps or gastrointestinal symptoms [see *Adverse Reactions* (6)].

Give the patient:

- Instructions on what to do if significant discomfort, excessive vaginal bleeding or other adverse reactions occur
- A phone number to call if the patient has questions following the administration of the misoprostol
- The name and phone number of the healthcare provider who will be handling emergencies.

2.3 Post-treatment Assessment: Day 7 to 14

Patients should follow-up with their healthcare provider approximately 7 to 14 days after the administration of MIFEPREX. This assessment is very important to confirm that complete termination of pregnancy has occurred and to evaluate the degree of bleeding. Termination can be confirmed by medical history, clinical examination, human Chorionic Gonadotropin (hCG) testing, or ultrasonographic scan. Lack of bleeding following treatment usually indicates failure; however, prolonged or heavy bleeding is not proof of a complete abortion.

The existence of debris in the uterus (e.g., if seen on ultrasonography) following the treatment procedure will not necessarily require surgery for its removal.

Patients should expect to experience vaginal bleeding or spotting for an average of 9 to 16 days. Women report experiencing heavy bleeding for a median duration of 2 days. Up to 8% of women may experience some type of bleeding for more than 30 days. Persistence of heavy or moderate vaginal bleeding at the time of follow-up, however, could indicate an incomplete abortion.

If complete expulsion has not occurred, but the pregnancy is not ongoing, patients may be treated with another dose of misoprostol 800 mcg buccally. There have been rare reports of uterine rupture in women who took MIFEPREX and misoprostol, including women with prior uterine rupture or uterine scar and women who received multiple doses of misoprostol within 24 hours. Patients who choose to use a repeat dose of misoprostol should have a follow-up visit with their healthcare provider in approximately 7 days to assess for complete termination.

Surgical evacuation is recommended to manage ongoing pregnancies after medical abortion [see *Use in Specific Populations* (8.1)]. Advise the patient whether you will provide such care or will refer them to another provider as part of counseling prior to prescribing MIFEPREX.

2.4 Contact for Consultation

For consultation 24 hours a day, 7 days a week with an expert in mifepristone, call Danco Laboratories at 1-877-4 Early Option (1-877-432-7596).

3 DOSAGE FORMS AND STRENGTHS

Tablets containing 200 mg of mifepristone each, supplied as 1 tablet on one blister card. MIFEPREX tablets are light yellow, cylindrical, and bi-convex tablets, approximately 11 mm in diameter and imprinted on one side with "MF."

4 CONTRAINDICATIONS

- Administration of MIFEPREX and misoprostol for the termination of pregnancy (the "treatment procedure") is contraindicated in patients with any of the following conditions:
 - Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass (the treatment procedure will not be effective to terminate an ectopic pregnancy) [see *Warnings and Precautions* (5.4)]
 - Chronic adrenal failure (risk of acute adrenal insufficiency)
 - Concurrent long-term corticosteroid therapy (risk of acute adrenal insufficiency)
 - History of allergy to mifepristone, misoprostol, or other prostaglandins (allergic reactions including anaphylaxis, angioedema, rash, hives, and itching have been reported [see *Adverse Reactions* (6.2)])
 - Hemorrhagic disorders or concurrent anticoagulant therapy (risk of heavy bleeding)

- Inherited porphyrias (risk of worsening or of precipitation of attacks)
- Use of MIFEPREX and misoprostol for termination of intrauterine pregnancy is contraindicated in patients with an intrauterine device (“IUD”) in place (the IUD might interfere with pregnancy termination). If the IUD is removed, MIFEPREX may be used.

5 WARNINGS AND PRECAUTIONS

5.1 Infection and Sepsis

As with other types of abortion, cases of serious bacterial infection, including very rare cases of fatal septic shock, have been reported following the use of MIFEPREX [see *Boxed Warning*]. Healthcare providers evaluating a patient who is undergoing a medical abortion should be alert to the possibility of this rare event. A sustained (> 4 hours) fever of 100.4°F or higher, severe abdominal pain, or pelvic tenderness in the days after a medical abortion may be an indication of infection.

A high index of suspicion is needed to rule out sepsis (e.g., from *Clostridium sordellii*) if a patient reports abdominal pain or discomfort or general malaise (including weakness, nausea, vomiting, or diarrhea) more than 24 hours after taking misoprostol. Very rarely, deaths have been reported in patients who presented without fever, with or without abdominal pain, but with leukocytosis with a marked left shift, tachycardia, hemoconcentration, and general malaise. No causal relationship between MIFEPREX and misoprostol use and an increased risk of infection or death has been established. *Clostridium sordellii* infections have also been reported very rarely following childbirth (vaginal delivery and caesarian section), and in other gynecologic and non-gynecologic conditions.

5.2 Uterine Bleeding

Uterine bleeding occurs in almost all patients during a medical abortion. Prolonged heavy bleeding (soaking through two thick full-size sanitary pads per hour for two consecutive hours) may be a sign of incomplete abortion or other complications, and prompt medical or surgical intervention may be needed to prevent the development of hypovolemic shock. Counsel patients to seek immediate medical attention if they experience prolonged heavy vaginal bleeding following a medical abortion [see *Boxed Warning*].

Women should expect to experience vaginal bleeding or spotting for an average of 9 to 16 days. Women report experiencing heavy bleeding for a median duration of 2 days. Up to 8% of all subjects may experience some type of bleeding for 30 days or more. In general, the duration of bleeding and spotting increased as the duration of the pregnancy increased.

Decreases in hemoglobin concentration, hematocrit, and red blood cell count may occur in patients who bleed heavily.

Excessive uterine bleeding usually requires treatment by uterotonics, vasoconstrictor drugs, surgical uterine evacuation, administration of saline infusions, and/or blood transfusions. Based on data from several large clinical trials, vasoconstrictor drugs were used in 4.3% of all subjects, there was a decrease in hemoglobin of more than 2 g/dL in 5.5% of subjects, and blood transfusions were administered to ≤ 0.1% of subjects. Because heavy bleeding requiring surgical uterine evacuation occurs in about 1% of patients, special care should be given to patients with hemostatic disorders, hypocoagulability, or severe anemia.

5.3 Mifepristone REMS Program

MIFEPREX is available only through a restricted program under a REMS called the mifepristone REMS Program, because of the risks of serious complications [see *Warnings and Precautions* (5.1, 5.2)].

Notable requirements of the mifepristone REMS Program include the following:

- Prescribers must be certified with the program by completing the Prescriber Agreement Form.
- Patients must sign a Patient Agreement Form.
- MIFEPREX must only be dispensed to patients by or under the supervision of a certified prescriber, or by certified pharmacies on prescriptions issued by certified prescribers.

Further information is available at 1-877-4 Early Option (1-877-432-7596).

5.4 Ectopic Pregnancy

MIFEPREX is contraindicated in patients with a confirmed or suspected ectopic pregnancy because MIFEPREX is not effective for terminating ectopic pregnancies [see *Contraindications* (4)]. Healthcare providers should remain alert to the possibility that a patient who is undergoing a medical abortion could have an undiagnosed ectopic pregnancy because some of the expected symptoms experienced with a medical abortion (abdominal pain, uterine bleeding) may be similar to those of a ruptured ectopic pregnancy. The presence of an ectopic pregnancy may have been missed even if the patient underwent ultrasonography prior to being prescribed MIFEPREX.

Patients who became pregnant with an IUD in place should be assessed for ectopic pregnancy.

5.5 Rhesus Immunization

The use of MIFEPREX is assumed to require the same preventive measures as those taken prior to and during surgical abortion to prevent rhesus immunization.

6 ADVERSE REACTIONS

The following adverse reactions are described in greater detail in other sections:

- Infection and sepsis [see *Warnings and Precautions* (5.1)]
- Uterine bleeding [see *Warnings and Precautions* (5.2)]

6.1 Clinical Trials Experience

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

Information presented on common adverse reactions relies solely on data from U.S. studies, because rates reported in non-U.S. studies were markedly lower and are not likely generalizable to the U.S. population. In three U.S. clinical studies totaling 1,248 women through 70 days gestation who used mifepristone 200 mg orally followed 24-48 hours later by misoprostol 800 mcg buccally, women reported adverse reactions in diaries and in interviews at the follow-up visit. These studies enrolled generally healthy women of reproductive age without contraindications to mifepristone or misoprostol use according to the MIFEPREX product label. Gestational age was assessed prior to study enrollment using the date of the woman's last menstrual period, clinical evaluation, and/or ultrasound examination.

About 85% of patients report at least one adverse reaction following administration of MIFEPREX and misoprostol, and many can be expected to report more than one such reaction. The most commonly reported adverse reactions (>15%) were nausea, weakness, fever/chills, vomiting, headache, diarrhea, and dizziness (see Table 1). The frequency of adverse reactions varies between studies and may be dependent on many factors, including the patient population and gestational age.

Abdominal pain/cramping is expected in all medical abortion patients and its incidence is not reported in clinical studies. Treatment with MIFEPREX and misoprostol is designed to induce uterine bleeding and cramping to cause termination of an intrauterine pregnancy. Uterine bleeding and cramping are expected consequences of the action of MIFEPREX and misoprostol as used in the treatment procedure. Most patients can expect bleeding more heavily than they do during a heavy menstrual period [see *Warnings and Precautions (5.2)*].

Table 1 lists the adverse reactions reported in U.S. clinical studies with incidence >15% of women.

Table 1
Adverse Reactions Reported in Women Following Administration of Mifepristone (oral) and Misoprostol (buccal) in U.S. Clinical Studies

Adverse Reaction	# U.S. studies	Number of Evaluable Women	Range of frequency (%)	Upper Gestational Age of Studies Reporting Outcome
Nausea	3	1,248	51-75%	70 days
Weakness	2	630	55-58%	63 days
Fever/chills	1	414	48%	63 days
Vomiting	3	1,248	37-48%	70 days
Headache	2	630	41-44%	63 days
Diarrhea	3	1,248	18-43%	70 days
Dizziness	2	630	39-41%	63 days

One study provided gestational-age stratified adverse reaction rates for women who were 57-63 and 64-70 days; there was little difference in frequency of the reported common adverse reactions by gestational age.

Information on serious adverse reactions was reported in six U.S. and four non-U.S. clinical studies, totaling 30,966 women through 70 days gestation who used mifepristone 200 mg orally followed 24-48 hours later by misoprostol 800 mcg buccally. Serious adverse reaction rates were similar between U.S. and non-U.S. studies, so rates from both U.S. and non-U.S. studies are presented. In the U.S. studies, one studied women through 56 days gestation, four through 63 days gestation, and one through 70 days gestation, while in the non-U.S. studies, two studied women through 63 days gestation, and two through 70 days gestation. Serious adverse reactions were reported in <0.5% of women. Information from the U.S. and non-U.S. studies is presented in Table 2.

Table 2
Serious Adverse Reactions Reported in Women Following Administration of Mifepristone (oral) and Misoprostol (buccal) in U.S. and Non-U.S. Clinical Studies

Adverse Reaction	U.S.			Non-U.S.		
	# of studies	Number of Evaluable Women	Range of frequency (%)	# of studies	Number of Evaluable Women	Range of frequency (%)
Transfusion	4	17,774	0.03-0.5%	3	12,134	0-0.1%
Sepsis	1	629	0.2%	1	11,155	<0.01%*
ER visit	2	1,043	2.9-4.6%	1	95	0
Hospitalization Related to Medical Abortion	3	14,339	0.04-0.6%	3	1,286	0-0.7%
Infection without sepsis	1	216	0	1	11,155	0.2%
Hemorrhage	NR	NR	NR	1	11,155	0.1%

NR= Not reported

* This outcome represents a single patient who experienced death related to sepsis.

6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of MIFEPREX and misoprostol. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Infections and infestations: post-abortion infection (including endometritis, endomyometritis, parametritis, pelvic infection, pelvic inflammatory disease, salpingitis)

Blood and the lymphatic system disorders: anemia

Immune system disorders: allergic reaction (including anaphylaxis, angioedema, hives, rash, itching)

Psychiatric disorders: anxiety

Cardiac disorders: tachycardia (including racing pulse, heart palpitations, heart pounding)

Vascular disorders: syncope, fainting, loss of consciousness, hypotension (including orthostatic), light-headedness

Respiratory, thoracic and mediastinal disorders: shortness of breath

Gastrointestinal disorders: dyspepsia

Musculoskeletal, connective tissue and bone disorders: back pain, leg pain

Reproductive system and breast disorders: uterine rupture, ruptured ectopic pregnancy, hematometra, leukorrhea

General disorders and administration site conditions: pain

7 DRUG INTERACTIONS

7.1 Drugs that May Reduce MIFEPREX Exposure (Effect of CYP 3A4 Inducers on MIFEPREX)

CYP450 3A4 is primarily responsible for the metabolism of mifepristone. CYP3A4 inducers such as rifampin, dexamethasone, St. John's Wort, and certain anticonvulsants (such as phenytoin, phenobarbital, carbamazepine) may induce mifepristone metabolism (lowering serum concentrations of mifepristone). Whether this action has an impact on the efficacy of the dose

regimen is unknown. Refer to the follow-up assessment [see *Dosage and Administration* (2.3)] to verify that treatment has been successful.

7.2 Drugs that May Increase MIFEPREX Exposure (Effect of CYP 3A4 Inhibitors on MIFEPREX)

Although specific drug or food interactions with mifepristone have not been studied, on the basis of this drug's metabolism by CYP 3A4, it is possible that ketoconazole, itraconazole, erythromycin, and grapefruit juice may inhibit its metabolism (increasing serum concentrations of mifepristone). MIFEPREX should be used with caution in patients currently or recently treated with CYP 3A4 inhibitors.

7.3 Effects of MIFEPREX on Other Drugs (Effect of MIFEPREX on CYP 3A4 Substrates)

Based on *in vitro* inhibition information, coadministration of mifepristone may lead to an increase in serum concentrations of drugs that are CYP 3A4 substrates. Due to the slow elimination of mifepristone from the body, such interaction may be observed for a prolonged period after its administration. Therefore, caution should be exercised when mifepristone is administered with drugs that are CYP 3A4 substrates and have narrow therapeutic range.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

MIFEPREX is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Risks to pregnant patients are discussed throughout the labeling.

Refer to misoprostol labeling for risks to pregnant patients with the use of misoprostol.

The risk of adverse developmental outcomes with a continued pregnancy after a failed pregnancy termination with MIFEPREX in a regimen with misoprostol is unknown; however, the process of a failed pregnancy termination could disrupt normal embryo-fetal development and result in adverse developmental effects. Birth defects have been reported with a continued pregnancy after a failed pregnancy termination with MIFEPREX in a regimen with misoprostol. In animal reproduction studies, increased fetal losses were observed in mice, rats, and rabbits and skull deformities were observed in rabbits with administration of mifepristone at doses lower than the human exposure level based on body surface area.

Data

Animal Data

In teratology studies in mice, rats and rabbits at doses of 0.25 to 4.0 mg/kg (less than 1/100 to approximately 1/3 the human exposure based on body surface area), because of the antiprogestational activity of mifepristone, fetal losses were much higher than in control animals. Skull deformities were detected in rabbit studies at approximately 1/6 the human exposure, although no teratogenic effects of mifepristone have been observed to date in rats or mice. These deformities were most likely due to the mechanical effects of uterine contractions resulting from inhibition of progesterone action.

8.2 Lactation

MIFEPREX is present in human milk. Limited data demonstrate undetectable to low levels of the drug in human milk with the relative (weight-adjusted) infant dose 0.5% or less as compared to maternal dosing. There is no information on the effects of MIFEPREX in a regimen with

misoprostol in a breastfed infant or on milk production. Refer to misoprostol labeling for lactation information with the use of misoprostol. The developmental and health benefits of breast-feeding should be considered along with any potential adverse effects on the breast-fed child from MIFEPREX in a regimen with misoprostol.

8.4 Pediatric Use

Safety and efficacy of MIFEPREX have been established in pregnant females. Data from a clinical study of MIFEPREX that included a subset of 322 females under age 17 demonstrated a safety and efficacy profile similar to that observed in adults.

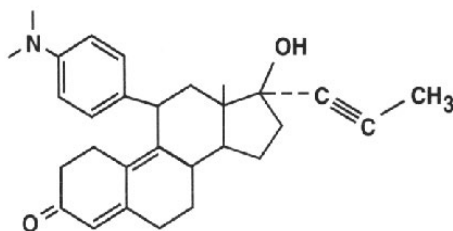
10 OVERDOSAGE

No serious adverse reactions were reported in tolerance studies in healthy non-pregnant female and healthy male subjects where mifepristone was administered in single doses greater than 1800 mg (ninefold the recommended dose for medical abortion). If a patient ingests a massive overdose, the patient should be observed closely for signs of adrenal failure.

11 DESCRIPTION

MIFEPREX tablets each contain 200 mg of mifepristone, a synthetic steroid with antiprogestational effects. The tablets are light yellow in color, cylindrical, and bi-convex, and are intended for oral administration only. The tablets include the inactive ingredients colloidal silica anhydrous, corn starch, povidone, microcrystalline cellulose, and magnesium stearate.

Mifepristone is a substituted 19-nor steroid compound chemically designated as 11 β -[p-(Dimethylamino)phenyl]-17 β -hydroxy-17-(1-propynyl)estra-4,9-dien-3-one. Its empirical formula is C₂₉H₃₅NO₂. Its structural formula is:



The compound is a yellow powder with a molecular weight of 429.6 and a melting point of 192-196°C. It is very soluble in methanol, chloroform and acetone and poorly soluble in water, hexane and isopropyl ether.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The anti-progestational activity of mifepristone results from competitive interaction with progesterone at progesterone-receptor sites. Based on studies with various oral doses in several animal species (mouse, rat, rabbit, and monkey), the compound inhibits the activity of endogenous or exogenous progesterone, resulting in effects on the uterus and cervix that, when combined with misoprostol, result in termination of an intrauterine pregnancy.

During pregnancy, the compound sensitizes the myometrium to the contraction-inducing activity

of prostaglandins.

12.2 Pharmacodynamics

Use of MIFEPREX in a regimen with misoprostol disrupts pregnancy by causing decidual necrosis, myometrial contractions, and cervical softening, leading to the expulsion of the products of conception.

Doses of 1 mg/kg or greater of mifepristone have been shown to antagonize the endometrial and myometrial effects of progesterone in women.

Antiglucocorticoid and antiandrogenic activity: Mifepristone also exhibits antiglucocorticoid and weak antiandrogenic activity. The activity of the glucocorticoid dexamethasone in rats was inhibited following doses of 10 to 25 mg/kg of mifepristone. Doses of 4.5 mg/kg or greater in human beings resulted in a compensatory elevation of adrenocorticotrophic hormone (ACTH) and cortisol. Antiandrogenic activity was observed in rats following repeated administration of doses from 10 to 100 mg/kg.

12.3 Pharmacokinetics

Mifepristone is rapidly absorbed after oral ingestion with non-linear pharmacokinetics for C_{max} after single oral doses of 200 mg and 600 mg in healthy subjects.

Absorption

The absolute bioavailability of a 20 mg mifepristone oral dose in females of childbearing age is 69%. Following oral administration of a single dose of 600 mg, mifepristone is rapidly absorbed, with a peak plasma concentration of 1.98 ± 1.0 mg/L occurring approximately 90 minutes after ingestion.

Following oral administration of a single dose of 200 mg in healthy men (n=8), mean C_{max} was 1.77 ± 0.7 mg/L occurring approximately 45 minutes after ingestion. Mean AUC_{0-∞} was 25.8 ± 6.2 mg*hr/L.

Distribution

Mifepristone is 98% bound to plasma proteins, albumin, and α_1 -acid glycoprotein. Binding to the latter protein is saturable, and the drug displays nonlinear kinetics with respect to plasma concentration and clearance.

Elimination

Following a distribution phase, elimination of mifepristone is slow at first (50% eliminated between 12 and 72 hours) and then becomes more rapid with a terminal elimination half-life of 18 hours.

Metabolism

Metabolism of mifepristone is primarily via pathways involving N-demethylation and terminal hydroxylation of the 17-propynyl chain. *In vitro* studies have shown that CYP450 3A4 is primarily responsible for the metabolism. The three major metabolites identified in humans are: (1) RU 42 633, the most widely found in plasma, is the N-monodemethylated metabolite; (2) RU 42 848, which results from the loss of two methyl groups from the 4-dimethylaminophenyl in position 11β; and (3) RU 42 698, which results from terminal hydroxylation of the 17-propynyl chain.

Excretion

By 11 days after a 600 mg dose of tritiated compound, 83% of the drug has been accounted for by the feces and 9% by the urine. Serum concentrations are undetectable by 11 days.

Specific Populations

The effects of age, hepatic disease and renal disease on the safety, efficacy and pharmacokinetics of mifepristone have not been investigated.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

No long-term studies to evaluate the carcinogenic potential of mifepristone have been performed.

Mutagenesis

Results from studies conducted *in vitro* and in animals have revealed no genotoxic potential for mifepristone. Among the tests carried out were: Ames test with and without metabolic activation; gene conversion test in *Saccharomyces cerevisiae* D4 cells; forward mutation in *Schizosaccharomyces pombe* P1 cells; induction of unscheduled DNA synthesis in cultured HeLa cells; induction of chromosome aberrations in CHO cells; *in vitro* test for gene mutation in V79 Chinese hamster lung cells; and micronucleus test in mice.

Impairment of Fertility

In rats, administration of 0.3 mg/kg mifepristone per day caused severe disruption of the estrus cycles for the three weeks of the treatment period. Following resumption of the estrus cycle, animals were mated and no effects on reproductive performance were observed.

14 CLINICAL STUDIES

Safety and efficacy data from clinical studies of mifepristone 200 mg orally followed 24-48 hours later by misoprostol 800 mcg buccally through 70 days gestation are reported below. Success was defined as the complete expulsion of the products of conception without the need for surgical intervention. The overall rates of success and failure, shown by reason for failure based on 22 worldwide clinical studies (including 7 U.S. studies) appear in Table 3.

The demographics of women who participated in the U.S. clinical studies varied depending on study location and represent the racial and ethnic variety of American females. Females of all reproductive ages were represented, including females less than 18 and more than 40 years of age; most were 27 years or younger.

Table 3
Outcome Following Treatment with Mifepristone (oral) and Misoprostol (buccal)
Through 70 Days Gestation

	U.S. Trials	Non-U.S. Trials
N	16,794	18,425
Complete Medical Abortion	97.4%	96.2%
Surgical Intervention*	2.6%	3.8%
Ongoing Pregnancy**	0.7%	0.9%
* Reasons for surgical intervention include ongoing pregnancy, medical necessity, persistent or heavy bleeding after treatment, patient request, or incomplete expulsion. ** Ongoing pregnancy is a subcategory of surgical intervention, indicating the percent of women who have surgical intervention due to an ongoing pregnancy.		

