ORIGINAL RESEARCH ARTICLE

"Of course I would tell a friend about self-management with pills": the role of hotlines in increasing access to self-managed abortion in Kenya

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Abstract

Safe abortion hotlines operating in highly restrictive abortion settings provide critical information about safe self-managed medication abortion. The Mobilizing Activists around Medical Abortion (MAMA) Network has pioneered this model in the African region and supports various safe abortion hotlines across the continent. The aim of this study was to document the experiences of callers using a safe abortion hotline in Kenya and to better understand the role that safe abortion hotlines can play in facilitating access to abortion information. In this paper, we present findings from interviews with 19 hotline callers seeking information about medication abortion from a hotline in Kenya, between February and May 2019. Emergent themes included support from hotline counselors, readiness to self-manage, abortion experiences, preference for medication abortion, and the role of hotlines in reducing abortion stigma. Our findings shed light on important components related to the quality of the care provided by the hotlines and their role in destigmatizing abortion care, while serving as an example of the crucial work of feminist activists in expanding pregnant people's health and autonomy in highly restrictive abortion settings. *(Afr J Reprod Health 2025; 29 [6]: 108-116)*

Keywords: Abortion; medication abortion; hotlines; Africa; self-managed abortion in Kenya

Résumé

Les lignes d'assistance téléphonique pour l'avortement médicalisé, opérant dans des contextes très restrictifs, fournissent des informations essentielles sur l'avortement médicamenteux autogéré et sécurisé. Le réseau MAMA (Mobilizing Activists around Medical Abortion) a été le pionnier de ce modèle en Afrique et soutient plusieurs lignes d'assistance téléphonique pour l'avortement médicalisé sur tout le continent. L'objectif de cette étude était de documenter les expériences des personnes utilisant une ligne d'assistance téléphonique pour l'avortement médicalisé au Kenya et de mieux comprendre le rôle que ces lignes peuvent jouer pour faciliter l'accès à l'information sur l'avortement. Dans cet article, nous présentons les résultats d'entretiens menés auprès de 19 personnes ayant appelé une ligne d'assistance téléphonique au Kenya pour obtenir des informations sur l'avortement médicamenteux auprès d'une ligne d'assistance téléphonique, entre février et mai 2019. Les thèmes qui ont émergé comprenaient le soutien des conseillers de la ligne d'assistance, la disposition à l'autogestion, les expériences d'avortement, la préférence pour l'avortement médicamenteux et le rôle des lignes d'assistance téléphonique dans la réduction de la stigmatisation liée à l'avortement. Nos résultats mettent en lumière des éléments importants liés à la qualité des soins fournis par les lignes d'assistance téléphonique et à leur rôle dans la déstigmatisation des soins liés à l'avortement, tout en illustrant le travail crucial des militantes féministes pour améliorer la santé et l'autonomie des femmes enceintes dans des contextes très restrictifs. *(Afr J Reprod Health 2025; 29 [6]: 108-116).*

Mots-clés: Avortement ; avortement médicamenteux ; lignes d'assistance téléphonique ; Afrique ; avortement autogéré au Kenya

Introduction

Medication abortion (i.e., misoprostol alone or in combination with mifepristone) is effective, safe, and reliable throughout pregnancy.[1–6] A growing body of literature from around the world indicates that the practice of self-managing medication abortion is safe when individuals have access to information on how to procure and use the pills, and recognize complication signs.[1] In 2022, the World Health Organization (WHO) revised their abortion care guidance to include recommendations for self-managed medication for pregnancies below 12 weeks.[7] Legal restrictions limiting access to safe

abortion methods (medication and surgical abortion) and rates of maternal mortality as a result of unsafe abortion are pervasive[8]. Mortality from unsafe abortion disproportionately affects women in Africa, where 62% of unsafe abortion-related deaths worldwide occur.[8,9] In Kenya, abortion is prohibited "unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger".[10] The rates of morbidity and mortality from unsafe abortion are consistently high in Kenya due to a multitude of reasons, including differences in provider interpretations of the law, a lack of trained providers, and limited awareness of safe abortion options both within and outside of formal health settings.[11] In settings where abortion is legally restricted and permitted but not widely accessible—like Kenya—people are increasingly choosing self-managed medication abortion (SMA) to terminate unwanted pregnancies outside of the legally prescribed process and/or formal healthcare system.[8,9] This is due to fear of judgment by providers, inability to pay for formal care, lack of access to abortion services, or a preference for the privacy of SMA.[2]