The results for clinical studies that reported outcomes, including failure rates for ongoing pregnancy, by gestational age are presented in Table 4.

Table 4
Outcome by Gestational Age Following Treatment with Mifepristone and
Misoprostol (buccal) for U.S. and Non-U.S. Clinical Studies

	≤49 days			50-56 days			57-63 days			64-70 days		
	N	%	Number of Evaluable Studies	N	%	Number of Evaluable Studies	N	%	Number of Evaluable Studies	N	%	Number of Evaluable Studies
Complete medical abortion	12,046	98.1	10	3,941	96.8	7	2,294	94.7	9	479	92.7	4
Surgical intervention for ongoing pregnancy	10,272	0.3	6	3,788	0.8	6	2,211	2	8	453	3.1	3

One clinical study asked subjects through 70 days gestation to estimate when they expelled the pregnancy, with 70% providing data. Of these, 23-38% reported expulsion within 3 hours and over 90% within 24 hours of using misoprostol.

16 HOW SUPPLIED/STORAGE AND HANDLING

is only available through a restricted program called the Mifepristone REMS Program [see *Warnings and Precautions* (5.3)].

MIFEPREX is supplied as light yellow, cylindrical, and bi-convex tablets imprinted on one side with "MF." Each tablet contains 200 mg of mifepristone. One tablet is individually blistered on one blister card that is packaged in an individual package (National Drug Code 64875-001-01).

Store at 25°C (77°F); excursions permitted to 15 to 30°C (59 to 86°F) [see USP Controlled Room Temperature].

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide), included with each package of MIFEPREX. Additional copies of the Medication Guide are available by contacting Danco Laboratories at 1-877-4 Early Option (1-877-432-7596) or from www.earlyoptionpill.com.

Serious Infections and Bleeding

- Inform the patient that uterine bleeding and uterine cramping will occur [see *Warnings and Precautions* (5.2)].
- Advise the patient that serious and sometimes fatal infections and bleeding can occur very rarely [see *Warnings and Precautions* (5.1, 5.2)].
- MIFEPREX is only available through a restricted program called the Mifepristone REMS Program [see *Warnings and Precautions* (5.3)]. Under the mifepristone REMS Program:
 - Patients must sign a Patient Agreement Form.
 - MIFEPREX is only dispensed by or under the supervision of certified prescribers or by certified pharmacies on prescriptions issued by certified prescribers.

Provider Contacts and Actions in Case of Complications

- Ensure that the patient knows whom to call and what to do, including going to an Emergency Room if none of the provided contacts are reachable, or if the patient experiences complications including prolonged heavy bleeding, severe abdominal pain, or sustained fever [see *Boxed Warning*].
-

Compliance with Treatment Schedule and Follow-up Assessment

- Advise the patient that it is necessary to complete the treatment schedule, including a follow-up assessment approximately 7 to 14 days after taking MIFEPREX [see *Dosage and Administration* (2.3)].
- Explain that
 - prolonged heavy vaginal bleeding is not proof of a complete abortion,
 - if the treatment fails and the pregnancy continues, the risk of fetal malformation is unknown,
 - it is recommended that ongoing pregnancy be managed by surgical termination [see *Dosage and Administration* (2.3)]. Advise the patient whether you will provide such care or will refer them to another provider.

Subsequent Fertility

- Inform the patient that another pregnancy can occur following medical abortion and before resumption of normal menses.
- Inform the patient that contraception can be initiated as soon as pregnancy expulsion has been confirmed, or before resuming sexual intercourse.

MIFEPREX is a registered trademark of Danco Laboratories, LLC.

Manufactured for:
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P.O. Box 4816
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1-877-4 Early Option (1-877-432-7596)
www.earlyoptionpill.com

01/2023

MEDICATION GUIDE

Mifeprex (MIF-eh-prex) (mifepristone tablets, for oral use)

Read this information carefully before taking Mifeprex and misoprostol. It will help you understand how the treatment works. This Medication Guide does not take the place of talking with your healthcare provider.

What is the most important information I should know about Mifeprex?

What symptoms should I be concerned with? Although cramping and bleeding are an expected part of ending a pregnancy, rarely, serious and potentially life-threatening bleeding, infections, or other problems can occur following a miscarriage, surgical abortion, medical abortion, or childbirth. Seeking medical attention as soon as possible is needed in these circumstances. Serious infection has resulted in death in a very small number of cases. There is no information that use of Mifeprex and misoprostol caused these deaths. If you have any questions, concerns, or problems, or if you are worried about any side effects or symptoms, you should contact your healthcare provider. You can write down your healthcare provider's telephone number here _____.

Be sure to contact your healthcare provider promptly if you have any of the following:

- **Heavy Bleeding.** Contact your healthcare provider right away if you bleed enough to soak through two thick full-size sanitary pads per hour for two consecutive hours or if you are concerned about heavy bleeding. In about 1 out of 100 women, bleeding can be so heavy that it requires a surgical procedure (surgical aspiration or D&C).
- **Abdominal Pain or "Feeling Sick."** If you have abdominal pain or discomfort, or you are "feeling sick," including weakness, nausea, vomiting, or diarrhea, with or without fever, more than 24 hours after taking misoprostol, you should contact your healthcare provider without delay. These symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).
- **Fever.** In the days after treatment, if you have a fever of 100.4°F or higher that lasts for more than 4 hours, you should contact your healthcare provider right away. Fever may be a symptom of a serious infection or another problem.

If you cannot reach your healthcare provider, go to the nearest hospital emergency room.

What to do if you are still pregnant after Mifeprex with misoprostol treatment. If you are still pregnant, your healthcare provider will talk with you about a surgical procedure to end your pregnancy. In many cases, this surgical procedure can be done in the office/clinic. The chance of birth defects if the pregnancy is not ended is unknown.

Talk with your healthcare provider. Before you take Mifeprex, you should read this Medication Guide and you and your healthcare provider should discuss the benefits and risks of your using Mifeprex.

What is Mifeprex?

Mifeprex is used in a regimen with another prescription medicine called misoprostol, to end an early pregnancy. Early pregnancy means it is 70 days (10 weeks) or less since your last menstrual period began. Mifeprex is not approved for ending pregnancies that are further along. Mifeprex blocks a hormone needed for your pregnancy to continue. When you use Mifeprex on Day 1, you also need to take another medicine called misoprostol 24 to 48 hours after you take Mifeprex, to cause the pregnancy to be passed from your uterus.

The pregnancy is likely to be passed from your uterus within 2 to 24 hours after taking Mifeprex and misoprostol. When the pregnancy is passed from the uterus, you will have bleeding and cramping that will likely be heavier than your usual period. About 2 to 7 out of 100 women taking Mifeprex will need a surgical procedure because the pregnancy did not completely pass from the uterus or to stop bleeding.

Who should not take Mifeprex?

Some patients should not take Mifeprex. Do not take Mifeprex if you:

- Have a pregnancy that is more than 70 days (10 weeks). Your healthcare provider may do a clinical examination, an ultrasound examination, or other testing to determine how far along you are in pregnancy.
- Are using an IUD (intrauterine device or system). It must be taken out before you take Mifeprex.
- Have been told by your healthcare provider that you have a pregnancy outside the uterus (ectopic pregnancy).
- Have problems with your adrenal glands (chronic adrenal failure).
- Take a medicine to thin your blood.
- Have a bleeding problem.
- Have porphyria.
- Take certain steroid medicines.
- Are allergic to mifepristone, misoprostol, or medicines that contain misoprostol, such as Cytotec or Arthrotec.

Ask your healthcare provider if you are not sure about all your medical conditions before taking this medicine to find out if you can take Mifeprex.

What should I tell my healthcare provider before taking Mifeprex?

Before you take Mifeprex, tell your healthcare provider if you:

- cannot follow-up within approximately 7 to 14 days of your first visit
- are breastfeeding. Mifeprex can pass into your breast milk. The effect of the Mifeprex and misoprostol regimen on the breastfed infant or on milk production is unknown.
- are taking medicines, including prescription and over-the-counter medicines, vitamins, and herbal supplements.
Mifeprex and certain other medicines may affect each other if they are used together. This can cause side effects.

How should I take Mifeprex?

- Mifeprex will be given to you by a healthcare provider or pharmacy.
- You and your healthcare provider will plan the most appropriate location for you to take the misoprostol, because it may cause bleeding, cramps, nausea, diarrhea, and other symptoms that usually begin within 2 to 24 hours after taking it.
- Most women will pass the pregnancy within 2 to 24 hours after taking the misoprostol tablets.

Follow the instruction below on how to take Mifeprex and misoprostol:

Mifeprex (1 tablet) orally + misoprostol (4 tablets) buccally

Day 1:

- Take 1 Mifeprex tablet by mouth.

24 to 48 hours after taking Mifeprex:

- Take 4 misoprostol tablets by placing 2 tablets in each cheek pouch (the area between your teeth and cheek - see Figure A) for 30 minutes and then swallow anything left over with a drink of water or another liquid.
- The medicines may not work as well if you take misoprostol sooner than 24 hours after Mifeprex or later than 48 hours after Mifeprex.
- Misoprostol often causes cramps, nausea, diarrhea, and other symptoms. Your healthcare provider may send you home with medicines for these symptoms.



Figure A (2 tablets between your left cheek and gum and 2 tablets between your right cheek and gum).

Follow-up Assessment at Day 7 to 14:

- This follow-up assessment is very important. You must follow-up with your healthcare provider about 7 to 14 days after you have taken Mifeprex to be sure you are well and that you have had bleeding and the pregnancy has passed from your uterus.
- Your healthcare provider will assess whether your pregnancy has passed from your uterus. If your pregnancy continues, the chance that there may be birth defects is unknown. If you are still pregnant, your healthcare provider will talk with you about a surgical procedure to end your pregnancy.
- If your pregnancy has ended, but has not yet completely passed from your uterus, your provider will talk with you about other choices you have, including waiting, taking another dose of misoprostol, or having a surgical procedure to empty your uterus.

When should I begin birth control?

You can become pregnant again right after your pregnancy ends. If you do not want to become pregnant again, start using birth control as soon as your pregnancy ends or before you start having sexual intercourse again.

What should I avoid while taking Mifeprex and misoprostol?

Do not take any other prescription or over-the-counter medicines (including herbal medicines or supplements) at any time during the treatment period without first asking your healthcare provider about them because they may interfere with the treatment. Ask your healthcare provider about what medicines you can take for pain and other side effects.

What are the possible side effects of Mifeprex and misoprostol?

Mifeprex may cause serious side effects. See “What is the most important information I should know about Mifeprex?”

Cramping and bleeding. Cramping and vaginal bleeding are expected with this treatment. Usually, these symptoms mean that the treatment is working. But sometimes you can get cramping and bleeding and still be pregnant. This is why you must follow-up with your healthcare provider approximately 7 to 14 days after taking Mifeprex. See “How should I take Mifeprex?” for more information on your follow-up assessment. If you are not already bleeding after taking Mifeprex, you probably will begin to bleed once you take misoprostol, the medicine you take 24 to 48 hours after Mifeprex. Bleeding or spotting can be expected for an average of 9 to 16 days and may last for up to 30 days. Your bleeding may be similar to, or greater than, a normal heavy period. You may see blood clots and tissue. This is an expected part of passing the pregnancy.

The most common side effects of Mifeprex treatment include: nausea, weakness, fever/chills, vomiting, headache, diarrhea and dizziness. Your provider will tell you how to manage any pain or other side effects. These are not all the possible side effects of Mifeprex.

Call your healthcare provider for medical advice about any side effects that bother you or do not go away. You may report side effects to FDA at 1-800-FDA-1088.

General information about the safe and effective use of Mifeprex.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. This Medication Guide summarizes the most important information about Mifeprex. If you would like more information, talk with your healthcare provider. You may ask your healthcare provider for information about Mifeprex that is written for healthcare professionals.

For more information about Mifeprex, go to www.earlyoptionpill.com or call 1-877-4 Early Option (1-877-432-7596).

Manufactured for: *Danco Laboratories, LLC*
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This Medication Guide has been approved by the U.S. Food and Drug Administration. Approval
 01/2023



Essay

The Origins and Proliferation of Unfounded Comparisons Regarding the Safety of Mifepristone

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Abstract: As part of the substantial public discourse surrounding the distribution and use of mifepristone, which is used with misoprostol to facilitate drug-induced abortions, claims comparing the safety of this regimen to that of common pharmaceuticals have emerged and proliferated. Offered in forums ranging from social media to the Supreme Court, these claims have so gained public acceptance that they are now echoed without scrutiny and, at times, reference. Yet the simplistic slogan that “mifepristone is safer than Tylenol”, though easily disseminated, defies both an intuitive understanding of how we evaluate drug safety and our norms and regulations for doing so. Indeed, if such an assertion was attributable to the manufacturer, it would precipitate a reprimand by the FDA given the lack of specific, controlled, and head-to-head evidence rightly required for its support. To the extent that these claims persist, however, including among the outputs of medical societies, abortion centers, clinical researchers, and government officials, and to the extent that they aim to inform both individual and public decision-making, it is critical that the evidence offered for their support be thoroughly explored. Such examination reveals these claims to be wholly unfounded, offering deficient and disingenuous representations of safety for any of the drugs compared.

Keywords: abortion; communication; comparative safety; drug advertisement; FDA; mifepristone; regulation; side effects

Key Contribution: This work investigates the origins and subsequent expansion of the comparative claims drawn between mifepristone and other common drugs, assessing the evidence offered on their behalf and comparing them to established best practices for the communication of drug safety. The manifest deficiencies identified by this examination provide case studies in the importance of such scrutiny and may dissuade the continued deployment of these misleading and dangerous claims in the medical, legal, regulatory, and public realms.



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1. Introduction

Since the initial approval of the mifepristone-misoprostol abortion regimen in 2000, the fraction of drug-induced abortions in the United States has continually increased, with estimates surpassing 60% for the first time in 2023 [1]. Accompanying this trend has been a public conversation surrounding mifepristone’s distribution and safety, with a recent proliferation of comparisons between this drug regimen and common pharmaceuticals. Such comparisons are largely aimed at decreasing regulation and assuaging concerns of those contemplating abortion.

Indeed, we are now inundated with claims that the safety of this regimen compares similarly or favorably to that of many common pharmaceuticals, including acetaminophen

(Tylenol), ibuprofen (Advil), aspirin, penicillin, and sildenafil (Viagra). These claims can be found not only in the mass media [2–14] but also in journal articles [15–20] and other academic outputs [21–23], legal documents [24–29], statements from government officials and their offices [30–39], and patient-facing informational material [40–46]. In recent years, perhaps influenced by the short form of social media, the claim has often coalesced to a concise and oft-repeated refrain that “mifepristone is safer than Tylenol”, to which varying combinations of the other listed drugs are at times appended.

The central problem with this claim is simultaneously a chief cause of its spread: its simplicity. A reductionist claim concerning the safety of a drug should ordinarily draw scrutiny, as it collapses a set of complex and vitally important considerations into a simple assertion or slogan. Instead, this particular claim and those like it have proliferated, aided in part by major medical organizations and abortion centers that should be providing full, informed consent to their patients on the risks attendant to any drug.

The scrutiny demanded by the claim that “mifepristone is safer than Tylenol” and those like it reveals what should be an obvious truth: these are entirely inappropriate comparisons that have never been, and indeed cannot be, investigated in the rigorous, scientific manner rightfully demanded of medical information. Furthermore, the evidence offered on their behalf is severely lacking, a wholly insufficient assessment of safety from which no comparison can reasonably be drawn. These are, therefore, dangerous and unfounded claims that are yet being presented to patients, policymakers, jurists, and the public as “consensus” facts on which patient decision-making should be based and regulatory action taken.

2. The Requirements of an Adequate Comparison

In October 2024, 18 attorneys general filed a motion for summary judgment in their lawsuit concerning U.S. Food and Drug Administration (FDA) restrictions on the distribution of mifepristone [24]. In support of this action, Attorney General William Tong of Connecticut, a participant in the suit, issued the following statement:

“Mifepristone is safer than Tylenol. We have more than 20 years of clear and conclusive scientific evidence proving that. We’re asking the judge now to cut to the chase—to strike the needless political red tape and order new rules based on science and safety” [30].

While the history of this claim will be investigated below, the statement raises a more essential question: what evidence is required to prove, clearly and conclusively, that one drug is safer than another?

Prior to adjudicating the validity of a comparison, one must establish on what grounds the comparison is being made. Drug safety, as the FDA has made clear throughout its history, is not a concept easily simplified. Across its application procedures, safety is assessed through a battery of data including that from in vitro and animal studies, previous use in humans in the U.S. or abroad, and clinical trials [47,48]. All safety information is required to be stratified amongst subgroups of demographic and/or clinical interest, including assessments “as applicable” on the effects of the drug in pediatric populations and on “reproduction and . . . the developing fetus” [48]. Further assessments are made across categories as disparate as the drug’s manufacturing pathway, its potential for abuse, and its interactions with other drugs. Each of these factors provides an important angle from which to assess a comprehensive picture of drug safety.

Of course, these considerations in their totality need not be represented in every communication regarding the drug. Manufacturers may justifiably desire to provide information about the drug’s safety, including through comparative claims, to medical professionals or the public via media that cannot fully encompass this complexity. It is

precisely for this reason that the FDA provides regulation, guidance, and warnings related to the claims made in the public square via pharmaceutical advertisements.

A claim of this nature, according to FDA regulations, is “false, lacking in fair balance, or otherwise misleading” if it “represents or suggests that a drug is safer or more effective than another drug in some particular when it has not been demonstrated to be safer or more effective in such particular by substantial evidence or substantial clinical experience” [49]. Such evidence is described as the result of “adequate and well-controlled investigations, including clinical investigations”, and such experience as “substantial clinical experience adequately documented in medical literature or by other data” from which “qualified experts” could “fairly and responsibly” reach the same determination. To assist manufacturers in the practical implementation of these rules, legal analyses have been assembled that summarize their historical interpretation. One such resource, a practice guide for pharmaceutical advertising in the United States, notes:

“Comparative claims regarding a drug’s efficacy or safety are generally permitted if they are based on the approved indication of a drug to the same approved indication of another drug and are supported by scientifically appropriate and statistically sound data (e.g., head-to-head study, clinically relevant to patients, not false or misleading). Comparative claims should not suggest superior efficacy or safety based solely on the differences in product labeling or the results of two different studies” [50].

It is true that the claims cited in this work are made outside the purview of the manufacturers to whom such regulations are chiefly directed. Yet this guidance, beyond simply dictating these requirements, also yields translatable definitions for “false...or otherwise misleading claims”, “substantial evidence”, and “substantial clinical experience” that can and should be used to scrutinize these comparisons made in the public square. It also provides best practices for making these claims, which, as will be described, are routinely violated in comparisons regarding mifepristone. Finally, it is critical to note that these claims have been propagated by public officials, medical associations, and patient-facing groups who aim to inform policy, regulations, and patient decision-making through their assertions. These are the same realms with which the FDA is chiefly concerned as it addresses false and misleading comparisons. It is not unreasonable, therefore, to expect that statements of this gravity and influence be properly supported by adequate evidence, particularly when the statements themselves claim such evidence exists.

It is essential to state unequivocally that there has never been a single study appropriately comparing the safety of mifepristone and acetaminophen or any of the common drugs presented in these claims, let alone a 20-year history of “clear and conclusive scientific evidence” to this end. Indeed, given that such a study would require similar indications for use, it is not possible for one to be undertaken. This alone is sufficient reason to qualify such comparisons as false and/or misleading and to contest their use to influence public and individual decision-making. To the extent that they still proliferate, however, it is also informative to examine the claims as they are presented. Such examination reveals the manifest deficiencies and disingenuousness of the assertions, in which statistics are presented that are neither comparable nor contextualized to fairly represent their limitations in assessing safety. What follows is an elaboration of these deficiencies, beginning first with a brief history of the claim.

3. The Origin of the Claim and Its Spread

Though the roughly two decades referenced by the Tong statement contain no scientific interrogation of this question, they do hold the origin of this line of argumentation. In a 2003 *Chicago Tribune* article detailing the death of a teenager after taking mifepristone, Dr. David Grimes, an abortion provider and past chief of the U.S. Centers for Disease Control

and Prevention (CDC) abortion surveillance branch, was asked for comment [2]. Against the CDC's then-current figure of slightly less than one per 100,000 deaths in those seeking abortion, he juxtaposed an uncited two per 100,000 death rate associated with penicillin and concluded that "having an abortion this way is safer than that". Comparisons to sildenafil and acetaminophen soon followed in a 2004 editorial in the journal *Contraception*. There, authors from the Association of Reproductive Health Professionals and the University of California, San Francisco (UCSF) wrote that "...mifepristone is safer than Viagra", again citing death rates, and that "acetaminophen (Tylenol) causes more deaths each year" [15].

These comparisons patterned the majority of those deployed in the following two decades: using death counts or death rates from different studies, at different times, and in vastly different populations, they asserted a reductionist definition of safety and compared numbers that are entirely incomparable. Paradoxically, the editorial itself provided ample ground for such criticism. Entitled "Presenting health risks honestly: mifepristone, a case in point", it provided recommendations for the medical community to explain "objective health information. . .in a way that is clear, fair, and not misleading" [15]. But in comparing mifepristone to uncontextualized death rates and counts for sildenafil and acetaminophen, the latter of which was unsupported by its sources, the editorial violated three of its own recommendations: to compare drugs to their "reasonable alternatives", to "put risk in context", and to hold paramount "the importance of honesty". These contradictions, as well as the violations of FDA guidance by all comparisons drawn between mifepristone and common drugs, will be explored below.

Irrespective of this unsteady foundation, the claim began to proliferate. Abortion provision organization Women on Waves [43] and research organization Gynuity Health Projects [46] picked up the comparison in the late 2000s, the former to penicillin and sildenafil and the latter to penicillin alone. Both resources presented the argument in Frequently Asked Questions sections, assuring women seeking abortion as well as abortion providers that concerns about its safety were unfounded. Interestingly, the comparison to acetaminophen largely laid dormant until 2016, when the group Advancing New Standards in Reproductive Health (ANSIRH) at UCSF picked up the claim published 12 years prior. In an issue brief on abortion restrictions, the authors repeated the comparisons and references offered in the *Contraception* editorial [22].

ANSIRH has since published three analyses, in 2019 [51], 2022 [52], and 2024 [21], in which the comparison is repeated. While a new reference is offered for the acetaminophen claim, these documents again provide an estimate of the number of yearly deaths associated with the drug in the United States, which, as in the case of the *Contraception* editorial, is not supported by its source. This number, in combination with the death rates attributed to penicillin and sildenafil, are the support offered for the conclusion repeated across all three documents that drug-induced abortion is safer than "using other common medications". When claims of mifepristone's superior safety to these three pharmaceuticals are cited, one of these ANSIRH documents is often the provided reference [3,7,8,12,13,23,42,53]. Included among these sources is Hey Jane, a telehealth abortion provider, which assures its clientele in state-specific resources that "the abortion pill is safer than Tylenol" and, later, Viagra, with both citing ANSIRH [42]. In another case, a magazine article linked to one of these analyses to support the statement that "[p]eer-reviewed research has shown that mifepristone is safer than Tylenol, which is widely available without a prescription" [12].

In some cases, however, it appears that the claim has reached such a consensus status that it need not be cited at all. Planned Parenthood's topline text on its "How safe is the abortion pill?" page states that "it's safer than many other medicines like penicillin, Tylenol, and Viagra" without citation [45]. In a particularly striking example, 12 major medical organizations co-signed an amicus brief in *Alliance for Hippocratic Medicine (AHM) v. FDA*

that stated: “Mifepristone’s safety profile is on par with common painkillers like ibuprofen and acetaminophen, which more than 30 million Americans take in any given day” [29]. The in-line reference for this claim only supports the 30 million user figure; elsewhere in the brief, a footnote quotes a comparison drawn between mifepristone and NSAIDs, which will be addressed later in this work for its manifold deficiencies. Nowhere in the document is there a description of how a safety comparison to acetaminophen, or ibuprofen specifically amongst the broader class of NSAIDs, was drawn or sourced. As an ANSIRH source is cited elsewhere and for different purposes in the document, a plausible explanation is that the acetaminophen claim was internalized from that source and incorporated in a “summary” of mifepristone’s safety. The end result, however, is that an assertion is made with the appearance of common fact, not necessitating a direct reference for its substantiation.

That claims of this gravity, offered by organizations of such influence, should not be made without adequate reference, or any reference at all, is self-evident. Their continued advancement is evidence of the dangers of allowing this line of argumentation to proceed through the public square without the scrutiny that it demands. The claim comparing mifepristone to acetaminophen will provide the first case study in this scrutiny.

4. The Deficiencies of Reductive Comparisons

In recent ANSIRH documents, the reference provided for the comparison between mifepristone and acetaminophen is a study of FDA postmarketing data on painkillers from 2015 to 2016 [54]. Though this source notes 602 fatalities across the two-year timeframe studied, it is miscited to support the claim that “[a]cetaminophen...accounts for over 600 deaths annually” [21,51,52]. Prior to this, a separate source was cited in both the 2016 ANSIRH issue brief and the *Contraception* editorial that initiated the claim. Here, an investigation of the 308 liver failure cases observed across 41 months at 17 tertiary care centers noted that 120 were attributable to acetaminophen overdose, of which 87 survived [55]. The editorial used this source to state that “150 people are estimated to die each year in the US from acetaminophen-induced liver failure” [15], though the paper made no such attempt to extrapolate beyond its study of cases. ANSIRH, on the other hand, simply used the source to state that “medication abortion is safer than many common drugs in the US, including acetaminophen” [22].

These inaccuracies aside, the citation of these sources in no way meets the standard of providing “substantial evidence” for such comparative claims. Apart from this, their use can also be analyzed independently as a wholly inadequate representation of the safety considerations of either mifepristone or acetaminophen. Briefly, this concern arises from two considerations: the extent to which safety is rightly considered and the extent to which a reasonable basis of comparison is offered.

4.1. An Inadequate Consideration of Safety

In these sources, as in those cited in many similar statements, the only implied point of comparison is the death of the individual consuming the drug. Yet as described above, the FDA rightly considers far more than this in its assessments of safety. At the outset, it must be acknowledged that one such criteria is the effect of the drug “on the developing fetus” [48]; these comparisons drawn on mortality rates highlight the unignorable contradiction that a drug for any other indication that resulted in fetal death would be deemed unsafe, whether or not it was being compared with other drugs. Even with a sole focus on the individual consuming the drug, however, mortality alone fails as an adequate surrogate for drug safety. A few paragraphs removed from Dr. Grimes’s comparison to penicillin in the *Chicago Tribune* article, the author captures one reason why such a reductionist approach is inadequate:

“One problem with the drug...worries some mifepristone providers—it can be difficult for doctors to tell when a patient is truly in distress from the medicine. That’s because mifepristone, which is given along with the contraction-inducing drug misoprostol, routinely causes intense painful cramps and bleeding that last for five hours or more. The symptoms are similar to what might result from an infection or other life-threatening reactions” [2].

These concerns are prominently featured on mifepristone’s prescribing information in an FDA-mandated boxed warning—the “most well-known and serious” warning used by the FDA to communicate drug safety information on labeling [56]—that severe and life-threatening bleeding and infections can occur, the latter of which can defy typical presentation and be difficult to detect [57]. They are also addressed in the patient and prescriber agreements required as part of the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone [58]. The possibility of these adverse events, compounded by the risk that they may be masked by commonly experienced effects of the drug, is an unignorable consideration regarding its safety.

It should also be noted that the description of side effects in the *Chicago Tribune* article is conservative. Mifepristone’s label states bleeding or spotting is expected for an average of 9–16 days, with up to 8% of patients bleeding for 30 days or more [57]. A small interview-based Norwegian study sought to relay anecdotes of women after drug-induced abortions: while some noted pain that was less intense than anticipated, others described pain that was “out of this world”, “much worse than giving birth”, and “a day in hell” [59]. These results were repeated in a recent study in which 1596 survey respondents described their pain experience after at-home drug-induced abortions [60]. On a ten-point scale, 41.5% of respondents rated their pain at least an eight; when asked to compare this pain to their anticipated experience, 30.4% selected that the pain was “a lot more than expected”. Yet because these side effects are known results of the drug’s mechanism of action, such experiences are dismissed despite both their severity and the possibility that they may mask an emergent condition. Indeed, after one patient in the Norwegian study “cried and screamed for eight hours”, she consulted the emergency department but was simply told that her experience was “quite normal”.

Because they are expected results, these side effects are also not listed in the table of reported adverse reactions on mifepristone’s label [57]. Explanatory text describing this omission has been echoed in public discussions, including a recent *New York Times* article that described papers cited in *AHM v. FDA* as “point[ing] to patient experiences that are common and expected, such as bleeding and pain” [61]. But these discussions also feature a similar dismissive approach to more serious complications such as surgical procedures to address incomplete abortions and emergency room visits, which were noted in preclinical studies to occur in 2.6–3.8% and 2.9–4.6% of abortions, respectively [57]. The *Times* article describes the former as “not typically dangerous” and the latter as “not a clear measure of serious complications”. A researcher at ANSIRH expressed the same, calling emergency room visits “not an indicator of abortion safety” [62]. Yet mifepristone’s boxed warning specifically mentions that an emergency room visit may be necessary should the patient experience symptoms such as “sustained fever, severe abdominal pain, [or] prolonged heavy bleeding” and be unable to reach a provided contact [57]. The patient agreement advises the same, warning that such symptoms “may be a sign of a serious infection or another problem” and “could require emergency care” [63].

Regardless of how one chooses to classify these events, it is entirely uncontroversial that they are critical considerations when evaluating and communicating the safety of a drug. Similarly, the concern expressed by mifepristone providers in the *Tribune* article, that commonly experienced effects of the drug can mask emergent complications, cannot be

ignored. To brush aside these clinical realities and collapse all considerations of safety into a simple comparison of mortality is irresponsible and dangerous.

4.2. *An Inconsistent Basis of Comparison*

Beyond these concerns, even the statistics offered representing deaths in the comparator drugs are insufficient to make a valid comparison on that count alone. Though the sources were incorrectly cited, the implied comparison to the presented deaths per year associated with acetaminophen is the 32 deaths reported to the FDA as associated with mifepristone across a study period dating from 28 September 2000 to 31 December 2022 [64]. Presenting statistics in this fashion, however, ignores critical numerical and clinical context.

Numerically, a basic requirement of comparison is that raw numbers be normalized and not presented in isolation. But here we encounter one of many impossibilities in drawing direct comparisons between mifepristone and acetaminophen, that they are used by different populations, in a variety of dosages and forms (in the case of acetaminophen), and for vastly different purposes. To be clear, even if deaths per dose consumed were available as a metric, this would not enable an adequate comparison given that the users do not share a consistent basis across any of the above characteristics. This reality is presented plainly by the pharmaceutical advertising legal analysis in its notes that unrelated studies should not be juxtaposed side-by-side and that similar indications for use are required to make valid comparisons [50]. These are critical reasons why a well-controlled scientific investigation comparing the drugs has not been undertaken.

To the extent that raw death numbers are still cited as valid evidence for a safety claim, however, it cannot be ignored that these deaths occur within a vastly larger user base. Though the estimate of 30 million doses per day cited in the amicus brief above applies only to NSAIDs, acetaminophen use is also expansive. A 2006 study on the topic estimated that 19% of U.S. adults consumed acetaminophen per week; this translated to roughly 40 million Americans at that time [65]. Using another metric, 24.6 billion doses of acetaminophen-containing products were sold in 2008 alone [66]. While none of these numbers can be used to calculate a comparative mortality rate, they do provide an important perspective on the relative magnitude of acetaminophen use in the United States. In the 22-year timeframe noted above in which 32 mifepristone-associated deaths were reported to the FDA, there were an estimated 5.9 million mifepristone abortions [64].

More important than the numerical concerns with these claims, however, is the clinical context of the numbers referenced. In describing the patients with acetaminophen-induced liver failure, the study cited by the *Contraception* editorial and the 2016 ANSIRH brief specifically identified acetaminophen overdose as the cause of the observed liver failure, with a median dose of 13.2 grams per day consumed against the labeled maximum of four [55]. In this study, 36.67% of overdoses were described as intentional, 56.67% as accidental (occurring without intention for self-harm), and 6.67% unknown. A larger study of U.S. mortality and emergency databases found that intentional acetaminophen overdose accounted for between 55% and 74% of fatal cases, with 8–26% attributed to unintentional overdoses and 5–20% unable to be determined [67]. Of note, the authors of the former study wrote that “there is very little evidence of liver injury when acetaminophen is used according to package recommendations” [55].

Comparing the labeled use of one drug with the misuse of another in a safety claim is disingenuous. Not only do such constructs contradict the *Contraception* editorial recommendations noted above, they also directly satisfy yet another definition of a false or misleading claim by the FDA: an assertion that “presents information from a study in a way that implies that the study represents larger or more general experience with the drug than it actually does” [49]. More broadly, the inability to account for important numerical and

clinical context in these comparisons is specifically identified by the FDA in its warnings against using postmarket data for this purpose [68].

5. Other Comparative Claims

As the other comparative claims involving mifepristone also cite only deaths or similarly reductionist metrics, the first element of scrutiny above, on the adequate consideration of safety, is broadly applicable. Regarding the second, on an inconsistent basis of comparison, the statistics offered in support of each individual comparison similarly break down under examination.

5.1. Penicillin

The originator of this style of claim, the comparison provided by Dr. Grimes, offers a penicillin death rate of two per 100,000 as its comparative metric. Though Grimes did not cite the statistic, subsequent publications reference a 2001 review article [69]. The authors of this work did not conduct the study behind this metric, and the citations offered on its behalf do not provide clear support for it. Following other citations in the review, however, and the publications that they in turn cite, it appears that the statistic of two per 100,000 may ultimately trace to a 1968 World Health Organization bulletin [70]. There, an author described a study he performed a year earlier: interviewing the 211 physicians in a Swiss town of approximately 200,000 people, he recorded four fatal anaphylactic reactions to penicillin. Later in the work, he rightfully cautions that “longitudinal community studies and epidemiological research on these phenomena are needed to illustrate their true frequency”.

Since then, improvements in the preparation and administration of penicillin, along with advances in our understanding and awareness of anaphylaxis, have drastically decreased the risk associated with the drug [71]. In an eight-year survey ending in 2017 across which nearly 6 million courses of penicillin were studied, 25 cases of anaphylaxis were reported with zero fatalities [72]. While the FDA specifically cites “favorable information about a drug, . . . which [has] been rendered invalid by contrary and more credible recent information” as another example of a false and/or misleading claim [49], the persistence of this penicillin statistic despite more recent and rigorous evidence could be a reasonable corollary. Thus, claims made comparing mifepristone and penicillin both present a reductionist vision of safety and offer not only incomparable but also outdated statistics as their sole support.

5.2. Sildenafil

Most works claiming mifepristone’s superior safety relative to sildenafil cite a 2000 *JAMA* piece that discusses the 564 deaths reported across roughly 11 million patients prescribed Viagra in its first 1.5 years of approval [73]. While highlighting the need for further investigation, the article also notes the challenge of interpreting these deaths. Quoting the then-president elect of the International Society of Pharmacoepidemiology, the author writes that drugs like sildenafil are largely taken by individuals with preexisting complex diseases, making it difficult to disentangle the roles of the drug and the underlying condition(s) in the observed mortality. In fact, the condition for which sildenafil is primarily prescribed, erectile dysfunction, is a known indicator or precursor of cardiovascular disease and other associated comorbidities [74,75], a noteworthy link given that the described mortality was largely attributable to cardiac events. Still, the risks of taking sildenafil were investigated further in the following years; a synthesis of clinical trials and a prospective observational cohort study conducted from 2001 to 2004 found similar rates of both myocar-

dial infarction and all-cause mortality in patients taking sildenafil versus placebo across over 1000 person-years of observation in each group [76].

Interestingly, ANSIRH's recent analyses on mifepristone have ceased citing the 2000 *JAMA* article and now instead reference a study from 2010 on the adverse event reports associated with various phosphodiesterase-5 (PDE-5) inhibitors [77], of which sildenafil is a member. This paper does not offer the death rate ANSIRH claims; rather, it notes an unknown denominator of men using PDE-5 inhibitors, as well as the inability of its data source to establish causality. As will be described below, the FDA also advises against the calculation of such a rate using this data. Beyond the inability to provide a mortality rate, the source further makes known its inability to declare safety differences, even between members of this drug class, using its data. Another source on sildenafil safety makes a similar argument, noting that "it is not valid to compare the clinical efficacy and safety of [two other PDE-5 inhibitors] to sildenafil without the results of properly designed and conducted comparative studies" [78]. If members of the same drug class cannot be compared without a properly designed study, it is certainly the case that these works are in no way adequate support for a comparison with mifepristone.

This recent source aside, comparisons of drugs like sildenafil to mifepristone exemplify a key rationale underlying the caution against side-by-side comparisons of different studies. Here, the vast differences in those study populations' respective risk factors cannot be properly accounted for when attempting to draw a safety comparison. Furthermore, as with the example of penicillin, both more recent evidence and the necessity to consider a more expansive definition of safety exacerbate the inappropriateness of this claim.

5.3. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

The aforementioned amicus brief from major medical organizations in *AHM v. FDA* compared mifepristone to acetaminophen alongside ibuprofen [29]; aspirin is also occasionally claimed. The evidence the brief offers for the ibuprofen comparison presumably rests in a later-cited National Academies of Science, Engineering, and Medicine report, which concluded that "the reported risks [of drug-induced abortion] are both low and similar in magnitude to the reported risks of serious adverse effects of commonly used prescription and over-the-counter medications", later clarified to include NSAIDs and antibiotics [79]. Unlike the sources described above, this report includes both death and some adverse events (AEs) in its comparison. Regarding NSAIDs, the report offers risk rates of hospitalization and death linked to NSAID use amongst elderly populations in the U.K. [80] and U.S. [81], which are then compared with the rates of significant AEs ("hospital admission, surgery, blood transfusion, emergency department treatment, or death") and deaths associated with mifepristone use recorded in a 2017 study on telemedicine abortion [82].

The first concern with these statistics, like those presented by the sildenafil comparison, is at the level of population. The report admits that the cited morbidity and mortality risks are assessed only in elderly patients. To give this admission more context, another study estimating mortality from NSAID-associated gastrointestinal events noted that the mean age in fatality cases was 76 years and that 89.7% of such fatalities occurred in those over 60 years of age [83]. The same study noted that approximately half had a history of gastrointestinal disease and that nearly 57% of deaths were not due to the event itself but rather were "a consequence of complications developed during hospitalization prompted by the gastrointestinal event", an occurrence more likely in the population in which the statistic is being assessed. Again, we encounter the impossibility of comparing two entirely disparate populations, particularly those with different risk factors for morbidity and mortality.

The second concern exemplifies another rationale against combining unrelated studies in a comparison: differences in protocol. Investigation of the statistics used to represent risk rates for NSAIDs reveals that they are not even internally consistent within the report, let alone comparable to separate studies of mifepristone deaths and AEs. One presented metric, a 0.23% risk of hospitalization amongst elderly U.K. residents, was calculated by extrapolating a study of gastrointestinal bleed hospitalizations owing to NSAID exposure to the general population level and then dividing by the estimate of U.K. elderly who take NSAIDs [80]. The risk rate for mortality was constructed in a similar manner. On the other hand, the cited “even higher” hospitalization risk rate of 1.25% in the U.S. took hospitalizations observed in an elderly Tennessee Medicaid cohort from 1984 to 1986 and normalized to person-years of study [81]. After subtracting out baseline hospitalizations, the authors found an excess rate of 12.5 per 1000 person-years. These numbers are not comparable to each other, let alone to the serious AE and death rates presented in a 2017 prospective cohort study on telemedicine abortion.

The support provided for the claim that mifepristone is safer than, or as safe as, NSAIDs perfectly encapsulates the dangers of juxtaposing unrelated studies. These reports, taken from different time periods, assessing different populations, and using different methods, cannot be reasonably compared.

5.4. Claims Made Between Multiple Drugs on Adverse Event Rates

While the National Academies report cited a study that assessed its own serious AE rates for telehealth abortion, other claims that incorporate AEs into their safety discussions typically cite one of two sources for mifepristone or its comparators: premarket data described in the drug label and postmarket data presented through the FDA’s AE reporting infrastructure. The utilization of any AE data, whether from these sources or outside them, for a comparison exacerbates the dangers of combining unrelated studies; while the concerns about different conditions, populations, and indications for use continue to apply, AE data also suffers from inconsistent definitions and incomplete reporting. These realities are acknowledged by the FDA in explicit warnings against using such data for the purposes of comparison.

Premarket AE data, communicated under the corresponding section on a drug’s label, is recommended by FDA guidance to be preceded by the following statement: “Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice” [84]. This statement makes clear that even drugs within the same class and with the same indication for use should not be compared in this manner. Similar cautions are applied to postmarket data, as described above, with the FDA noting that this data “cannot be used to calculate the incidence of an adverse event or medication error in the U.S. population” and that it “should not be used to determine the safety profile of one drug compared to another” [68]. These cautions have many origins, including the inability of AE reports to establish causality, an unknown denominator of those taking the drug, and the passive reporting structure of AEs in which medical professionals and/or consumers voluntarily report experiences to the FDA. Though the mifepristone prescriber agreement originally supplemented this process with a requirement that prescribers report serious AEs (death, life-threatening complication, or hospitalization) of which they became aware [85], even these have been noted to be severely undercounted, attributable to both failures in the mandatory chain [86] and management of abortion complications outside of that chain [87].

Despite these warnings and realities, several sources still leverage this data and, in doing so, provide case studies in these dangers. One such resource is a document by

NARAL Pro-Choice America (now Reproductive Freedom for All) entitled “Mifepristone is a Safe Choice”, in which mifepristone and 15 unrelated drugs are compared on AE rates [88]. Each is presented favorably against a cited mifepristone rate of 0.28%, a striking juxtaposition for many of the drugs listed (e.g., Advair Diskus, an asthma medication with a listed rate of “at least 27%”). The rates for the 15 comparator drugs are cited to premarket data, which alone demonstrates the tenuousness of such a construct: according to the respective labels, the 27% of Advair users who experienced an upper respiratory tract infection [89], for example, are compared with the 13.9% of Xanax users who experienced depression [90]. These numbers are reported independently of their placebo baselines (14% and, importantly, 18.1%, respectively) and are, as the authors note, sometimes selectively presented: “some particularly high outliers” are omitted, as are “some especially common side effects”. This caveat, however, is not the explanation for the exclusion of all seven AEs listed on the same section of mifepristone’s label with rates between 18 and 75%. Instead, this exclusion traces to the presentation of postmarketing data for mifepristone, a choice unique amongst the comparator drugs. The cited source for the 0.28% rate, an FDA summary of AE reports, only presents raw counts of reports received across various AE categories and an estimate of 1.52 million mifepristone abortions in the same timeframe [91]. Interestingly, a rate of 0.28% cannot be calculated from any of this data; yet the far more critical point is that the data cannot in any way be used in the calculation of such a percentage. Its deployment, and its use against already ill-advised comparisons between premarket AE rates in other drugs, is disingenuous and, again, dangerous. The effects of colocalizing these incomparable percentages in a table were reflected in a peer-reviewed academic article, which cited the NARAL resource to state that “in the 17 years since mifepristone has been approved in the United States, there have been far fewer adverse events than from either acetaminophen or fluticasone [Advair]” [16].

The NARAL source is not alone in improperly describing AEs attributable to mifepristone in the service of a comparison. A model resolution provided by the Public Leadership Institute [92] and introduced in Missouri [93] and Wisconsin [94] claims that “medication abortion causes no complications in more than 99.9 percent of cases, making it safer than Tylenol, aspirin and Viagra”. Another example is found in a resolution adopted by the American Academy of Family Physicians (AAFP) College of Delegates, which notes a “0.05% risk of major complications” for mifepristone and an unspecified “higher complication rate” for “acetaminophen, aspirin, loratadine, and sildenafil” [95]. Online resources for the former reference a Guttmacher Institute Policy Report [96], which does not offer such a percentage. It does, however, cite the same FDA postmarket summary as the NARAL resource in claiming that “of the 1.52 million women in the United States who used Mifeprex between 2000 and 2011, 612 were hospitalized”. Despite the inappropriateness of using this source, and of treating incomplete hospitalization records as representative of complications, this statistic is on record in two statehouses and on offer to others. The latter claim is of particular note given its adoption by a major medical society; it is also among the sources offered for the comparison in the attorneys general’s motion introduced at the outset of this work [24]. Here, rather than citing sources incorrectly, the AAFP resolution simply cites incorrect sources: though one version of the document contains no citation, another references a study on aspiration abortions that makes no mention of mifepristone [97].

Though most comparisons drawn between mifepristone and other drugs deal solely with mortality in those consuming the drug, those that introduce AE rates demonstrate the particular dangers that can befall such an approach. The FDA is clear that such data, whether from clinical trials or postmarketing surveillance, should not be used for such a purpose. Beyond this, the examples above also display the profound risks of selectively or incorrectly presented data leveraged in these lines of argumentation.