Self-managed medication abortion began as a practical solution among women and has now grown to become a global movement enabling autonomous, person-centred practice and reducing maternal mortality.[12] The 2022 WHO abortion care guidelines indicate the pivotal role of accompaniment from trained health workers and self-management in improving access, privacy, and convenience in restricted settings and beyond.[7] One such example of this community health level support comes in the form of safe abortion hotlines that are operated by community-based organizations or extensions of the formal health care system.[13] Where access to mobile phones are prevalent, safe abortion hotlines aim to provide callers with the necessary information about safe, self-managed medication abortion.[14] Hotlines build on the human right to information, [15] a right that exists independently of the legal status of abortion and that plays a crucial role in empowering people by de-mystifying and de-medicalizing knowledge.[14,16,17] Hotlines can potentially reduce abortion-related morbidity and mortality by expanding the cadre of providers and increasing access to safe abortion.[18] Variations on this have been implemented globally, including in Indonesia, Poland, Thailand, and multiple African countries; by 2021, at least 50 community-based or health care extension safe abortion hotlines operated globally.[13] Hotlines are a tool used historically to facilitate access to sexual and reproductive health care and their importance has increasingly become visible and important, especially during the COVID-19 pandemic.[13] Through abortion hotlines, and the SMA movement at large, activists are able to bridge gaps in abortion provision by providing evidence-based abortion information and support to those seeking abortion care.[19] For these reasons, advocates have called for the recognition of the critical role of self-managed abortion in expanding access to abortion care by embracing a radical paradigm transformation.[20] It is important to recognize that SMA is not just a measure of last resort, but an alternative care model that many people find works better for them for a myriad of different reasons.[1,21]

In Kenya, one safe abortion hotline provides free, reliable, safe, and confidential sexual and reproductive health and rights (SRHR) information, including abortion. Given the limited evidence on the use of safe abortion hotlines in Kenya,[13,22] the objective of our study was to document the experiences of safe abortion hotline callers and to better understand the role that this safe abortion hotline can play in facilitating access to abortion information to Kenyans.

Methods

In order to reach hotline callers, we partnered with The Mobilizing Activists around Medical Abortion (MAMA) Network, which convenes more than 50 organizations, including safe abortion hotlines, working across Africa to share evidence-based and stigma-free information about self-managed medical abortion.[14] One MAMA Network hotline in Kenya provides SRHR information in line with WHO guidelines on topics such as prevention of unplanned pregnancy, safe abortion, contraceptives, and STI prevention and treatment. On the topic of safe abortion, the hotline provides information ranging from pregnancy dating, abortion options, what to expect during a medication abortion, when to seek medical care, and how to confirm the abortion is

complete. Counsellors undertake extensive training as part of their onboarding process into the hotline work which includes counselling skills, protocols for self-managed abortion, and security. There is also a requirement for basic counselling skills or education qualification in relevant fields, such as public health, gender studies, or community development.

Between February and May 2019, we conducted twenty in-depth telephone interviews with people who contacted the hotline. Callers were eligible for the study if they were age 13 or older spoke English or Kiswahili and had called the hotline information on how to self-manage a medication abortion. Recruitment for the study took place between January 1st, 2019 to May 31st, 2019. Eligible participants were recruited in two ways. Eligible participants were either notified about the study at end of their initial call to the hotline, or callers were asked if they would be willing to be contacted in the future for research opportunities. If the participant said they would like to be contacted, they received follow-up calls from hotline counselors up to three months after their initial call to the hotline. Hotline counselors collected their contact information and scheduled a time for their interview.