It must finally be noted that future similar assertions, should they continue to be made, will rest on data that will be even more inadequate to assess safety. Changes in mifepristone regulations in 2016 [98], 2021 [99], and 2023 [58] collectively repealed the prescribers' requirements to report serious adverse events besides death and eliminated all requirements for in-person visits. Recent years have also witnessed the rise of "self-managed abortions" in which pills are obtained and used without any contact in the U.S. healthcare system [1]. Though the FDA recommends against this practice [100] and has issued warning letters on the topic [101,102], the practice continues: a study surveying such sources across the U.S. found an average of 5931 "provisions per month" between July and December of 2022 [103]. With this method, the reporting chain to the FDA is definitively broken so that even deaths resulting from mifepristone may be unknown. Emerging trends in the counseling of patients that disclosure of their abortion is unnecessary when presenting with complications [5,104,105], as well as the recent recommendation by the American College of Obstetricians and Gynecologists to avoid reporting outcomes of self-managed abortion unless legally compelled [106], further limit the identification of AEs, including deaths, associated with mifepristone. Collectively, these developments have further lessened the already limited ability of postmarket reports to inform reliable discussions of mifepristone's safety, let alone to be deployed in already unadvised comparisons.

6. Conclusions

The reductive claim that "mifepristone is safer than Tylenol" and the class of similar comparisons that it represents are wholly inadequate distillations that attempt to inform a topic of critical public concern. That the FDA would demand a controlled head-to-head study to support such a claim by the manufacturer is informative; that one has never been undertaken is similarly illuminating. Put simply, it is not possible to draw any conclusion from the comparison of drugs with different uses, administered in different manners, and used by individuals with different risk factors.

Not only have the comparisons between mifepristone and other drugs failed in their duty to adequately assess this impossibility, but they have also demonstrated a complete disregard for the need to communicate comprehensive and truthful safety information to patients, policymakers, jurists, and the public. In collapsing complex safety considerations into simplistic comparisons that leverage wholly incomparable metrics, these assertions systematically violate the norms and regulations that inform evidence-based biomedical communication. Despite this, however, they have reached both the most diffuse and influential levels of our discourse over the span of roughly two decades, buoyed by the false and dangerous perception of scientific reference and expert consensus.

Thus, while a primary offering of this work is a direct counterpoint to these claims, their proliferation also merits broader consideration. In these case studies, assertions meant to decrease regulations and quell public concerns about a drug advanced without the scrutiny that should have been demanded of them. As demonstrated in this work, the interrogation of source material and comparison to established norms are effective and necessary tools to this end. Indeed, in this case, exploring cited references served as a particular validation of those norms as warnings and guardrails against the multiplicity of errors that can befall any unfounded safety comparison drawn between drugs. Finally, the role of large groups, most notably medical societies, in the proliferation of these claims cannot be understated. In a particular way, this analysis offers a call for awareness of the memberships on whose behalf these claims are made, who in this instance were presented as a unified body of experts supporting an untenable consensus.

The pace at which these claims have proliferated, the breadth of venues in which they are offered, and the now growing assignment of them to the realm of common fact

collectively demonstrate the profound ramifications of failing to identify them as what they are: unfounded, misleading, and entirely dangerous assertions. We can and should demand more of those who present drug safety data in this manner and oppose the use of these claims in informing regulation, policy, and patient decision-making.

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Abbreviations

The following abbreviations are used in this manuscript:

AAFP	American Academy of Family Physicians
AE	Adverse Event
AHM	Alliance for Hippocratic Medicine
ANSIRH	Advancing New Standards in Reproductive Health
CDC	U.S. Centers for Disease Control and Prevention
FDA	U.S. Food and Drug Administration
NSAID	Non-Steroidal Anti-Inflammatory Drug
PDE-5	Phosphodiesterase-5
REMS	Risk Evaluation and Mitigation System
UCSF	University of California, San Francisco

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Click on the following links for more information

Medication Abortion —

A medication abortion, also known as a medical abortion, refers to an abortion that results from taking a combination of two FDA-approved medications, **mifepristone** and **misoprostol**. Many clinical trials of medication abortion have demonstrated to be exceptionally effective and safe. Click on our Support & Resources tab to see summaries of published clinical research studies.

Telehealth medication abortion +

Mifepristone +

Misoprostol +

Advance provision +

Privacy, confidentiality, and data security +

Abortion Shield Law +

Possible legal risks to you +

About medication abortion

Who is eligible for medication abortion?



Is medication abortion safe?



Is medication abortion effective?



Is it legal to take abortion pills where I live?



Are abortion pills FDA approved?



Yes, the US Food and Drug Administration (FDA) approved [mifepristone](#) (the first of two medicines used in a medication abortion) in 2000.

Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation

Mifeprex (mifepristone) and its generic, Mifepristone Tablets, 200 mg (collectively mifepristone) are approved, in a regimen with misoprostol, to end an intrauterine pregnancy through ten weeks gestation (70 days or less since the first day of a patient's last menstrual period). The FDA first approved Mifeprex in 2000 and approved a generic version of Mifeprex, Mifepristone Tablets, 200 mg, in 2019.

Risk Evaluation and Mitigation Strategy (REMS) Information

Mifeprex and its generic, Mifepristone Tablets, 200 mg, are available under a single, shared system risk evaluation and mitigation strategy (REMS), known as the Mifepristone REMS Program, which sets forth the requirements that must be followed for prescribing and dispensing mifepristone for medical termination of pregnancy through ten weeks gestation.

Under the Mifepristone REMS Program, mifepristone must be prescribed by certified prescribers and must be dispensed by or under the supervision of a certified prescriber or by a certified pharmacy on a prescription issued by a certified prescriber. Under the Mifepristone REMS Program, mifepristone may be dispensed in person or by mail.

Mifeprex was first approved in 2000 with restrictions to assure its safe use. Mifeprex was deemed to have in effect an approved REMS under the Food and Drug Administration Amendments Act of 2007. In 2019, at the same time the FDA approved the generic version of Mifeprex, the agency approved the Mifepristone REMS Program, a single, shared system REMS for mifepristone products for the medical termination of intrauterine pregnancy through 70 days gestation.

In 2021, after conducting a review of the Mifepristone REMS Program, the FDA determined that the available data and information support modification of the REMS to reduce burden on the health care delivery system and to ensure the benefits of the product outweigh the risks. After reviewing supplemental applications from the applicants for Mifeprex and the approved generic, the FDA approved a modification to the Mifepristone REMS Program on January 3, 2023. As modified, the Mifepristone REMS Program includes the following requirements, among others:

- Mifepristone must be prescribed by a health care provider that meets certain qualifications and is certified under the Mifepristone REMS Program.
- In order to become certified to prescribe mifepristone, health care providers must complete a Prescriber Agreement Form.
- The Patient Agreement Form must be reviewed with and signed by the patient and the health care provider, and the risks of the mifepristone treatment regimen must be fully explained to the patient before mifepristone is prescribed.
- The patient must be provided with a copy of the Patient Agreement Form and mifepristone Medication Guide (FDA-approved information for patients).
- Mifepristone may only be dispensed by or under the supervision of a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber.
- To become certified to dispense mifepristone, pharmacies must complete a Pharmacy Agreement Form.
- Certified pharmacies must be able to ship mifepristone using a shipping service that provides tracking information.
- Certified pharmacies must ensure mifepristone is dispensed to the patient in a timely manner.

To learn more, please see [Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation \(/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation\)](https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation).

FDA Does Not Recommend Buying Mifepristone Online

Mifepristone prescribed under the Mifepristone REMS Program will be dispensed to you by your health care provider (or someone under the supervision of your health care provider), or by a pharmacy to which your health care provider has submitted your prescription. You can ask your health care provider whether they are certified in the Mifepristone REMS Program (or working under the supervision of someone who is). The FDA does not recommend purchasing mifepristone outside of the Mifepristone REMS Program – e.g. buying it online or personally transporting it from a foreign country. If a person does so, they would be bypassing important safeguards specifically designed to protect their health. Prescription medicines that are approved for use in the United States have been reviewed for safety, effectiveness, and quality by the FDA, and are subject to FDA-regulated manufacturing controls, including inspection of manufacturing facilities. Generally, prescription medicines purchased from foreign sources are not the FDA-approved versions. The FDA does not have regulatory oversight of prescription medicines from outside the legitimate U.S. drug supply chain; therefore, the FDA cannot ensure the safety, effectiveness, or quality of those medications.

To learn more about buying drugs safely, please see [BeSafeRx: Your Source for Online Pharmacy Information \(/drugs/buying-using-medicine-safely/besaferrx-your-source-online-pharmacy-information\)](#)

Related Information

- [Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation \(/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex\)](#)
- Previous REMS
 - [REMS Approved in 2011 \(/media/164648/download?attachment\)](#)
 - [REMS Approved in 2016 \(/media/164649/download?attachment\)](#)
 - [REMS Approved in 2019 \(/media/164650/download?attachment\)](#)
 - [REMS Approved in 2021 \(/media/164651/download?attachment\)](#)
- [Historical Information on Mifepristone \(marketed as Mifeprex\) \(http://wayback.archive-it.org/7993/20161022205309/http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111334.htm\)](#)
[↗ \(http://www.fda.gov/about-fda/website-policies/website-disclaimer\)](#)

Labeling and Other Important Information

Mifeprex (mifepristone)

- [Mifeprex Prescribing Information \(https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s0251bl.pdf\)](#)
- [Mifeprex Medication Guide \(https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s0251bl.pdf#page=16\)](#)
- [Mifeprex Patient Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf\)](#)
- [Mifeprex Prescriber Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_03_23_Prescriber_Agreement_Form_for_Danco_Laboratories_LLC.pdf\)](#)
- [Mifeprex Pharmacy Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_Pharmacy_Agreement_Form_Danco_Laboratories.pdf\)](#)

Mifepristone Tablets, 200 mg

- [Mifepristone Tablets, 200 mg Prescribing Information \(/media/164653/download?attachment\)](#)
- [Mifepristone Tablets, 200 mg Medication Guide \(/media/164654/download?attachment\)](#)
- [Mifepristone Tablets, 200 mg Patient Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf\)](#)
- [Mifepristone Tablets, 200 mg Prescriber Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_03_23_Prescriber_Agreement_Form_for_GenBioPro_Inc..pdf\)](#)
- [Mifepristone Tablets, 200 mg Pharmacy Agreement Form \(https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2023_01_03_Pharmacy_Agreement_Form_GenBioPro_Inc.pdf\)](#)

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Abortion Options

How do abortion pills work?



How do abortion procedures work?



Is abortion legal in the US?



Do my abortion options depend on the state I am in?



Do my abortion options depend on how many weeks pregnant I am?



Yes. Many states allow abortions, but only up to a certain number of weeks of pregnancy. We currently do not provide abortion pills to patients who are more than 80 days pregnant, but you can still find care at an in-person clinic or from other trusted pills-by-mail providers. After 14 weeks, an abortion procedure will be your only option. If you are past 80 days of pregnancy, use <https://www.ineedana.com/> to find your closest clinic or use <https://www.plancpills.org/> to find another online pill provider.

What are my abortion options if I'm under 16 years old?



Who can I talk to about legal questions?





Getting Started with Southern Woven

What states do you serve?



What ages do you serve?



How does the consultation process work?



Do I need an ultrasound before getting abortion pills?



How far in pregnancy can I use abortion pills?



We help people access pills through **12 weeks and 6 days** of pregnancy. The medications work best when used in the first 10 weeks.

- If you have a mailing address in any of the 50 U.S states and its territories
- Pregnant person who are **15 and older**.
- Pregnant person who have a gestational age of **13 weeks 6 days or less**. Gestational age is how long you've been pregnant. It's measured from the first day of your last menstrual period. An ultrasound is required if you are 10 or more weeks.
- Pregnant person who are medically eligible.

It's rare to have a medical condition that would make medication abortion unsafe.

Prior to getting treatment with Choices Rising, a provider will go over your intake questionnaire responses to make sure treatment with Choices Rising is safe for you.

Choices Rising does not discriminate against any person on the basis of race, age, gender identity or expression, sexual orientation, body size, immigration status, religion, parental status, disability, or any characteristic protected by law.

To verify the identity of the pregnant person, we ask them to upload a photo of their ID with their name, photo, and date of birth.

We require the person who is pregnant to complete our intake process for both the medical safety of the patient and to meet legal requirements.

Additionally, in order to be confirmed for treatment with Choices Rising, patients must meet our medical eligibility requirements—which patients will be asked about during the intake process. This allows us to safely approve and prescribe medications.

If for some reason patients don't meet our medical eligibility requirements, we may recommend that they go get an ultrasound before treatment or seek in-person care.

(3/12)

ABORTION PILLS AFTER 12 WEEKS

(2024)

Yes, it's also medically *safe* to take the pills after 12 weeks.

The risk of life-threatening complications (like needing a blood transfusion) is less than 1%. It's safer than many commonly used medications, including penicillin and Tylenol.

@INeedAnACom

@AbuzzHealth

@AbortionOnOurOwnTerms



abuzzhealth and 3 others



abuzzhealth 100w

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- ✦ For peer support, contact @reprocare_healthline

Other great resources:

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@wetestify @sass_usa
@shoutyourabortion

...
Yes, people all over the world have



October 22, 2024

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How do I know if the abortion pills worked?



The pills work for 98 out of 100 people who use them. If you had bleeding and cramping after taking misoprostol, your bleeding and cramping are now getting better, and your pregnancy symptoms like morning sickness or breast tenderness are going away, the abortion pills worked. You should take a pregnancy test 4-6 weeks after using the misoprostol to be sure.

About medication abortion

Who is eligible for medication abortion?



Is medication abortion safe?



Is medication abortion effective?



Yes. Using mifepristone & misoprostol effectively ends pregnancy 98% of the time. Effectiveness can be impacted by dosage timing or if the pregnancy is more advanced than suspected.

Is it legal to take abortion pills where I live?



Are abortion pills FDA approved?





How to Safely Buy Abortion Pills Online in 2026: Your Comprehensive Guide from A Safe Choice

 July 30th, 2025

In today's digital age, privacy, safety, and reliability are paramount when making decisions about reproductive health. For women seeking discreet, dependable access to abortion pills, telemedicine is a trusted, affordable, and accessible solution. Telemedicine providers, such as those in the A Safe Choice Network, offer secure, affordable, and confidential medication abortion services. This comprehensive guide provides essential information to empower you to make an informed, safe, and private choice.



English

Understanding Abortion Pills

Medication abortion involves two FDA-approved medications: Mifepristone and Misoprostol. Mifepristone slows the pregnancy process by blocking the pregnancy hormone, progesterone. Misoprostol causes the uterus to contract, which in turns causes a miscarriage. The overall result, and how one experiences the process, is often similar to one's usual menstrual period.

Medication abortions with Mifepristone and Misoprostol is an FDA-approved process that is effective at least 95% of the time. Serious adverse events occur less than 1% of the time.

Many people prefer medication abortion over a surgical procedure because it is safe, effective affordable, and relatively easy and convenient.

Navigating the Legal Landscape in 2026

The legality surrounding abortion pills varies significantly across the United States due to regulatory shifts since the Supreme Court's Dobbs decision in 2022.

On the one hand, several states have recently made it illegal for healthcare providers licensed to perform either surgical or medical abortions. On the other hand, eight states have established "shield laws" that make it explicitly legal for healthcare providers licensed in those states to send medication abortion pills to people living in any US state or territory.



Over the past few years, FDA regulations have been substantially relaxed. The FDA now allows certified pharmacies and healthcare providers such as those in the A Safe Choice Network to dispense and mail abortion pills without requiring in-person visits.

Platforms such as [Plan C](#) provide detailed, state-specific guidelines to help you understand legal issues that may apply to you.

Why Choose A Safe Choice?

People trust doctors in the A Safe Choice Network because they offer safe, reliable, and comprehensive care. Our telemedicine services are provided in accordance with strict FDA-approved medical guidelines, ensuring safety comparable to that of traditional in-person visits. Our highly qualified clinicians who are readily available to provide clinical support have achieved a medication abortion success rate of approximately 99%.

Privacy is at the forefront of our approach; we encrypt your data and rigorously adhere to HIPAA standards. Moreover, we understand that medication abortion is more than just medical. Our comprehensive care includes clinical support via telephone, if needed, by highly experienced and caring doctors who are certified by the FDA to dispense and mail Mifepristone.

In addition to prioritizing privacy and safety, we strive to make medication abortions affordable and accessible to as many people as possible. Doctors in the A Safe Choice Network can help people who live anywhere in the US. Want to  English of

pricing? Our detailed guide on [how much the abortion pill costs](#) breaks down what is included, how prices compare elsewhere, and where financial assistance may be available.

Step-by-Step Guide: How to Order Medication Abortion Pills from an A Safe Choice Network doctor:

All you need to do to order medication abortion pills is to complete a secure, online consultation form with one of the A Safe Choice Network doctors. You can access this form via [this link](#) or by clicking on the “Order Now” button on the [A Safe Choice website](#). A one-time payment of \$150 can be made on this form via a credit or debit card.

On the same day or the next business day after completing the consultation form and submitting your payment, your medications will be shipped to you via USPS Priority Mail in a discreet package. Shipping via USPS Priority Mail typically takes 1-4 business days. We will send you an email with your USPS tracking number and a separate email that provides clear and detailed instructions about how to take the medications and what to expect. If you have difficulty locating your tracking number 24 or more hours after submitting a consultation, please check your email spam folder.

A Safe Choice Network doctors are available by phone 7 days per week to answer questions or address concerns.

Is an Ultrasound Test Needed for a Medication Abortion?

It is important to know that an ultrasound and in-person visits with a local healthcare provider are not necessary for the vast majority of people, either before or after a medication abortion.

How to Take Mifepristone and Misoprostol

1. Swallow the Mifepristone pill with water.
2. **IMPORTANT:** Wait 24 to 48 hours.
3. Take 4 Misoprostol pills by placing them in your mouth, either between your cheeks and gums, or under your tongue. Keep the pills in your mouth for 30 minutes. After 30 minutes, either swallow what is left of the pills, or spit them out. By this time, your body will have absorbed enough of the medicine.

What to Expect After Taking the Mifepristone and Misoprostol Pills

You will likely not experience significant effects within 24 to 48 hours after taking the single mifepristone pill. However, you may begin to experience cramping and bleeding—and often also nausea and diarrhea—soon after taking the 4 Misoprostol pills. There is a very good chance that you will pass the pregnancy within 24 hours of taking the 4 misoprostol pills. You will likely experience menstrual-like bleeding and cramping for the next 4-7 days.

Aftercare Support

We recognize that undergoing an abortion can be difficult in a variety of different ways. A Safe Choice Network doctors offer clinical support via telephone and can provide medical advice to answer questions you may have before, during, and after you have taken the medications.

Your Safe Choice for Reproductive Autonomy

In 2026, A Safe Choice empowers people to manage their reproductive health online safely and privately. Our comprehensive approach, including medical oversight, transparent practices, legal compliance, and extensive support, ensures peace of mind throughout this sensitive journey. Your reproductive decisions deserve trusted and compassionate support, and A Safe Choice is committed to providing precisely that.

Related Resources

Before choosing an online provider, learn how [mifepristone](#) and [misoprostol](#) work. Our [California telehealth abortion guide](#) also explains the provider and shield-law framework behind A Safe Choice. Two guides are especially helpful once you decide: a full timeline of [what to expect after abortion pills](#), and a clear breakdown of [abortion pill cost](#), including what the \$150 flat rate covers.



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A Safe Choice and the doctors in our network will never give or sell any of your information. We use the best and latest data security technology to ensure that whatever information you share with us stays with us.

Abortion PILL

EASY STEPS TO GET YOUR ABORTION PILL

Have photo ID and debit/credit card handy.
There is no need to have a telehealth consultation.
Communication can happen via the secure
communication portal.

 **STEP 1** Complete a 5 – 7 Minute Online Questionnaire 

 **STEP 2** Complete the Registration Process 

 **STEP 3** You have been approved to receive care! 

 **STEP 3** Get your medication delivered 

Now we will ask questions to determine your estimated pregnancy dating.

Please note that an ultrasound is not required. If you have not had an ultrasound, or if you had a very early ultrasound that did not provide a clear dating estimate, please select 'no' below and we will ask about your last period instead.

Have you had an ultrasound during this pregnancy? *

☐ yes

☐ no

Back

Next

I am worried that something went wrong with the abortion. What do I do?



Most abortions are successful. People only need some kind of follow-up help, like an instrumentation procedure or more medication, in about 2 out of 100 cases. However, if you are worried, you can get an ultrasound at an emergency department or through a primary care doctor or gynecologist. If you get an ultrasound, you do not need to tell them you used abortion pills. You can tell them you are pregnant and had some bleeding, and want to know if everything is OK.

How Safe & Effective Is Medication Abortion?

Medication abortion is very safe and highly effective. Here are the facts:

Safety Record

FDA-approved since 2000 - Over 20 years of safety data

Extremely safe - Safer than Tylenol, wisdom teeth removal, and childbirth (14 times safer than childbirth)

Low complication rate - Serious complications occur in less than 0.4% of cases

Rarely requires emergency care - Less than 1% need to visit an ER

Does not affect future fertility - You can get pregnant again within weeks

Effectiveness Rates

Through 8 weeks: 98% effective

9-10 weeks: 96-97% effective

11-12 weeks: 94-95% effective

If it doesn't work completely: About 2-5% of people need additional medication or a procedure. This is safe and straightforward - our team will guide you through next steps.

Medical Organization Support

Medication abortion is recommended by every major medical organization:

American College of Obstetricians and Gynecologists (ACOG)

World Health Organization (WHO)

National Abortion Federation (NAF)

Society of Family Planning

American Medical Association (AMA)

Emergency Care (If Needed)

While complications are rare, if you do need emergency care: Medication abortion is medically identical to miscarriage. Treatment is the same for both. Emergency room staff cannot tell the difference. You have a right to emergency medical care. Less than 1% of people need emergency care.

Our 24/7 support team helps you determine when to seek care versus when symptoms are normal.

<https://reprolegalhelpline.org/legal-services-and-resources/>

During and after an abortion in a state where it is banned, prioritizing your personal safety and well-being is paramount, which includes protecting your privacy, seeking support from trusted sources, and understanding your legal rights. To minimize the risk of exposure, please use a secure browser, delete your search history, and follow all digital security guidelines for abortion care:

<https://digitaldefensefund.org/ddf-guides/abortion-privacy>

Regarding testing for abortion pills, if misoprostol was taken orally, it is not possible to determine that medication was used to end the pregnancy. In the unlikely event that follow-up care is necessary or a past pregnancy is relevant for future medical attention, you can simply describe your symptoms, as they are identical to those of a miscarriage. Any requisite follow-up treatment would also be consistent for both an abortion and a miscarriage.

“Out of This World”: Norwegian Women’s Experiences of Medical Abortion Pain

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Introduction: Medical abortion has rapidly become the dominant abortion method in western countries. Pain is a known adverse effect; however, few studies have explored women’s subjective experience of medical abortion pain.

Purpose: To explore Norwegian women’s experiences of pain when performing a medical abortion at home.

Material and Methods: We recruited 24 women through an advertisement on Facebook and conducted semi-structured, face-to-face interviews. The interviews were transcribed verbatim and the data were analyzed using a phenomenological hermeneutical method.

Results: Our findings consisted of two main themes: 1) Being in pain or becoming pain, and 2) Being caught off guard and struggling to cope. Participants described undergoing severe pain, comparable to giving birth, during the medical abortion. Unprepared for the type and intensity of the pain, they felt anxious and insecure. Pain is physical, but it also has important psychological, social, and existential dimensions. Our culture (in)forms our thoughts and feelings about our pain, affecting our ability to endure suffering. The participants’ experiences of abortion pain prompt timely questions concerning gendered socio-cultural and existential meanings connected to pain, specifically in relation to female reproductive functions.

Conclusion: Women need realistic information about the type and intensity of abortion pain, as well as evidence-based pain medication. Psychological factors may affect the experience of abortion pain and should therefore be taken into account in abortion care.

Keywords: gender, medical abortion, pain, phenomenological hermeneutical study, women’s sexuality, women’s reproductive functions

Introduction

Unsafe abortion remains a major global health issue and is a leading cause of unnecessary maternal deaths and morbidities.¹ Sixty-one percent of all unintended pregnancies and 29% of all intended pregnancies end in induced abortions.¹ Globally, 45% of all abortions that occur every year are unsafe, and most of these occur in low resource settings.² Access to safe, affordable, timely and respectful abortion care is essential to women’s physical and mental well-being.¹ In recent decades, the dominant abortion method has rapidly changed from surgical to medical in Western countries.^{3,4} With the introduction and access to medical abortion, unsafe abortions have decreased and morbidity and mortality related to abortion have improved.² Medical abortion is a non-surgical termination procedure that uses medication, most often a combination of mifepristone and misoprostol, or misoprostol alone.² The procedure may take place in a clinic or at home, administered by a health professional and/or the woman herself. In early pregnancy, medical abortion is considered a safe, effective and acceptable method.⁵

Pain is a known adverse effect of medical abortion. Some studies have found that medical abortion pain can be compared to menstruation pain.⁶ Other studies have found that approximately one in four women experienced severe pain during medical abortion.^{7,8} More recent studies, however, indicate that more than half of the women who carry out medical abortion have severe pain.^{9,10} Teenagers tended to report higher levels of pain than adult women. In addition, studies indicate that a medical abortion at home involves more pain and distress than in a hospital.¹¹

Most women who have a medical abortion need help to cope with the pain; pain medication is therefore often offered as prophylactic treatment. Several studies support non-steroidal anti-inflammatories as treatment for women undergoing abortion procedures; acetaminophen (paracetamol), however, has not been found effective in reducing pain.^{12,13} A recent study indicates that the majority of women need analgesics in addition to prophylactic pain medication.¹⁰ Alongside the experience of severe pain, inadequate pain management during the abortion has been reported by women.⁹ This represents a challenge because high-quality abortion care depends on appropriate pain management.¹⁴ In Norway, different clinics offer different pain medications, most often acetaminophen (paracetamol) and/or non-steroidal anti-inflammatories (Ibuprofen or Voltaren). Over the counter pain medication may be inadequate for some women, yet stronger pain medication requires a prescription which may represent as a barrier to access.

In Norway, medical abortions were introduced in 1998 and in 2021, 95% of 10841 abortions were medical, which represents nine per 1000 women aged 15–49 years.³ A recent Norwegian study found that women performing a medical abortion at home felt unprepared and received insufficient information about the procedure.¹⁵ Another study found that Norwegian women found the abortion care to be mechanical, like an “assembly line”, and they felt that they were a burden or not full-fledged patients. Many women also felt deceived by health care personnel with regard to information about the level of pain and the nature of the abortion process.¹⁶ Norwegian women report finding the abortion process lonely and challenging, involving feelings of shame, guilt and anxiety.¹⁷ Secrecy about the abortion was important and emotional distancing was described by the women as a pervasive coping strategy.

Pain is a subjective experience that may be impacted by psychological and contextual factors.^{18,19} The political, cultural, and social context as well as individual factors are of importance for our understanding of abortion pain. Consequently, the subjective experience of abortion pain may vary between different socio-cultural and political settings. However, few studies have explored women’s subjective experience of pain during a home medical abortion, and we could not identify any studies in the Norwegian context. In this study, we explore Norwegian women’s experiences of pain when performing a home abortion.

Materials and Methods

In this study we have used a qualitative research design from within a phenomenological hermeneutical perspective, which strength lies in the opportunity it provides to explore and describe people’s lived experiences of a phenomenon.^{20,21}

Recruitment of Participants and Data Collection

The study is part of a larger research project exploring 24 Norwegian women’s experiences of medical abortion at home. A team of five researchers with varied backgrounds in health care and teaching, including public health nursing, psychology and midwifery, are involved in the project. In this study we focus on a subset of the data material, revealing the participants experience of abortion pain.

We recruited participants through an advertisement published on a university website and on Facebook. To be included in the study, women had to have carried out a medical abortion at home before 11 + 6 weeks gestational age. We included 24 women who satisfied the inclusion criterion and confirmed their participation by email. One participant lived in the UK and the remaining participants resided in various parts of Norway, in both urban and rural settings. All abortions took place in Norway. The women were Caucasian, aged 24 to 45 years, and all but one were of Norwegian origin. Education level and civil status varied, and the 24 women had had a total of 28 medical abortions, mainly between 2010 and 2019. Fifteen women had one or more children born before or after the abortion, while eight women were childless.

We conducted individual interviews with the women from October 2019 to January 2020. The women chose the location, either in their homes or in a neutral setting. Two women were interviewed via telephone or video call, and the others face-to-face. The interviews were semi-structured with three open-ended questions about the women’s experiences of self-administering an abortion at home, their experiences of being informed and supported by health care providers, and the follow-up care they received after the abortion. The introductory question was: “Can you tell me about the abortion you had some time ago?” In addition, we asked:

What was your experience of having a medical abortion at home? How did you find the interaction with the health service during the process? What follow-up were you offered after the abortion?

The interviews lasted between 19 and 71 minutes (mean 47 min) and were digitally recorded and transcribed verbatim.

Data Analysis

We used a phenomenological hermeneutical method for interpretation of the interview texts.^{20,21} This method aims to elucidate the meaning of lifeworld phenomena and is influenced by the phenomenology of Husserl and the interpretation theory of Paul Ricoeur.²²

Our analysis was based on the texts of interviews conducted with 24 women with experience of a home medical abortion, and the analysis was conducted by the first and last authors.

The analysis process consisted of three steps or phases: naïve understanding, thematic structural analysis and comprehensive understanding. These steps involved a dialectic movement between explanation (what the text said) and understanding (what the text spoke about), constituting a hermeneutic circle between parts of the text and the text as a whole. When we detected differences in interpretation of the text, these were resolved upon further reflection and discussion.

Naïve Understanding

We started with a naïve or open-minded reading of the interview texts several times to gain an understanding of the women's lived experiences of pain related to self-administering a medical abortion at home. In this phase, we tried to bracket (set aside) our preunderstandings and switch from a natural to a phenomenological attitude, allowing ourselves to become touched and moved by the text. We formulated the naïve reading as a text, using phenomenological language. This text was used to guide and validate the next steps in the analysis.

Thematic Structural Analysis

Next, we conducted a thematic structural analysis in a word table, starting by dividing the interview texts into meaning units (sentences, parts of sentences or paragraphs with related meaning penetrating all or parts of the text). The process of dividing the text into meaning units involves decontextualization, ie, the text is viewed objectively. We condensed the meaning units to formulate expressions of meaning in concise and everyday language and merged them into sub-themes and themes based on their similarities and differences. The last part of the structural analysis involved reflecting on the themes and comparing them with our naïve understanding for validation. The themes and sub-themes are presented in the Findings section.

Comprehensive Understanding

Continuing the dialectical movement between explanation and understanding, we read the text again as a whole (critical reading) and formulated a comprehensive understanding, taking into account our preunderstandings, the naïve reading, and the thematic structural analysis, in addition to relevant literature. The combination of an open and critical reflective approach helped us to bracket our preunderstandings, and the use of suitable literature enabled us to deepen our understanding of the phenomenon under study. This required the use of imaginative skills, recontextualization and closeness to the text. The comprehensive understanding is presented in the Discussion section.

Ethics

We conducted the study in accordance with the World Medical Association Declaration of Helsinki Principles for Medical Research Involving Human Subjects.²³ It was approved by the Norwegian Center for Research Data (22708) and assessed by the Regional Committee for Medical and Health Research Ethics, which considered it to be outside the remit of the Act on Medical and Health Research (36616). The participants received oral and written information about the study and gave their informed oral and written consent before the interviews started. Their consent included publication of anonymized responses and they were informed about their right to withdraw from the study at any time.

Results

Being in Pain or Becoming Pain

Being in Pain: A Straightforward Experience

For some women, the abortion was less painful than they expected, while for most others it was more painful. The women who described the abortion as less painful than expected, often found the abortion process to be a straightforward experience with tolerable pain, similar to a heavy menstruation. “I didn’t think it was particularly painful. For me, it felt more like that gurgling stomach I get during my period” [participant 4]. They were surprised that the process went smoothly and with less pain than they had imagined.

I normally have heavy periods, so it hurt a bit more than that. Maybe for only an hour when it was at its worst. But nothing like.

I thought it would be a lot more painful, based on what I’d read.[participant 8]

One woman with a previous very painful abortion experience felt surprise and relief at the level of pain “Well, it did hurt, but not as much as the first time, so I was positively surprised, and a bit relieved about it” [participant 2]. Nevertheless, she emphasized that at some point during the abortion, the pain was so intense that she felt sorry for herself.

Some had searched the Internet, where they found stories of other women’s painful abortion experiences, making them dread the abortion and the pain. Surprised that the process went so smoothly, they had expected a totally different scenario.

...but I actually think the whole process went quite well in fact. I was really a bit surprised that it went so well in fact. because of course I’d read. and when you start searching on the Internet, all this yucky stuff comes up. All the worst stuff very often comes up then.[participant 6]

Most of the women, however, experienced the abortion as more painful than expected. They described the abortion process as very painful, and many called the pain “extreme” or like “a day in hell”. Their pain, often accompanied with nausea and a general sick feeling, could last for hours. During the abortion process, women described losing control over their body; they were not only in pain, but in a state of helplessness where they felt that they “became pain”. It was a different state of consciousness where nothing but the painful and sick body existed. “I felt like my body was doing something. like nothing else existed, in fact. I completely lost control of my body because of that pain” [participant 20]. Having become pain, their focus was directed inwards towards the pain and the bodily processes, making it difficult to communicate and reach out for help. One woman described her pain experience as so extreme that it was “out of this world”, finding herself totally incapacitated and doubled up by the pain.

I couldn’t walk, I couldn’t stand up straight. When I went to the toilet, I had to bend forward because it hurt so much to stretch.

So it wasn’t much fun, you see. It’s okay to have a bit of stomach pain sometimes, but that was out of this world.[participant 11]

Another woman described the pain as so excruciating that she screamed and cried throughout the entire process, leaving her completely exhausted. The pain medication did not remove the pain, only some of her anxiety.

I cried and screamed for eight hours. I was in bed, all alone, in a huge amount of pain. My husband didn’t know what to do.

I called the emergency room to tell them I had terrible pain, and they said it was quite normal. I felt like a goner. Because of the pain... and I was so exhausted. With no strength in my body. I don’t remember walking. Like a sack of potatoes, from the bed to the toilet to the shower. Back to bed - vomited. Back to the toilet.[participant 12]

Afraid that something was wrong, she contacted the emergency room, where she was told that this level of pain and physiological reaction were normal. Another woman described how the pain sensation ended up in her throat, creating a stifling feeling.

I kind of felt like the pain was spreading upwards in my throat anyway, so it felt a bit tight. Like when you get a lot of pain, you almost feel like you’re going to vomit.[participant 15]

At some point the pain was so extreme that she almost regretted what she had done. Some reported panicking because of the extreme pain, afraid that something was wrong or abnormal. Some were afraid of dying “I was scared. I mean, if I’m

going to die, or if there's something wrong, is it really like this?" [participant 20] The women described being tensed up and crumpling to the bathroom floor in pain, feeling trapped with no means of escape. One woman said:

I was just tensing up, because ouch, it hurt, and what could I do to get out of this? There's nothing I could do, so then you kind of panic, and then you get more tense, and then well, then it actually gets worse. I wouldn't wish that experience on anyone. [participant 20]

At some point during the abortion, many of the women described feeling totally exhausted and drained. Several eventually collapsed on the bathroom floor, unable to speak or move. A few women described fainting because of the pain. "I actually think I passed out once. like I wasn't fully conscious. my partner almost called an ambulance several times" [participant 20]. Several women locked themselves in the bathroom. They wanted privacy because they felt they were losing control of their bodies, expelling not only the fetus but also excrement.

So I didn't want him to be involved in it, so I kept him outside [the bathroom] for quite a while. I don't think he came in until right at the end in fact, until I almost fell off the toilet.[participant 20]

Participants also mentioned vomiting during the abortion, and reflected that this may have had a negative impact by reducing the effective dosage of pain medication.

The Pain is a Mini-Version of Being in Labor

The women in our study compared the physical process of abortion as similar to labor, with painful regular uterine contractions over an extended period of time. "They tell you there will be some strong period pains, but it really wasn't like that. It was much more like giving birth" [participant 2]. Some even described the abortion as more painful than giving birth. One woman said:

You know, I've given birth twice since then, but that was my worst experience ever. It's much worse than giving birth. It was just so incredibly painful. I vomited from the pain, I was writhing on the floor.[participant 23]

One woman felt as if she was giving birth despite having no previous birthing experience: "Very soon, my body felt that this was a birth, it was a contraction" [participant 7]. She found it strange to experience a "birth" without a positive outcome. "You can't push, there's nothing you can do. there's no baby to be born, so there's nothing to do" [participant 7]. She struggled to understand why it had to be like that.

The women described how the painful contractions compelled them to move around to try to find a less painful position, crying or screaming in pain, and moving back and forth between the bed and the bathroom. One woman experienced the painful process as somewhat animalistic, where she made sounds that reminded her of cows bellowing.

Being Caught off Guard and Struggling to Cope Unprepared for the Pain and the Process

Many of the women described receiving insufficient or no information, which left them unprepared for the type and intensity of pain during the abortion. They expressed an element of surprise. "I remember feeling terrible pain. I think it surprised me a bit how much it really hurt" [participant 9]. Most were informed that they might have period-like pain and feel nauseous and sick. Many of the women felt that this was a massive understatement, although they acknowledged that it might be impossible to prepare anyone for the intensity of the pain. They described it like this:

OK, well, you put it (the pill) into your vagina, then it should open, which makes it easier. And then you take these and anti-nausea tablets, because you'll be nauseous, or you might feel sick, and you're also going to bleed a bit." And that was an understatement. So I had a day in hell. She did say: "You shouldn't be by yourself." But it wasn't like: "You might not be able to walk." [participant 24]

One woman said that she corrected the nurse when she was told that she might have some pain, as she knew from previous experience that the abortion would be very painful.

I had to crawl up those stairs and I'd just got in the front door before I was down on the floor, just screaming in fact, because it was so extremely, unbelievably painful.[participant 18]

Several believed that healthcare providers held back on information about the severity of the pain, because if they told women how painful the process would be, the women would refuse to go home.

I'm sure they don't dare say it's going to hurt a lot and you'll be in excruciating pain. then people will probably say: "Well, I'm not going home then... I don't want to be at home alone and have that experience.[participant 20]

Some women were assured by the health professionals that they could handle the pain because they had previously given birth. One woman thought that since she was sent home to have the abortion, the pain would not be too bad, and another felt that she did not deserve pain medication because she had been careless and put herself in the predicament. The participants felt that the painful abortion was their punishment for not being careful and in control. "It hurt like hell... to have a medical abortion... that was my punishment for being careless" [participant 16]. The women not only felt unprepared for the pain, but also for the abortion process. They did not expect it to be like labor with severely painful contractions. Some women were also unprepared for the duration of the process. One woman unexpectedly found that the abortion process suddenly started a week after she had inserted the abortion pills, and six weeks later she had two episodes of massive bleeding: "It just kept bleeding, it went on and on and on and on and it never stopped" [participant 18]. When she eventually contacted a doctor, and was told that she was still pregnant, all her bottled-up emotions burst out. In hindsight, she realized that she had needed more information about the abortion process, what was normal, and when to contact the hospital.

The women in our study wanted more concrete and realistic information about the intensity of the pain. They expressed a need to know that even if they experienced intense and excruciating pain, they would not die from the abortion. The participants stated that lack of information led to more insecurity and increased pain. One woman explicitly said that if she had known more about the abortion process, she might have handled the pain better: "Your body cooperates more when you feel confident" [participant 12].

Coping with the Pain

The women described different strategies for coping with the pain. A few of them believed that pain during abortion was natural and to be endured, not medicated away. Some described the female body as born to tolerate being in pain, or felt that it was expected of them to put up with pain. One woman described the ability to endure pain as an ingrained Norwegian character trait. "But in Norway they do what's most natural, as natural as possible. So then it will hurt a bit, and how much pain can you put up with?" [participant 12] A negative attitude towards pain medication was also reported as a reason for not taking the medication.

Most women in our study, however, felt pain medication to be necessary to endure the process. The participants found the pain medication they received at the hospital to be insufficient. "And that's when I realized that those tablets, well, they weren't exactly strong enough" [participant 16]. They felt out of control, and were unable to focus on anything else but being in pain. Based on the painful experience of a previous medical abortion, some stressed the importance of taking a prophylactic dose and then according to their own needs.

But the second time it didn't hurt as much, and I was better prepared, so that if I felt the pain starting to get worse, I took painkillers before it got really bad.[participant 2]

A few relied on alternative medicine in addition to pain medication. Several said that it was important to receive information about when to take pain medication, and that it was difficult to know what was normal in relation to taking the medication.

Discussion

In this phenomenological-hermeneutical study of women's experiences of pain during a self-administered medical abortion at home, we identified two main themes: "Being in pain or becoming pain" and "Being caught off guard and struggling to cope". In this section, we will discuss our findings in relation to contemporary research in the field as well as gendered socio-cultural and existential meanings connected to pain, specifically in relation to female reproductive functions.

Some of the women in our study described their medical abortion as a straightforward experience and the pain as tolerable or as less pain than anticipated, compared to previous medical abortions. Most of the women, however, described the abortion as very, or even extremely, painful and disabling, rendering them unable to function or even walk upright. Some described the abortion pain as the worst pain they had ever experienced in their life, where they finally became so exhausted that they collapsed or fainted on the bathroom floor or in bed. Our findings are supported by recent studies reporting high pain intensity in women undergoing medical abortion.^{9,10} Kemppainen et al¹⁰ found that 57.7% experienced severe pain, while Georgsson and Carlsson⁹ found that more than half of their participants recollected moderate to high peak pain during medical abortion. These findings, as well as those of our own study, contradict the findings of the study by Suhonen et al,⁶ namely that medical abortion pain can be compared to period pain. The findings of Suhonen et al seem to agree with the information given to women by health care personnel at the abortion clinic and in abortion information pamphlets in Norway. Most of the women in our study viewed this as a massive understatement, leaving them unprepared for the type and intensity of the pain. They described the experience as not merely having pain as a sensation, but as becoming pain. These descriptions of severe abortion pain can be understood as narratives of insufficient pain medication. Some studies suggest that high doses of non-steroidal anti-inflammatory drugs (NSAIDs), such as 800–1600 mg Ibuprofen, may be effective in managing pain for women undergoing abortion procedures, while acetaminophen (paracetamol) has not been found to be effective.^{12,13,24,25} However, there is limited knowledge on effective pain management for abortion pain, indicating a need for further research.^{10,13}

The participants in our study not only found the pain to be more severe, but also essentially different in quality, than menstruation cramps. Many of the women experienced the abortion as painful contractions similar to or worse than giving birth at full term. Similar findings were reported in Georgsson and Carlsson's⁹ study, where women compared the abortion pain to other painful conditions, including giving birth. We ask why abortion pain is commonly downplayed and portrayed as similar to period pain, when the majority of women have severe pain and find the process to be more like labor or giving birth. Could this partly be explained by gender bias when estimating others' pain? Several studies support this hypothesis, reporting that women experience more frequent and greater pain than men, but that their pain is often underestimated, and they tend to receive less adequate treatment than men for their pain.^{26,27} Gender bias has been connected to gender-stereotypical beliefs that women are more willing to express pain than men, which can partly explain why their pain complaints are more often psychologized, and why they are more often given sedatives instead of pain medication compared to men.^{28–30}

Cultural meanings of pain connected to female bodily functions may influence healthcare professionals and the affected women's perceptions and actions in their respective roles.³¹ Feminist theory of the body argues that the male body is considered as normal and good, while specific female attributes that differentiate women from men are considered as inferior.^{32,33} It follows that female bodily functions such as menstruation, pregnancy, abortion, childbirth and lactation become symbols of female inferiority and lead to devaluation. For instance, Roberts et al³⁴ found that reminders of menstruation led to lower evaluations of a woman's competence and likeability or social status. We know that abortion stigma weighs heavily on women, and is still strongly present in both Western and developing countries.^{17,35} These negative cultural norms and values can explain why the women in our study were reluctant to talk about and seek treatment for the pain connected to the abortion.

From an existential perspective, the female reproductive functions may provoke negative feelings because they remind us of our connection to nature and our own mortality.³² De Beauvoir points out that women are given the primary burden of reproduction and continuation of the human species, with the continuous menstruation cycle, pregnancy, childbirth and breastfeeding. She states that these biological considerations are an important element of a woman's situation, because it is through her body that she grasps and constitutes the world. The reproductive functions, however, represent a form of alienation from her body and restrict her assertion as an individual. Of all the mammals, the female human is the one who most violently resists the alienation or restriction of her individuality. Abortion is the ultimate act of freedom, whereby the woman exercises her subjective will to reject the biological will of her body.

Lack of information about the abortion process and the severity of the pain were described by the women in our study; consequently, they felt unprepared and insecure or anxious during the abortion. Women presenting for abortion in Norway are routinely given information that the abortion process and pain are similar to menstruation. When the abortion

turns out to be much more painful than expected, of a longer duration or a different type, it may cause anxiety and troubling thoughts that something may be wrong. Studies show that psychological and contextual factors may affect the perception and experience of pain.^{18,19} Higher levels of anxiety and attachment insecurity have been associated with higher levels of perceived pain following abortion and during birth.^{36,37} In this connection, unnecessary medical examinations may prolong the waiting time between making an appointment and obtaining abortion services at an outpatient clinic, leading to an increase in gestational age. For instance, routine ultrasound has not been found to reduce serious adverse events.³⁸ The women in our study found this waiting period to be extremely difficult and meaningless, also increasing their feelings of shame and guilt.

Social and sexism-related stigma, like abortion stigma, have been associated with a lower pain threshold.³⁹ Our beliefs, thoughts and feelings about painful conditions are shaped by our previous experience, cultural factors and received information. If the pain is believed to be purposeful or productive, it may be experienced as non-threatening and more tolerable.¹⁸ If the pain is believed to be a punishment, or connected to feelings of guilt and shame, as was the case for participants in our study, it may then be exacerbated, leading to anxiety and social withdrawal. Such factors may prevent women from seeking adequate abortion care from healthcare providers.

Although pain is undoubtedly physical, it also has important psychological, social and existential dimensions.⁴⁰ According to Merleau-Ponty,⁴¹ pain is experienced within a horizon of cultural meaning (our lifeworld), which in(form)s our experience of the pain. Reciprocally, our painful embodied consciousness constitutes our lifeworld. In order to understand the meaning of abortion pain for women, we need to treat pain not only as a physical process, but also with important psychological and socio-cultural dimensions which (in)form the pain experience. With this in mind, pain treatment should include not only appropriate medication, but also interventions that reduce feelings of shame, guilt, anxiety, and loneliness.

Methodological Discussion

Qualitative in-depth interviews are well suited to explore women's experiences of medical abortion.⁴² Open and flexible questions during the interview allowed the women to freely express their experiences, which provided rich data. Recruitment through an advertisement in the social media channel Facebook allowed us to rapidly reach out to many people, who would view the content of the advertisement while it was online and open for recruitment. Such a selection process may reduce the risk of systematic recruitment bias; however, we cannot rule out the possibility that women with negative experiences of medical abortion were more inclined to participate in the study.⁴³ Using a Norwegian advertisement on Facebook excludes individuals who do not use the platform or understand the language. Additionally, since all but one participant were ethnic Norwegians, there is a risk of missing important insights from immigrant women in Norway. Nevertheless, our results yield generalized meanings that can be transferable to other women who perform a home medical abortion in similar socio-cultural settings.⁴⁴ Factors that strengthened the transferability of the results were that the participants lived in geographically diverse areas in Norway and received health care from hospitals in different health regions.

Implications

Ensuring effective pain medication for a home medical abortion is of vital importance for securing high-quality abortion care. Women who present for medical abortion need realistic information about the type and intensity of pain, as well as evidence-based pain medication. Psychological and cultural factors may affect the experience of abortion pain and should therefore be considered in pain care. More research is needed on how to best ensure sufficient pain medication at home, in addition to research on how to provide adequate psychological support before, during and after a medical abortion.

Conclusions

According to the WHO,¹ management of pain is an important public health concern; however, abortion pain still appears to be a neglected issue. Most of the participants in this hermeneutical-phenomenological study described suffering through severe pain when performing a medical abortion, which can be interpreted as narratives of insufficient pain medication. It seems expected of women who opt for a medical abortion to suffer through severe pain as a normal part of

the procedure. A timely question is whether this is humane and ethical treatment of women in today's society. We argue that realistic information about the type and intensity of the pain, and sufficient pain medication, are vital for high-quality abortion care. In addition, adequate psychological support may affect the pain experience and should be considered as part of pain care and treatment.

Disclosure

The authors report no conflicts of interest in this work.

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Expectations and experiences of pain during medical abortion at home: a secondary, mixed-methods analysis of a patient survey in England and Wales

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ABSTRACT

Objective To explore experiences of pain during medical abortion and provide patient-centred recommendations for improving abortion experience and pain counselling.

Methods We invited patients of British Pregnancy Advisory Service who underwent medical abortion up to 10 weeks' gestation to participate in an online, English language questionnaire from November 2021 to March 2022. Participants answered questions about pain, method preference, abortion experience, advice, and how they would describe pain experienced to a friend. In this secondary analysis, we analysed free-text responses using reflexive thematic analysis techniques. We used descriptive statistics and parametric tests to analyse quantitative responses.

Results Of 11 906 patients invited to participate, 1596 (13.4%) completed the questionnaire, including at least one free-text comment. Participants used a range of descriptors for medical abortion pain across three broad themes: pain severity, pain quality and comparisons to other reproductive pain. Some found the commonly used analogy to period pain misleading. Many felt unprepared for the level of pain they experienced, which they attributed to provider comparisons to period pain, as well as a lack of detailed, realistic anticipatory pain counselling. Qualitative and quantitative results suggest pain experiences impact method preference. Participants recommended better counselling for pain and abortion preparation, including first-hand accounts of medical abortion at home and a wide and accessible range of descriptions of pain.

Conclusions Abortion providers should use patient-centred recommendations to better prepare patients for pain during medical abortion. Setting realistic expectations can improve abortion experience and

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ While highly acceptable, medical abortion is painful and research is lacking on the best ways of managing pain.
- ⇒ Expectation management for pain is important for satisfaction with overall abortion experience and perceived quality of care.

WHAT THIS STUDY ADDS

- ⇒ Reinforcing recent literature, our findings emphasise how using comparisons of medical abortion pain to period pain can be misleading and unhelpful for managing some patients' pain expectations.
- ⇒ Patients want detailed, realistic anticipatory pain counselling as well as general preparatory advice, including first-hand experiences which reference a wide and accessible range of descriptions of pain.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND POLICY

- ⇒ Services that provide and counsel about medical abortion can use these findings to develop practitioner training tools and patient counselling materials, to better prepare patients for the pain they may experience and, where possible, to ensure informed method choice.

support informed method choice. Further research is needed to develop and test patient-centred counselling materials.

INTRODUCTION

In England and Wales, medical abortion is the most common method up to 10 weeks' gestation, with nearly all medical abortions carried out at home.¹ While highly acceptable, medical abortion is painful for most patients. Studies have yet to identify the best way to manage pain.² Trials show patients typically experience moderate to severe pain, with average pain scores between 5 and 8 out of 10.^{3–5} For many, pain is the worst feature of this method.⁶ Dissatisfaction with medical abortion at home is associated with dissatisfaction with pain control.⁷

Patients report that being well prepared for what to expect during and after an abortion contributes to overall satisfaction and perceived quality of care.^{8,9} Several qualitative studies have highlighted the importance of anticipatory counselling about pain management with medical abortion, and the impact that good counselling can have on fear, anxiety and pain experienced.^{9–12}

British Pregnancy Advisory Service (BPAS), a non-profit, independent abortion provider, operates clinics throughout England and Wales. Annually BPAS provides approximately 90 000 medical abortions at home up to 10 weeks' gestation.¹¹ If patients do not require an ultrasound, they can follow a remote pathway,¹¹ with a teleconsultation and medications mailed for self-administration.¹²

In 2021, BPAS made clinical policy changes in response to trial findings that opioids were no better than ibuprofen in managing medical abortion pain¹³ and reflecting increasing concerns about opioid addiction. Instead of providing codeine to all medical abortion patients for use when ibuprofen was insufficient, codeine was offered on an 'opt-in' basis following counselling. An evaluation¹⁴ found that participants in the opt-in group were significantly more likely to be satisfied with pain management than those in the universal group (adjusted odds ratio (aOR) 1.48, 95% CI 1.12 to 1.96, $p < 0.01$). One possible explanation for this difference was that the opt-in group may have been better prepared for pain. Despite higher satisfaction in the opt-in group, patients still reported

high pain scores (mean 6.7/10) and experienced more pain than anticipated (45.2%, 362/801). During that evaluation,¹⁴ we also collected qualitative responses about abortion experience. In this secondary analysis, we examined qualitative data to inform counselling guidance and materials, aiming to better prepare BPAS patients for pain management, and provide insights for other abortion services to consider.

METHODS

This is a secondary analysis of a previously published evaluation¹⁴ wherein we invited medical abortion patients up to 10 weeks' gestation to complete an online, anonymous questionnaire about pain management during medical abortion at home. Over a 4-month period (November 2021–March 2022), we invited eligible patients to participate via text or email. We did not offer remuneration. In this analysis, we included questions about future abortion method, as well as three optional free-text questions (table 1).

The Health Research Decision Aid tool did not classify this evaluation as research.¹⁵ On this basis, the BPAS Research Ethics Committee granted it exemption from full ethical review.

We used descriptive statistics to summarise quantitative responses. Using a Student's *t*-test, we compared mean pain scores by future method preference. We collated free-text responses from participants who completed the questionnaire with at least one free-text response. Data were stored and analysed using Excel. We followed reflexive thematic qualitative analysis principles.^{16,17} All authors participated in the analysis and contributed multidisciplinary perspectives including expertise in clinical, epidemiological and qualitative research methods related to abortion, endometriosis, chronic pelvic pain, and pain within other gynaecological procedures. One researcher (HM) led the analysis, familiarising themselves with the data and following an iterative process of coding. Codes were identified inductively from content and deductively from questions and relevant existing qualitative research. A second researcher (DP) worked with

Table 1 Method preference and pain with abortion variables used in quantitative and qualitative analyses in secondary analysis of evaluation

Variables	Measure
Quantitative variables	
If you had another abortion in the future, what method would you choose?	Used as a proxy for method preference
Was the pain you experienced a factor in why you would choose this method?	Impact of pain on method preference
On the following scale of 0–10, how would you rate the worst pain you recall during your medical abortion?*	Maximum pain experienced during abortion
Qualitative variables (optional free-text responses)	
How would you describe the pain you experienced to a friend?	
Is there anything else you would like to tell us about your experience of pain, or how it was managed?	
Is there anything you know now that you wish you had been told before your abortion?	
*Eleven-point numerical rating scale.	

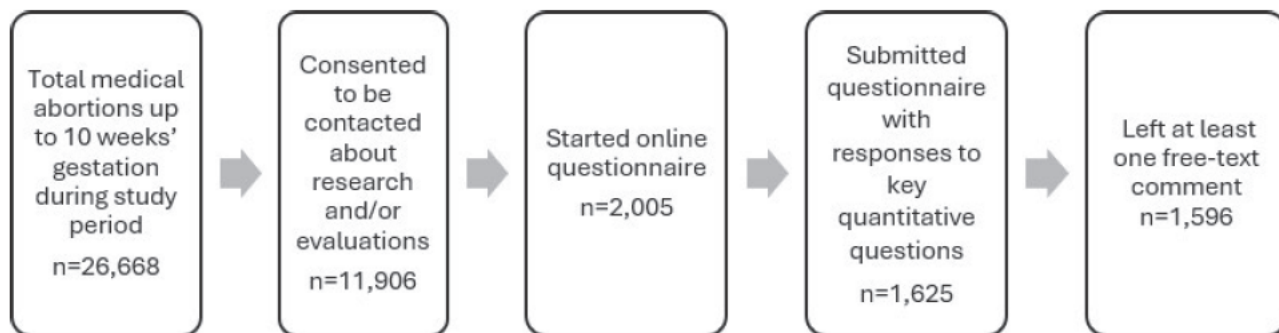


Figure 1 Flow chart for evaluation of pain management for medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service.

HM to further reflect on these codes, and refine into themes around central organising concepts. All authors met to discuss the coding framework (online supplemental file 1), including exemplar quotes, to come to a consensus on final refined themes. In reporting, we mirror participants' language and refer to pain experienced during menstruation as 'period pain'. Other scientific literature may reference 'menstrual cramping' or 'dysmenorrhea'.

RESULTS

Sample

We invited 11 906 eligible BPAS patients to participate and included 1596 in this secondary analysis (figure 1).

Quantitative results

As shown in table 2, one-third of patients had pregnancies that were 8 weeks and 0 days to 9 weeks and 6 days' gestation (33.2%, n=530) at abortion. Almost half were nulliparous (48.7%, n=777).

About half (48.4%, n=773) of the participants reported experiencing more pain than expected (table 3). Most (92.2%, n=1472) reported experiencing moderate to severe pain (pain score $\geq 4/10$). Of the 12.7% (n=202) who would choose to have a surgical abortion if they needed another abortion in the future, 82.7% (n=167) said that pain was a factor in this decision. Most (65.6%, n=1047) would choose a medical abortion, with just fewer than half (42.7%, n=447) indicating that pain was a deciding factor. Participants who would choose surgical abortion reported an average maximum pain score of 8.5 (SD 1.8), compared with 6.2 (SD 2.2) for those who would choose a medical abortion ($p<0.05$).

Qualitative results

We identified four themes, each of which are described below.

Patient descriptors of medical abortion pain are varied and complex. Participants shared their descriptions of medical abortion pain by recounting how they would describe their pain to a friend. We present these across three subthemes: severity of pain, quality of pain, and comparisons with other reproductive experiences.

Severity of pain

Participants provided descriptions of pain that ranged from no or little pain to severe pain, or the worst pain ever experienced. For example, "I didn't suffer any pain", "Very mild", "Moderate", "Very strong, but not severe", "Excruciating" and "The worst pain I have gone through".

Quality of pain

Participants used a wide range of physical sensations to illustrate the quality of their pain. For example,

Table 2 Demographics and health characteristics of participants undergoing medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service

Characteristic	Participants (N=1596) n (%)
Age (years)	
14–19	131 (8.2)
20–29	790 (49.5)
30–39	564 (35.3)
40–50	111 (7.0)
English as first language	
No	212 (13.3)
Yes	1384 (86.7)
Gestational age	
5 weeks 6 days or less	305 (19.1)
6 weeks 0 days to 7 weeks 6 days	748 (46.9)
8 weeks 0 days or more	530 (33.2)
Unsure/cannot remember	13 (0.8)
Parity	
Nulliparous	777 (48.7)
Parous	819 (51.2)
Previous abortion	
No	1115 (69.9)
Yes (medical)	355 (22.2)
Yes (surgical)	200 (12.5)
Medical history	
Anxiety	550 (34.5)
Depression	347 (21.7)
Chronic pelvic pain	27 (1.7)
Endometriosis	30 (1.9)

Table 3 Pain characteristics, satisfaction with pain management and impact on method preference among participants undergoing medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service

Parameter	Participants (N=1596) n (%)
Maximum pain score	
0–3	124 (7.8)
4–5	328 (20.9)
6–7	482 (30.2)
8–10	662 (41.5)
Actual versus expected experience of pain	
A lot more than expected	485 (30.4)
A little more than expected	288 (18.0)
About as much than expected	382 (23.9)
A little less than expected	277 (17.4)
A lot less than expected	164 (10.3)
Future method preference	
Medical	1047 (65.6)
Surgical	202 (12.7)
Not sure	347 (21.7)
Pain a factor in method preference	
Would choose medical and pain with medical abortion a factor (n=1047)	447 (42.7)
Would choose surgical and pain with medical abortion a factor (n=202)	167 (82.7)

they described it as “aching”, “crunching”, “pulling”, “squeezing”, “stabbing” or “twisting”. In some instances “cramping” or “contracting” were used, or the phrase “coming in waves”.

Descriptions often included the physical or mental impact of pain or accompanying symptoms, for example, vomiting or feeling faint. They often referred to additional facets of pain, for example, location, severity, intensity and duration.

“Like someone squeezing my stomach muscles, like my insides were being twisted.”

“The pain was intense and constant, in my lower back. It hurt so much that it made me throw up several times. I felt shaky and faint at points. After the pregnancy passed it became a lot easier.”

Comparisons with other reproductive experiences

Many participants used other reproductive experiences such as period or labour pain as reference points for medical abortion pain. Some did express pain that was like their regular period or a particularly severe period. However, participants often said abortion pain was worse than period pain, using multipliers to describe the difference.

“The pain felt like my normal period pains but just a little bit worse. Nothing extreme, but just that bit worse.”

“I suffer with endometriosis so have extremely painful and heavy periods normally so to me the

pain felt pretty much the same as I would experience during a period.”

Others made comparisons to birth pain, referencing “contractions” or labour pains that they had experienced. In some instances, participants anchored medical abortion pain somewhere between the severity of period and labour pain.

“Pain was so much stronger than period pain, it was like having contractions in labour. I’ve given birth three times and the pain really wasn’t too much different from that pain, the cramping contraction pain.”

Current counselling leaves some unprepared for pain

Some participants recounted an alignment between expected and experienced pain, suggesting good preparation. Some searched online forums to read first-hand experiences to prepare them while others reported that the service had sufficiently counselled them.

“All the help, advice and support I received was exceptional. My expectations were managed perfectly and nothing came as a surprise, I felt fully informed.”

Others said the pain they experienced was far greater than expected. Some directly attributed this to language or detail given to pain in consultations or information leaflets being “washed over”, “downplayed” or “sugar-coated”. A substantial number of participants reported how provider’s descriptions of medical abortion pain as period-like (eg, “like a period”, or “a bad period”, “period cramps” or “period cramping”) had played directly into their expectations. This influenced pain management plans, and then ultimately left them unprepared for the pain experienced, which was, for many, more painful or incomparable to their experience of period pain. For a small number, the lack of realistic pain preparation made them feel like they needed emergency help during their abortion.

“The pain was really a lot worse than I expected, perhaps because it was compared to bad period pain and my periods have always been fairly pain-free.”

“[I wish I had been told] how bad the pain actually would be not just ‘cramps’ cause it’s more than just cramps”.

“Pain was so severe, and yet everything I read or heard, and what little there was about the pain on the internet was it was slight cramping like a bad period...well it couldn’t be further from the truth.... The amount of pain you could go through is completely played down ... I understand they probably don’t want to scare many women, but I’d rather know how bad the pain can get.”

Greater-than-expected pain negatively impacts method choice

Several participants said that the pain they experienced would influence method preference if they needed an abortion again. Reflecting on their recent abortion,

Table 4 Participant recommendations for improving the experience of medical abortion with illustrative quotes

Subtheme	Patient recommendation	Illustrative quotes
Pain counselling	Provide comprehensive advice about possible pain, pain management and coping strategies, including timing of analgesia	<i>"The management of pain before during and after could be explained better, I do feel like it's washed over quickly and this can truly change the whole experience."</i> <i>"I wish that it had been made clearer how painful it would be, so I would know to take codeine from the start rather than as a reaction to pain."</i>
	Reference the broad range of possible pain severity, highlighting the potential for severe pain and reassurance for less painful experiences	<i>"The extremity of the pain, I would rather someone told me plainly just how painful it would be rather than trying to sugarcoat it."</i> <i>"I think it's worth reassuring people that just because it [pain] is stated severe it doesn't necessarily mean that it will be. I spent more time worrying about the possibilities of the side effects than needed!"</i>
	Avoid singular comparisons to period pain or cramps	<i>"Please stop telling people it's like period pain I've never felt anything like it."</i>
	Provide first-hand accounts or verbatim experiences of medical abortion at home, ensuring that an accessible range of descriptions are used	<i>"I did a lot of research and Google searches of people's experiences so I felt well prepared mentally."</i> <i>"I felt the pain was slightly downplayed, luckily I read some forums of other people's experiences so felt better prepared."</i> <i>"I think the word cramps, which was used during the consultation and on the BPAS website does not describe what happens. I would be more prepared if the term 'contractions' was used."</i>
Other advice	Encourage patients to consider being accompanied when self-managing abortion at home	<i>"[I wish I had been told] ensure you're with someone you're comfortable with to ensure they can support you throughout it. Having a partner [or I would have asked a friend] with me was supportive and I felt safe because at one point the pain was so much I wanted to call for more help in my panic but they were there to support me through it."</i>
	Suggest creating a comfortable and enabling environment (food, drink, positionality, space) in advance of taking medications	<i>"[I wish I had been told] to have water and light snacks [fruit, etc.] on hand as I was too drained to have been able to go and get anything."</i> <i>"I'm glad I stayed in a familiar place with a friend. I wish I was reminded to eat lots of food throughout though as I think I may have been sick due to taking codeine without eating."</i> <i>"A nurse advised me how to sit/stand up where possible [as opposed to lying down or sitting crunched up/bent over] during the medical abortion so that less pressure built up in my uterus. This advice helped greatly and allowed the pregnancy to pass and pain to start decreasing. This advice would have been really helpful in the guidance booklet."</i>
	Remind patients to review and obtain supplies to manage side effects (pain medication, menstrual pads, hot water bottle)	<i>"I also used a hot water bottle which helped a lot."</i> <i>"I was told to use sanitary towels I had ones for a light flow. Being advised to get ones for a heavier flow/night ones would have been useful."</i> <i>"Also, having blankets was a good way to keep warm as I noticed I was getting chills which increased the pain keep blankets with you at all times."</i>

some stated that they would have opted for a surgical abortion if they were aware of the possible severity of medical abortion pain. Two participants highlighted how adequate counselling for pain can influence informed choice to have an abortion.

"If I had known it was basically like inducing labour, I would not have taken the medical abortion route."

"From what was on the website and what I was told I had no indication it could be like that [so painful].... [Being transparent] might put some women off from abortion, however, I feel that patients have a right to fully understand the risks and benefits. This should be made absolutely transparent; shared and informed decision making is essential."

Patient-centred counselling recommendations to improve abortion experience and informed choices

Many participants provided recommendations to improve the abortion experience. Much of this advice, if shared within anticipatory counselling, could aid decision-making processes so that treatment choice is informed. We have divided these into recommendations for pain counselling and other advice to improve the abortion experience. These are outlined in [table 4](#) together with illustrative quotes.

DISCUSSION

This secondary analysis builds on a quantitative evaluation of a medical abortion pain management policy change at BPAS.¹⁴ We identified four key themes, offering insights and recommendations for improved counselling about pain.

We found that many participants experienced more pain than expected during their medical abortion, corroborating existing evidence.^{18 19} Qualitative data suggested that some felt that pre-abortion counselling did not focus enough time or detail on pain severity and management. The widespread adoption of telemedicine for abortion in England and Wales^{7 11} creates new challenges to ensuring patients are prepared to manage pain. Accurate information that is accessible at different time points is important to those having remote abortion care.²⁰ This is particularly salient for advice on pain, crucial information that Hoggart *et al* hypothesise could be lost amidst the volume of information typically provided in an abortion teleconsultation.²⁰

Some participants, perhaps indicating unmet informational needs, sought information about pain in online forums. Navigating online spaces comes with

the risk of both misinformation and disinformation.²¹ Abortion providers should give patients comprehensive, clear information on the full range of possible pain experiences.¹⁸ Counselling could include providing first-hand accounts or signposting to trusted online resources.²¹ Offering alternative media or tools that provide information about pain along the patient pathway could satisfy those who desire detail,¹⁸ while also acknowledging the potential for information overload within one teleconsultation.²⁰

Some of our participants recounted how comparisons to period pain had unprepared them for pain, showing the limitations of using this as a stand-alone comparator. This finding reflects and builds on existing evidence. In a multi-country qualitative study of medical abortion experiences, participants said pain was less severe than giving birth but worse than menstruation.²² In a recent UK study, participants similarly reported that period pain was a misleading comparator for abortion pain that resulted in uncertainty instead of clarifying expectations.¹⁰

In line with literature on decision-making about abortion methods,^{23 24} participants indicated that pain experienced would impact future method preferences. Some also reflected negatively on how informed their method choice was after experiencing more pain than anticipated. Choice of abortion method is a standard of quality care.²⁵ Abortion providers and commissioners recognise the importance of choice, but also emphasise the complexity and current challenge of practically offering it.²⁶ Constraining system factors that have eroded method choice, predominantly in the independent sector and particularly for surgical abortion, include commissioning, cost, infrastructure and workforce.²⁷ Providing accurate, realistic information on pain is not only important for preparing patients for medical abortion, but for supporting informed consent for abortion method choice, in the context of structural constraints. Further to this, while not simple, such structural issues must be confronted, so as to increase the availability of surgical options, ensuring meaningful method choice.²⁸

This evaluation has several strengths. The sample analysed is representative of the BPAS population,¹⁴ and the substantial quantity of free-text comments includes a range of pain experiences. The evaluation team included expertise and diverse experience from within and external to BPAS. A multidisciplinary team is a particular strength in reflexive thematic analysis, where reflection on an individual's own interpretive lens is integral.²⁹ Our primary publication outlines some limitations,¹⁴ namely the potential for recall bias around severity of pain, and limited generalisability due to low response rate. In addition, we recognise the possibility that patients with greater-than-expected pain may be more likely to respond. We also consider the pitfalls of survey methodology. While we gathered qualitative data, we were unable to use prompts,

unlike in interview studies which can therefore offer more in-depth analysis.^{10 22}

CONCLUSIONS

This evaluation demonstrated that patients described medical abortion pain using varying terms across a wide spectrum of severity and sensations. While many compared it to other reproductive pain, some found comparisons to period pain inaccurate and misleading. Many felt unprepared for pain, which affected future method preference. In response, BPAS has revised patient information to include descriptions of medical abortion pain based on this evaluation. We will assess whether these descriptions better prepare patients, or increase anticipation of pain or anxiety, factors known to be associated with pain.³⁰

Considering the permanence of telemedicine and the growing incidence of medical abortion at home,^{12 27} providers and researchers must optimise high-quality, patient-centred care.¹⁸ Future work should focus on identifying effective medical abortion analgesia,² and developing counselling tools that manage pain expectations, improve abortion experience and ensure informed choice.

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Contributors PAL conceived of this evaluation and the project was designed by NT, KCW and PAL. This secondary analysis was performed by HM with input from DP, NT, KCW and PAL. Manuscript preparation was led by HM with input from DP, NT, KCW and PAL. HM and PAL are responsible for the overall content as guarantors.

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Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study

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ABSTRACT

Objective To determine the risks of short term adverse events in adolescent and older women undergoing medical abortion.

Design Population based retrospective cohort study.

Setting Finnish abortion register 2000-6.

Participants All women (n=27 030) undergoing medical abortion during 2000-6, with only the first induced abortion analysed for each woman.

Main outcome measures Incidence of adverse events (haemorrhage, infection, incomplete abortion, surgical evacuation, psychiatric morbidity, injury, thromboembolic disease, and death) among adolescent (<18 years) and older (≥18 years) women through record linkage of Finnish registries and genital *Chlamydia trachomatis* infections detected concomitantly with abortion and linked with data from the abortion register for 2004-6.

Results During 2000-6, 3024 adolescents and 24 006 adults underwent at least one medical abortion. The rate of chlamydia infections was higher in the adolescent cohort (5.7% v 3.7%, $P<0.001$). The incidence of adverse events among adolescents was similar or lower than that among the adults. The risks of haemorrhage (adjusted odds ratio 0.87, 95% confidence interval 0.77 to 0.99), incomplete abortion (0.69, 0.59 to 0.82), and surgical evacuation (0.78, 0.67 to 0.90) were lower in the adolescent cohort. In subgroup analysis of primigravid women, the risks of incomplete abortion (0.68, 0.56 to 0.81) and surgical evacuation (0.75, 0.64 to 0.88) were lower in the adolescent cohort. In logistic regression, duration of gestation was the most important risk factor for infection, incomplete abortion, and surgical evacuation.

Conclusions The incidence of adverse events after medical abortion was similar or lower among adolescents than among older women. Thus, medical abortion seems to be at least as safe in adolescents as it is in adults.

INTRODUCTION

Pregnancies among teenagers are mostly unplanned and offer a special challenge to family planning

services. Most of all such pregnancies (up to 82% in the United States) are unintended.¹ The decision to continue or terminate a pregnancy is strongly associated with age. Besides age, being a student or being single are important factors in young women's decisions on abortion.² In the United States, 6% of all abortions are carried out in under 18s.¹ In the United Kingdom, 9.5% of abortions in 2009 were in adolescents.³ Thus abortions among teenagers are common and are an important public health problem.

The medical termination of pregnancy using the antiprogesterone mifepristone and a prostaglandin analogue has been widely established in several countries during the past decade. In 2009, 40% of abortions were medical in the United Kingdom.³ In Sweden and Finland the corresponding figures were 72% and 76%.^{4,5}

Increasing use of medical termination of pregnancy points to a need for appropriate studies to confirm its safety in various target groups. Using nationwide register based data we showed that both medical and surgical abortions are generally safe, with few serious complications when gestation is less than 63 days.⁶ The most common adverse events were haemorrhage and incomplete abortion. However, in that study we did not assess the safety of medical abortion among adolescents.

Data on the safety of medical abortion among adolescents are limited. In a small prospective study, medical abortion was found to be highly effective and well tolerated in adolescents aged 14 to 17 when gestation was less than 56 days. Initially, half of the participants experienced stress and fear, but these emotions improved significantly within the month after abortion.⁷

In the present nationwide study we compared the safety of medical abortion between adolescents and adults. To eliminate the possible influence of previous pregnancies on the outcome of termination of pregnancy, we carried out a subgroup analysis among primigravid women. In addition we assessed the impact of a positive *Chlamydia trachomatis* test result at the time of

abortion on the incidence of infections after abortion—a situation of great clinical relevance to adolescents.

METHODS

From the national abortion register compiled by the National Institute for Health and Welfare we identified all women who had undergone induced abortion in Finland during 2000–6. The study population consisted of women who had had a medical abortion (mifepristone alone or in combination with misoprostol or other prostaglandins) at 20 weeks or less of gestation. We divided the women into two cohorts based on age at the time of abortion: adolescents (<18 years) and adults (≥18 years). To keep the observations independent, we included only the first abortion for women who had more than one during the study period. To assess the potential learning curve in the introduction of medical abortion, we analysed the results in part separately for the first years (2000–3) of its use compared with established use (2004–6). We linked the data with the care register for health institutions (later called the hospital register) and the national infectious diseases register, both compiled by the National Institute for Health and Welfare, and the cause of death register of Statistics Finland. We followed the women for 42 days after the induced abortion and linked all events recorded in the hospital register and cause of death register with the abortion register.

The Finnish national register on induced abortions and sterilisations has been maintained since 1977. In accordance with the current legislation, doctors performing induced abortions are obliged to report cases to the register within one month, using a specific data collection form. In Finland, data on induced abortions are collected from all hospitals and clinics that carry out induced abortions. The register contains data on women having termination of pregnancy. These data include information on pregnancy history, occupation, type of residence, municipality, and marital status. Data on current pregnancy include information on duration of gestation at the time of abortion, indication for abortion, and method of termination.⁵

We have previously described Finnish legislation on induced abortion.⁸ Briefly, current legislation permits termination of pregnancy of up to 20 weeks' gestation

(24 weeks in cases of a medical condition of the fetus) for social, medical, or ethical reasons. A national guideline on the care of women seeking abortion was published in 2001 and updated in 2007.⁹ Based on this guideline all women should be screened for *C trachomatis* and treated if it is present and screened for bacterial vaginosis at the first visit before the termination of pregnancy. Prophylactic antibiotics are not routinely used.

Data collection

All hospitals in Finland are required by law to provide the hospital register with information on inpatient treatment (all hospitals) and outpatient visits (public hospitals). This register contains information on diagnosis (international statistical classification of diseases and related health problems, ICD-10¹⁰) and treatment (Nordic classification of surgical procedures¹¹), as well as the dates of the treatment episodes. To analyse adverse events related to induced abortion we linked information on the study participants in the hospital register for all hospital inpatient episodes and outpatient visits within 42 days after termination of pregnancy with data in the abortion register. We selected diagnoses and codes for surgical procedures in the cohorts for those considered to be of clinical importance.

We divided the complications into eight categories (see box): haemorrhage, infection, incomplete abortion, surgical evacuation, psychiatric morbidity, injury or other reason for surgical operation, thromboembolic disease, and death. The classification was based on that reported in the joint study of the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists¹² and modified for this and our previous study.⁶

The cause of death register contains data from death certificates and covers all deaths of Finnish citizens and permanent residents in Finland, classified according to ICD-10 codes. All the early deaths (within 42 days of termination of pregnancy) were classified as direct, indirect, or accidental.¹³

The National Department of Infectious Disease Epidemiology and Control at the National Institute for Health and Welfare collects information on cases of detected *C trachomatis* infections. Since 1997 it has been mandatory for laboratories to report all positive cases to the national infectious diseases register based on the Communicable Diseases Act and Decree of 1987.¹⁴ Since 2004, laboratory notifications have included personal identification numbers, enabling linkage of the data with that in other registries. Since 2004 genital *C trachomatis* has been detected by DNA or RNA testing.¹⁴

Statistical analysis

To assess differences between the groups we used the Mann-Whitney test for age and the χ^2 test for categorical variables. The χ^2 test was also used to calculate the difference in the incidence of adverse events, except for rare ones (psychiatric morbidity, injury, thromboembolic disease, and death) when we used Fisher's

Classification of adverse events

- Haemorrhage—all reported haemorrhage
- Infection—pelvic inflammatory disease, endometritis, cervicitis, wound infections, pyrexia of unknown origin, urinary tract infections, and septicæmia
- Any reported incomplete abortion
- Surgical evacuation
- Psychiatric morbidity—depression, intoxication, psychoses (ICD-10 codes F10–F48)
- Injury or other reason for surgical operation—all injuries, cervical laceration, uterine perforation, all surgical interventions during follow-up
- Thromboembolic disease—pulmonary embolism, deep vein thrombosis
- Death—death from any cause, pregnancy related death according to the World Health Organization definition

Table 1 | Characteristics of the two study cohorts. Values are numbers (percentages) unless stated otherwise

Characteristics	Adolescent cohort (<18 years) (n=3024)	Adult cohort (≥ 18 years) (n=24 006)	P value
Mean (median) age (years), range	16.1 (16.0), 13-17	27.6 (26.0), 18-50	<0.001
Previous pregnancies:			
None	2913 (96.3)	10 474 (43.6)	<0.001
Yes	111 (3.7)	13 532 (56.4)	
Previous deliveries:			
None	2972 (98.3)	12 059 (50.2)	<0.001
Yes	52 (1.7)	11 947 (49.8)	
Previous induced abortions:			
None	3004 (99.3)	19 432 (80.9)	<0.001
Yes	20 (0.7)	4574 (19.1)	
Marital status:			
Married	12 (0.4)	5634 (23.5)	<0.001
Cohabiting	126 (4.2)	4546 (18.9)	
Single	2882 (95.3)	13 785 (57.4)	
Data missing	4 (0.1)	41 (0.2)	
Type of residence:			
Urban	1979 (65.4)	17 977 (74.9)	<0.001
Densely populated	486 (16.1)	2986 (12.4)	
Rural	559 (18.5)	3043 (12.7)	
Duration of gestation (weeks):			
<9	2424 (80.2)	20 143 (83.9)	<0.001
9-12	139 (4.6)	660 (2.7)	
13-16	283 (9.4)	1741 (7.3)	
17-20	171 (5.7)	1151 (4.8)	
Data missing	7 (0.2)	311 (1.3)	
<i>Chlamydia trachomatis</i> positive test result*	99/1749 (5.7)	496/13 547 (3.7)	<0.001

*Data available for 2004-6.

exact test. We used the confidence interval analysis program to calculate the rates of adverse events.¹⁵ For small proportions we used the exact binomial method. The estimated risks of adverse events were determined by logistic regression analyses, and are presented as odds ratios with 95% confidence intervals. Variables that showed statistically significant associations with complications in univariate analysis (type of residence, marital status, duration of gestation, year of abortion, and adolescent or adult cohort) were further entered in multivariate analysis. SPSS 16.0 for Windows was used for the statistical analyses.

RESULTS

During 2000-6, 27 030 women underwent medical abortion between five and 20 weeks of gestation. Of these women, 3024 were younger than 18 (adolescent cohort) and the remaining 24 006 were older (adult cohort). Including only the first induced abortion for each woman during 2000-3, medical abortion was carried out in 1275 (29.3%) adolescents and in 10 459 (31.7%) adults. In 2004-6 the corresponding numbers were 1749 (61.9%) and 13 547 (63.3%).

The two cohorts differed significantly for various characteristics (table 1). The adolescents had fewer previous deliveries and induced abortions and were

more often single and living in a non-urban setting. In both groups, most of the medical abortions (over 80%) were performed before nine weeks of gestation, but the mean duration of gestation was more advanced among adolescents. The incidence of *C trachomatis* infections, diagnosed four weeks before to six weeks after abortion, was higher in the adolescent cohort, as calculated for 2004-6.

Table 2 describes the incidence of adverse events among the two cohorts, as well as among the primigravid women. The adult cohort had a significantly higher incidence of haemorrhage (3690 (15.4%) *v* 386 (12.8%), $P<0.001$), incomplete abortion (2450 (10.2%) *v* 212 (7.0%), $P<0.001$), and surgical evacuation of retained products of conception (3121 (13.0%) *v* 333 (11.0%), $P=0.002$). Odds ratios were calculated for main adverse events (haemorrhage, infection, incomplete abortion, and surgical evacuation), after adjustment for parity, previous abortions, marital status, type of residence, duration of gestation, and year of abortion. In the adolescent cohort the adjusted odds ratios were significantly lower for haemorrhage, incomplete abortion, and surgical evacuation than in the adult cohort. In addition, the adult cohort had more participants with adverse events (5535 (23.1%) *v* 575 (19.0%), $P<0.001$).

In the subgroup analysis carried out among the primigravid women, the proportion of women with haemorrhage (1505 (14.4%) *v* 374 (12.8%), $P=0.035$), incomplete abortions (887 (8.5%) *v* 201 (6.9%), $P=0.006$) and a higher overall number of adverse events (2224 (21.1%) *v* 552 (18.9%), $P=0.031$) was significantly higher in the adult cohort. After adjustment for marital status, type of residence, duration of gestation, and year of abortion, the risks for incomplete abortion and surgical evacuation were lower in the primigravid adolescents than in the primigravid adults (table 2).

The incidence of a psychiatric diagnosis was higher among the adolescents in both the cohort and the primigravid cohort, even though the overall numbers were low. Two deaths were reported during the follow-up period. Both of these occurred in adults and were unrelated to the pregnancy (intracranial trauma and melanoma).

The figure shows the results of logistic regression among the primigravid women for risk of main adverse events (haemorrhage, infection, incomplete abortion, and surgical evacuation). An increased risk of haemorrhage was associated with living in a densely populated area. The risk of bleeding after medical abortion was higher during 2004-6 than during 2000-3. Gestations of 9-12 or 13-16 weeks were associated with a lower risk of haemorrhage than gestations of less than nine weeks. The risk of haemorrhage was also significantly lower in the adolescent cohort.

Advanced duration of gestation (9-12, 13-16, and 17-20 weeks) was associated with an increased risk of infections after abortion (figure). Additionally, being married or cohabiting compared with being single was associated with an increased risk of infection.

Table 2 Incidence of adverse events in study cohorts for all women (3024 adolescents and 24 006 adults) and for primigravid women (2913 adolescents and 10 474 adults)

Adverse events	Adolescent cohort (≤ 18 years)	% (95% CI)	Adult cohort (≥ 18 years)	% (95% CI)	P value	Adjusted odds ratio (95%CI)*
All women						
Haemorrhage	386	12.8 (11.6 to 14.0)	3690	15.4 (15.0 to 16.0)	$<0.001^\dagger$	0.87 (0.77 to 0.99) †
Infection	60	2.0 (1.5 to 2.6)	489	2.0 (1.9 to 2.2)	0.742	0.97 (0.73 to 1.30)
Incomplete abortion	212	7.0 (6.1 to 8.0)	2450	10.2 (9.8 to 10.6)	$<0.001^\dagger$	0.69 (0.59 to 0.82) †
Surgical evacuation	333	11.0 (9.9 to 12.1)	3121	13.0 (12.6 to 13.4)	0.002 †	0.78 (0.67 to 0.90) †
Psychiatric morbidity	3	0.10 (0.02 to 0.29)	2	NA	0.012 †	—
Injury	4	0.13 (0.04 to 0.34)	35	0.15 (0.10 to 0.19)	1.000	—
Thromboembolic disease	2	0.07 (0.01 to 0.24)	26	0.11 (0.07 to 0.15)	0.764	—
Death	0	NA	2	NA	0.392	—
No of adverse events per woman:						
0	2449	81.0 (79.6 to 82.4)	18471	76.9 (76.4 to 77.5)	$<0.001^\dagger$	—
1	488	16.1 (14.8 to 17.4)	4456	18.6 (18.1 to 19.1)		—
2	82	2.7 (2.2 to 3.4)	994	4.1 (3.9 to 4.4)		—
3	5	0.17 (0.05 to 0.39)	83	0.35 (0.27 to 0.42)		—
4	0	NA	2	NA		—
Primigravid women						
Haemorrhage	374	12.8 (11.6 to 14.1)	1505	14.4 (13.7 to 15.0)	0.035 †	0.88 (0.78 to 1.00)
Infection	57	2.0 (1.5 to 2.5)	227	2.2 (1.9 to 2.5)	0.486	1.01 (0.75 to 1.37)
Incomplete abortion	201	6.9 (6.0 to 7.9)	887	8.5 (7.9 to 9.0)	0.006 †	0.68 (0.56 to 0.81) †
Surgical evacuation	311	10.7 (9.6 to 11.8)	1136	10.8 (10.3 to 11.4)	0.794	0.75 (0.64 to 0.88) †
Psychiatric morbidity	3	0.10 (0.02 to 0.30)	1	NA	0.034 †	—
Injury	4	0.14 (0.04 to 0.35)	10	0.10 (0.04 to 0.16)	0.521	—
Thromboembolic disease	2	0.07 (0.01 to 0.25)	10	0.10 (0.04 to 0.16)	1.00	—
Death	0	NA	1	NA	0.391	—
No of adverse events per woman:						
0	2361	81.1 (79.6 to 82.5)	8250	78.8 (78.0 to 79.5)	0.031 †	—
1	468	16.1 (14.7 to 17.4)	1838	17.5 (16.8 to 18.3)		—
2	79	2.7 (2.2 to 3.4)	356	3.4 (3.1 to 3.8)		—
3	5	0.17 (0.06 to 0.40)	30	0.29 (0.18 to 0.39)		—
4	0	NA	0	NA		—

NA=not applicable owing to small number of women.

*Adult cohort as reference for all women adjusted for parity, previous abortions, marital status, type of residence, duration of gestation, and year of abortion; adult cohort as reference for primigravid women adjusted for marital status, type of residence, duration of gestation, and year of abortion.

 † Statistically significant.

Also, the risk was higher in the later period (2004-6) than in 2000-3. The risk of infection was similar between the two cohorts.

Advanced duration of gestation was strongly related to the risk of incomplete abortion and surgical evacuation. The risk of incomplete abortion was lower in adolescents (odds ratio 0.69, 95% confidence interval 0.58 to 0.82) than in adults. The risk of surgical evacuation was increased in women living in rural areas and in those who were married or cohabiting. When abortion was carried out in the later period (2004-6) the risk of surgical evacuation was diminished (figure).

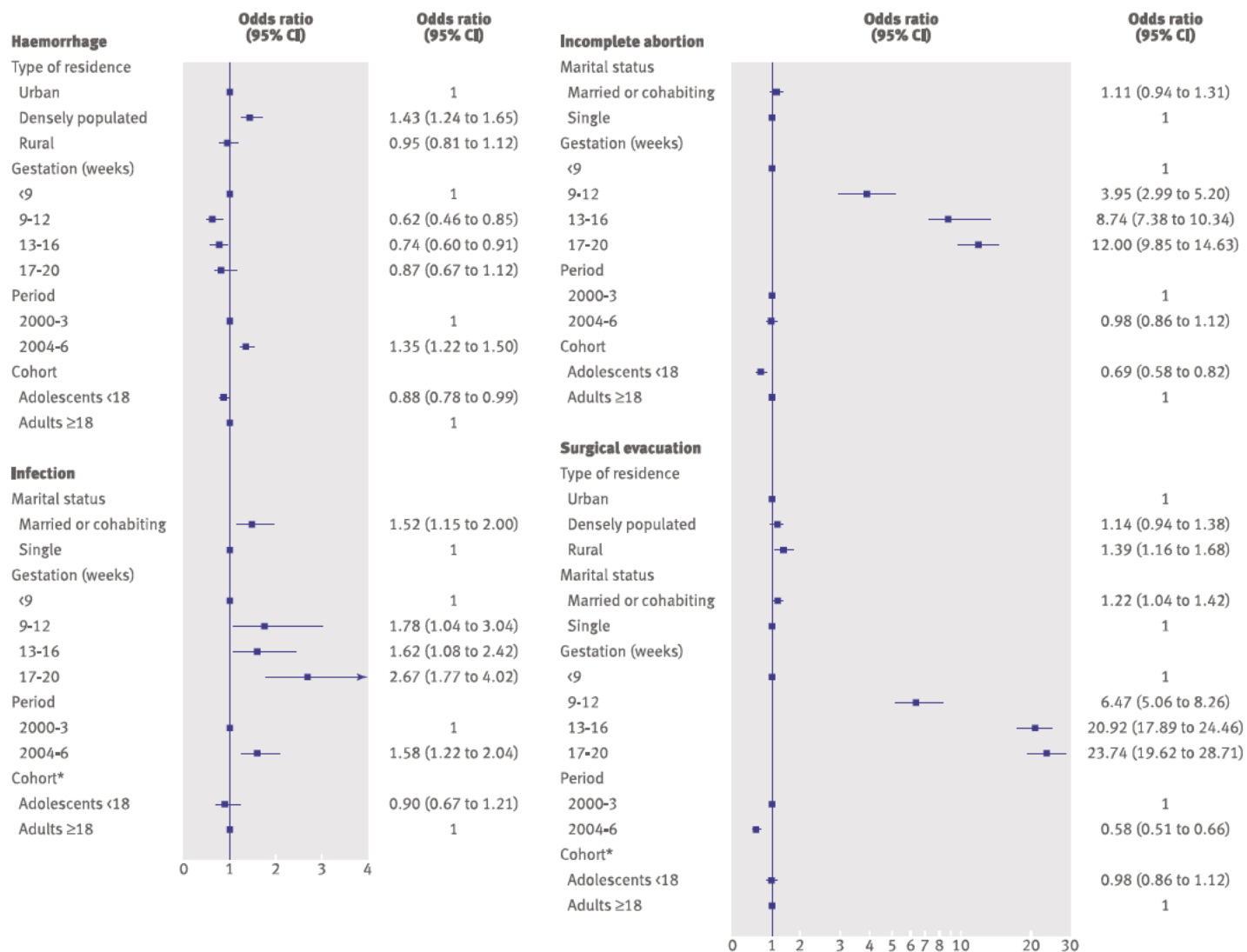
The risk of infections after abortion as a result of concurrent chlamydia infection was assessed among women who underwent abortion during 2004-6. In logistic regression analysis of the whole cohort, the risk of infection after abortion was not associated with concurrent chlamydia infection (1.02, 0.58 to 1.78). Moreover, no significant difference in the rate of infections after abortion emerged between adolescents and

those with a positive test result for *C. trachomatis* (data not shown).

DISCUSSION

In the present study the rate of adverse events and complications after medical abortion in adolescents was similar to or lower than that in adults. Various characteristics of the two cohorts differed significantly (table 1), but the risk of adverse events was calculated after adjustment for these factors. This study covered almost all abortions carried out in Finland in all regions and hospitals during a seven year period and thus shows reliable national trends. Earlier studies assessing the completeness of the Finnish abortion register found that 99% of abortions were reported to the register and at least 95% of information matched the medical records.^{16 17}

One limitation of the study is that the registry based data lack detailed information as the diagnoses were made on clinical grounds, and the severity of adverse



Logistic regression analysis of risk factors for main adverse events (haemorrhage, infection, incomplete abortion, and surgical evacuation) among primigravid women in entire cohort. Results of multivariate analysis are shown unless stated otherwise. Variables showing significance in univariate analysis are included.

*Derived from univariate analysis

events may vary substantially. Another drawback is that no conclusions can be made on the effects of abortion beyond the 42 days of follow-up. A further limitation is that data on *C trachomatis* could only be linked with registry data from 2004, when identification numbers were first archived.

More women sought help for bleeding after abortion when gestation was less than nine weeks. This finding parallels that reported in our previous study.⁶ This might be explained partly by the fact that medical abortions at nine weeks or more of gestation are carried out by hospitals, and not on an outpatient basis.⁹ Moreover, an increasing number of these early abortions are carried out at home using self administered misoprostol.

The risk of surgical evacuation of retained products after medical abortion decreased during 2004-6 compared with 2000-3, whereas the number of incomplete abortions remained the same. These findings probably

reflect a learning curve in providing medical abortion. However, the lower number of surgical evacuations occurred at the expense of an increased rate of consultations as a result of uterine bleeding. We took into account the possible bias caused by the differences between the study periods (2000-3 and 2004-6) by adjusting the odds ratios of adverse events by study period.

The rate of infections after abortion was higher (2.0%) than that reported in an earlier review in which medical abortion was assessed (0.9%).¹⁸ The higher figure may in part be a result of the register based nature of the present study—that is, the diagnostic criteria lacked uniformity. In recent reviews, however, the incidence of infections after medical abortion in the second trimester has been estimated to be about 3%.^{19,20} Thus in the present study, concerning pregnancies of up to 20 weeks' duration, the incidence of infections was comparable with that reported in the recent

WHAT IS ALREADY KNOWN ON THIS TOPIC

Teenage pregnancies are mostly unplanned and often result in induced abortion
 Medical abortion is increasingly used, albeit its safety has not been properly assessed among adolescents

WHAT THIS STUDY ADDS

The risk of adverse events (haemorrhage, incomplete abortion, infection) after medical abortion is similar or even lower in adolescent (<18 years) compared with adult women

reviews. The risk of infection was increased when the abortion was carried out in the later period (2004-6). The explanation for this is unclear. The incidence of *C trachomatis* infections in the Finnish population did not change at the same time.¹⁴

C trachomatis is a notable cause of pelvic inflammatory disease. Screening for and treatment of *C trachomatis* can prevent the development of the disease after abortion.²¹ To prevent infection after termination of pregnancy both prophylactic antibiotic therapy for all and screen and treat strategies are in use. In a recent study in the United States, routine provision of doxycycline at the time of medical abortion was associated with a significant reduction in the rate of serious infections.²²

We found no correlation between *C trachomatis* diagnosed at the time of abortion and subsequent infections. In Finland, systematic screening for *C trachomatis* after termination of pregnancy is enforced by national guidelines.⁹ In 2004-6 the national incidence of *C trachomatis* among girls and young women aged 10-19 was 1.7% in Finland,¹⁴ whereas a higher rate of 5.7% was detected in the present adolescent cohort. The results of this study do not rule out the possible association with infections after abortions in the cases of untreated *C trachomatis* infections, or with delayed antibiotic treatment. The present study suggests that by timely screening it is possible to treat the infection before the clinical manifestation.

In the present study psychiatric morbidity was significantly more common among adolescents than among adults, although the number of cases was small. Register based studies are not ideal for studying psychiatric disorders, as only some women seek professional help for mental disorders and only some women with mental disorders are treated in specialised healthcare. In a recent register based Danish study, the risk of a psychiatric disorder in women with no such previously detected disorders was not increased after induced abortion in the first trimester.²³ The risk of psychiatric contact was not, however, significantly affected by age. In a US survey, adolescents were not at increased risk for depression or lower self esteem after abortion than the controls during follow-up.²⁴ The present studies only assessed psychiatric diagnoses during the short follow-up but not possible psychiatric morbidity before abortion. Thus the association of mental disorders and termination of pregnancy among adolescents remains unresolved.

Experience of pain or satisfaction with care could not be studied in the present setting, as these outcomes are not registered in the Finnish abortion register. In a randomised study, women with higher gestational age and first pregnancy seemed to be less satisfied with medical abortion as a result of more pain during the termination.²⁵ The effective treatment of pain must be taken into account when adolescents, predominantly nulliparous women, undergo induced abortion.

Conclusion

The present population based national study provides evidence that medical abortion is not associated with additional risks of adverse events among adolescents in the short term compared with adult women. The data were derived from one country with a homogeneous population but can be generalised to populations with high quality healthcare and easy access to specialist treatment.

The preliminary results of this study were presented at the International Federation of Obstetrics and Gynecology (FIGO) meeting in Cape Town, South Africa October 2009, and in the International Federation of Professional Abortion and Contraception Associates (FIAPAC) meeting in Seville Spain, October 2010 (MN). We thank Aini Bloigu (National Institute for Health and Welfare, Oulu, Finland) for her professional help with the statistics.

Contributors: All authors participated in the design of the study. MN carried out the data analysis, wrote the first draft of the manuscript, and is a guarantor of the study. All authors contributed to the subsequent writing of the paper and gave substantial input into the study. OH obtained funding for the study. MG is in charge of the Finnish reproductive registries (including the abortion register).

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Competing interests: All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: OH has lectured at an educational event organised by Nordic Drugs and has been principal investigator in clinical studies sponsored by the Concept Foundation; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, no other relationships or activities that could appear to have influenced the submitted work.

Ethical approval: This study was approved by the ethics committee of the Northern Ostrobothnia Hospital District in October 2005 (No 46/2005). The Ministry of Social Affairs and Health, and Statistics Finland gave permission for the use of confidential personal level data from the registries. The data protection ombudsman was notified about the data linkage before the analyses, as required by national data protection legislation.

Data sharing: No additional data available.

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HEALTH, NATIONAL, POLITICS

Massachusetts Abortion Provider Serves Patients Living in States Banning Abortion

PUBLISHED 7/29/2024 by **CARRIE N. BAKER**

“We now have an exciting opportunity to create a new abortion system that is more equitable, accessible and affordable in all 50 states,” Dr. Angel Foster, medical director of the Massachusetts Medication Abortion Access Project.



FEMINIST DAILY NEWS

Virginia Voters Will Decide the Future of Reproductive Freedom, Marriage Equality, and Voting Rights This November





Left: Dr. Angel Foster. Right: A packet of abortion pills. (Soumyabrata Roy / NurPhoto via Getty Images)

Close to [two-thirds](#) of all abortions obtained through the formal medical system are now done with abortion pills. Almost [one-fifth](#) of abortions are done through telehealth consultations with clinicians, who then abortion mail pills to eligible patients. Since *Dobbs*, an increasing number of abortion providers are providing telemedicine abortion services to women living in states banning abortion.

Eight states have passed laws allowing clinicians to provide telehealth abortion care to out-of-state patients and shielding them from criminal and civil liability in anti-abortion states. In the second half of 2023 alone, over [40,000 women](#) in states with severe abortion bans or telehealth restrictions received medication abortion from healthcare providers located in states with provider shield laws, including Massachusetts, Washington, Colorado, Vermont, New York, California, Maine and Rhode Island.

Today there are four practices with over two dozen providers that [provide telehealth abortion services](#) to people in restrictive states. One of them is the [Massachusetts Medication Abortion Act Project](#), called The MAP for short.

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- U.S. Senators Urge FDA Update to Mifepristone Label for Miscarriage Use: 'Patients Should Have Access to the Most Effective Medication Available'

The MAP provides telemedicine services to people aged 16 and over who are up to 11 weeks pregnant in all 50 states for a sliding scale fee of up to \$250, with two- to five-day delivery of abortion pills. The MAP has four clinicians all licensed and residing in Massachusetts, who have served over 3,500 patients since they began offering telehealth abortion in October 2023.

Ms. spoke with the medical director of The MAP, Dr. Angel Foster, who is a Harvard-trained obstetrician/gynecologist and health sciences professor at the University of Ottawa, where she leads a large research group that's dedicated to global abortion work.

This interview has been lightly edited for clarity.



Carrie N. Baker: Why did you start The MAP?

Dr. Angel Foster: *Our first goal is to provide high-quality, safe, affordable abortion care to patients who are residing in banned or restricted states. Our second goal is to demonstrate the strength of the shield law. Our third is to create a model that could be tailored and replicated in other states.*

Baker: How did you start it?

Foster: *When Massachusetts passed its shield law in July of 2022, a small group of us started developing a shield law practice. After medical school, I participated in the first rigorous research on the safety and efficacy of misoprostol alone for abortion through de-medicalized strategies of the delivery in Thailand, Pakistan, Jordan, Uganda and other settings. A lot of what we learned from our de-*

medicalized medication abortion work in the global south informed the way that we approach The MAP and our comfort level with providing this care in the wake of Dobbs.

Baker: How does your service work?

Foster: *Patients find out about our service through a consolidator website, such as [Plan C](#) or [I Need An Abortion](#). On our website, we provide a lot of information about how our service works. The prospective patients fill out a brief eligibility screening form with some basic questions, including contact information, age, date of birth and last menstrual period, as well as the state, territory or APO address that the pills will be sent to. We serve patients who are within 11 weeks from the first day of their last menstrual period. Most of our patients contact us before seven weeks.*

Once the basic screening form is filled out, one of our team reviews it, makes sure they're eligible and then sends a link to a medical questionnaire and consent forms for the patient to sign. The questionnaire takes somewhere between five and 10 minutes to fill out, depending on how complicated the person's medical history is. We ask basic medical history that's relevant to providing care. A clinician then reviews the questionnaire and approves the patient. The patient will then receive an email asking them to pay.

Baker: How long does the eligibility process take?

Foster: *In general, it's a couple of hours. We have people who are operating our systems from about 6 a.m. until 11 p.m.. We try to turn requests around quickly. We've had patients who have gone from filling out the initial form to paying in an hour. We try to get back to patients in all cases*

within eight hours, and I would say, in most cases, it's within four.

Baker: What do you charge, how can people pay and do you take insurance?

Foster: *We do not take insurance. Our service costs \$250, but we use a pay-as-much-as-you-can model, no questions asked. We trust our patients. We do ask that patients make a five-dollar minimum payment, which we waive on a case-by-case basis.*

They can pay through PayPal, Cash App or Zelle. Once a patient pays, we send the pills via USPS Priority Mail. We usually mail the pills either the same or the next business day after we've received the payment, and USPS Priority Mail takes 2 to 5 business days. If they pay the full amount and an additional 25 dollars, we will use Express Mail so they can get the pills the next day.

Doses of mifepristone, the abortion pill, at Dr. Franz Theard's Women's Reproductive Clinic in Santa Teresa, N.M., on May 7, 2022. (Paul Ratje / The Washington Post via Getty Images)

Baker: How are you able to offer the sliding-scale fee?

Foster: *We had some initial foundation grants that helped us get started. We now work with about a dozen abortion funds, both national and local. Also, we've got individual donations that come in as well.*

A third of our patients pay 5 dollars or less, a third of our patients receive a subsidy of some kind and a third of our patients pay 250 dollars. We're able to do this because a lot of us are doing this as either volunteers or at below-market rates. Two of our clinicians volunteer their time. One of them volunteers part of her time. We pay a living wage to our office staff.

Our model is going to change on October 1. All of the core costs of the service will be covered by foundation grants and we will provide care for 5 dollars or more, rather than 250 dollars or less. We're hoping that we'll be able to secure patient payments of the 60 dollars that it costs us to cover the meds, the postage and the package. I'm excited about this experiment. It's a first step in trying to pilot a very different model of care.

Baker: This seems like a much more affordable way to provide abortion healthcare than funding people to travel long distances for in-clinic medication abortion.

Foster: *It is. We can provide about 15,000 abortions next year with this model based on our current setup. It ends up*

costing us about \$33 per abortion compared to the average cost of an in-clinic medication abortion of about \$600 plus travel.

Baker: What medications do you send to patients?

Foster: We send one mifepristone pill and eight misoprostol pills for anyone under nine weeks of pregnancy, and one mife and 12 miso for anyone who's nine weeks and above. In comparison to in-clinic care, we give an extra dose of miso gestationally. The reason that we ask them to take additional pills is to get the effectiveness up so that they don't have to follow up in person because we want to avoid having them go to in-person follow-ups if we can help it.

Baker: Does taking an extra four Miso make it harder on patients?

Foster: You're going to have a little bit more cramping and transient diarrhea, but we feel like that extra miso is beneficial because it can get us higher completion rates. We think it's worth that tradeoff, and we encourage everyone to take all the drugs we give them.

“ *Nine-five percent of our patients are from states that restrict abortion or telemedicine abortion.*

- Dr. Angel Foster

Baker: What guidance do you give your patients about how to use the medications?

Foster: We instruct them to take the misoprostol 24 to 48 hours after they've taken the mifepristone. We encourage everyone to take misoprostol buccally (in the cheek pouch) and swallow the pill remnants so there's no residue in case they need to go to an emergency department. In our materials, we give them language that they can use if they go to an emergency department and don't want to disclose that they've taken abortion pills.

We provide pills for immediate use, but we also provide pills in advance of need, and we provide period pills so they can be used around the time of an expected period, but before a positive pregnancy test. We provide information about how to take the pills in these different scenarios. We also provide information about how to use mifepristone as emergency contraception if a patient wants to do that, particularly for pills that have been procured in advance of need.

Mifepristone in hand works as well if not better than Plan B and progestin-only emergency contraception.

Baker: What other resources do you give to patients when you send the pills?

Foster: When the patients receive pills from us, they get information about ectopic pregnancy precautions. We tell patients how to contact Bedsider if they want to talk about contraception options, Repro Legal Helpline if they have legal questions and the Miscarriage and Abortion Hotline if they have any medical questions. Then we provide them with information about reproductive health clinics near them in case they want to see a provider that is pro-choice. That's not available in all states. We also provide a digital privacy

protection card about how to keep their information private, both in terms of what they should do with the physical materials we've sent, but also how to delete their online footprint. Finally, we provide them with a little handwritten card.

Baker: What follow-up care do you provide to your patients?

***Foster:** All of our patients get a phone number for our service that we only provide to patients. We're available 6 a.m. to 11 p.m. We get back to people quickly. We also have a secure email, and we use text. We send a questionnaire to our patients two weeks after we send the pills and then six weeks after.*

Baker: Are your patients satisfied with your service?

***Foster:** They love it. We get such great feedback. We've had a very small number of adverse outcomes in terms of continuing pregnancies or people needing to visit an emergency department for medical reasons.*

Baker: How many patients have you served since you opened in October of 2023?

***Foster:** We have served around 3,500 patients overall so far. We're serving about 500 patients a month now.*

Baker: What's your success rate as far as completed abortions?

Foster: We are in the 98 percent range—outcomes very comparable to in-clinic care.

Baker: Of those 3,500 patients, are they all coming from the states that ban abortion or restrict telemedicine?

Foster: Nine-five percent of our patients are from states that restrict abortion or telemedicine abortion. About a third of our patients are from Texas. About a third of our patients are from Florida and Georgia, with a smattering of other states, including Alabama and Louisiana. We serve a small number of folks who are in high-access states.

Baker: Do you require patients to provide identification?

Foster: We do not.

“ *It's been really exciting to see the amount of community support. The more ownership that people feel of this, the more protected we are. That's a really important part of distributing risk as well.*

- Dr. Angel Foster

Baker: What kinds of precautions do you take to protect the individuals involved in your organization from being targeted?

r: *The whole project is set up around distributed risk. Different people order our pills, package our pills, process the*

money, write the prescriptions and take the pills to the post office, which makes it harder to identify individuals as opposed to the practice.

In general, there's a commitment that people aren't going to travel to or through banned states, especially states like Texas and Idaho, where it appears that there are attorneys general or others who would like to make a case against shield law providers.

How our individuals choose to protect their assets in order to potentially withstand any kind of civil suits or decisions about travel are based on individual risk tolerance. Not all of the people who work with The MAP are public-facing.

We trust members of our team to make the decisions that are right for themselves, given their personal stories, lives and relationships. We also trust that the Commonwealth has our back and will protect us if folks come after us.

Baker: Has the community in Cambridge supported you?

Foster: There's been a lot of support in Massachusetts. We have a huge group of volunteers who work with our service. Twice a month, we have pizza and packing parties, where people come to our office and pack up the boxes for mailing. We've got somebody with clinic management experience who's volunteered to manage some of our data storage issues. We have people who are working with us to develop newsletters. It's been really exciting to see the amount of community support. The more ownership that people feel of this, the more protected we are. That's a really important part of distributing risk as well.

Bo 's the Massachusetts telemedicine abortion shield law as strong as you'd like it to be, or are there

improvements that the state could make?

Foster: *The Massachusetts shield law is the most comprehensive in the country. It protects clinicians, helpers and funders from criminal, civil and licensure penalties. We would love to see more work on how to strengthen interstate shield protections and reciprocity, but that has to be done in conjunction with the other states.*

Baker: What about physical security at your office?

Foster: *We chose an office space that's over a large cannabis dispensary because they are quite well-regulated and have security features and cameras. We also chose a space that was hard to protest. We're in a very busy pedestrian area in Davis Square.*

Baker: Do you have any final thoughts?

Foster: *There's a deep irony post-Dobbs. Things have been absolutely terrible for obstetrics, but it hasn't been nearly so bad for medication abortion. The reality is in states like Missouri, Texas or Mississippi, medication abortion is more available and affordable now than it was before Dobbs. Now we have this opportunity to provide care to folks throughout the country in a way that we haven't had before. We now have an exciting opportunity to create a new abortion system that is more equitable, accessible and affordable in all 50 states.*

Baker: How can Ms. readers support your work?

Foster: We accept individual [donations](#), large and small. The other way that Ms. readers can help is to let people know that high-quality, safe, FDA-approved abortion medication is available to people in all 50 states, and that shield laws allow this. One of the challenges that we face is a legitimacy challenge. People trust sources that are close to them, that are known to them, that are within their families and communities, so spreading this message locally is really important.

To donate to The MAP, go [here](#).

Read more:

[Abortion Pill FAQs: Get the Facts About Medication Abortion](#)

[Feminists React to the SCOTUS Abortion Pill Case: 'Access to Mifepristone Is Essential'](#)

U.S. democracy is at a dangerous inflection point—from the demise of abortion rights, to a lack of pay equity and parental leave, to skyrocketing maternal mortality, and attacks on trans health. Left unchecked, these crises will lead to wider gaps in political participation and representation. **For 50 years, Ms. has been forging feminist journalism—reporting, rebelling and truth-telling from the front-lines, championing the Equal Rights Amendment, and centering the stories of those most impacted.** With all that's at stake for equality, we are redoubling our commitment for the next 50 years. In turn, we need your help, [Support Ms. today with a donation—any amount that is meaningful to you.](#) For as little as [\\$5 month](#), you'll receive the print magazine along with our e-newsletters, action alerts, and invitations to Ms. Studios

events and podcasts. We are grateful for your loyalty and ferocity.

TAGGED: ABORTION ACCESS, ABORTION PILLS, ABORTION PROVIDERS, MASSACHUSETTS, ONLINE ABORTION PROVIDER (SERIES), SEXUAL AND REPRODUCTIVE HEALTH

ABOUT CARRIE N. BAKER

[Carrie N. Baker](#), J.D., Ph.D., is the Sylvia Dlugasch Bauman professor of American Studies and the chair of the [Program for the Study of Women and Gender](#) at Smith College. She is a contributing editor at *Ms.* magazine. Read her latest book at [Abortion Pills: U.S. History and Politics \(Amherst College Press, December 2024\)](#). You can contact Dr. Baker at cbaker@msmagazine.com or follow her on Bluesky [@carrienbaker.bsky.social](#).

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February 27

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12



April 7

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Limiting access to abortions doesn't take away the need for them

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and we will care for you.

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✨ Abortion care is healthcare ✨

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February 24, 2025

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2



November 10, 2024

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🇺🇸 English (United States) ▾

We accept new requests for care up to 12 weeks and 0 days of pregnancy.
(so that treatment can be initiated before 13 weeks)

Your current pregnancy dating is:

weeks

days

But don't worry. You can still have an abortion.

To find abortion providers and other resources for your stage of pregnancy, consider visiting:

ineedana.com (for pills and/or clinic-based care)

plancpills.org (for pills via community networks)

abortionfunds.org (for financial assistance and practical support)