All participants gave informed verbal consent and were interviewed by a member of the hotline staff. Participants were not interviewed by the hotline counselor that originally provided them with counselling to encourage participants to respond candidly. A semi-structured in-depth interview guide was used to ensure consistency across interviewers and to allow for new themes to emerge. The interview guide focused on callers' experience using the hotline, the usefulness of the information provided by counselors, how prepared callers felt to self-manage their abortion after speaking with a counselor, and their experience of having the abortion, their preference for self-managed medication abortion, and whether they would recommend self-managed medication abortion to a friend. All study participants received the equivalent of approximately 2 USD (200 Kenyan Shillings) to compensate for their time. This amount was determined by hotline and community leaders on the study team. Interviews were conducted in Kiswahili and English, depending on the interviewee's language preference. Interviews were digitally recorded, transcribed verbatim in the language they were recorded in. Interviews transcribed in Kiswahili were then translated into English for analysis. All transcriptions were coded using a thematic approach facilitated by Dedoose. A thematic approach was used to explore and identify themes across callers' subjective experiences with the hotline and thoughts around self-managed medication abortion.[23] An initial codebook was developed using the instruments as a framework and refined as additional themes emerged. Two members of the research team double blind-coded one transcript and resolved any discrepancies. The study team continued to meet after coding to discuss emergent themes, and discrepancies, and refine the codebook as needed. One interview was excluded from analysis due to irreparable problems to the audio file. The average length of interviews was 28 minutes and 44 seconds. Ethical approval was obtained from Allendale IRB.

Results

Participant characteristics

Table 1 represents participant demographics for 19 participants, ages 21-44. Nearly half of interview participants (n = 9) were between 18-24 years of age. The majority of participants reported completing secondary school or higher (n = 15). Most participants (n=15) described being between 1 and 2 months pregnant at the time of contacting the hotline.

Quality of information and support provided by hotline counselors

We asked participants to describe the information provided by the hotlines. Most participants described receiving information from hotlines counselors about how to take the medication abortion pills, what to expect, potential side effects, and when to seek medical attention. Several participants recalled the exact instructions for taking the medication abortion pills and described learning about the physical effects of the medication abortion pills such as cramping, bleeding, and nausea.

Table 1: Participant demographics

PARTICIPANT CHARACTERISTICS (N = 19)	
	n
Mean age (range)	27 (21-44)
Age group	
18-24	9
25-34	6
35-44	4
Highest level of education (N=18)	
Primary school	3
Secondary school	2
College	4
Some university/currently in university	6
Diploma	3
Gestational age	
>1 month	1
1-2 months	15
2-3 months	3

Participants also described the warning signs of complications and when to seek additional medical support. In addition, some participants also described receiving other logistical instructions, such as having a trusted support person present during the abortion process and getting a diagnostic test to confirm the gestational age of the pregnancy to determine eligibility for the medication abortion.

When asked about the clarity of information provided by the hotline counselors, the majority of participants said it was clear and easy to understand. In addition, several participants added that their understanding was aided by hotline callers speaking in their local language:

"[…] I didn't tell them that I can speak English, I only told them that I know Kiswahili. Cause I just wanted to know if they also deal with grassroots women who [can't] speak English but I realized that they are very friendly and in fact they […] spoke the language in which I was able to understand well." (22-years-old)

Participants also described receiving helpful information from hotline counselors which extended beyond abortion and appreciated the ways in which hotline counselors responded to their specific situations. For example, one 24-year-old participant said that after describing her situation of sexual violence, the hotline counselor helped by asking questions to better understand her experience and the support she had received after the event, and by helping her accurately calculate how far along she was in her pregnancy. Other participants also described receiving information about contraception and family planning, which they said would help them to manage their family planning in the future.

Participants were asked about their experiences speaking with the hotline counselors, including how they were treated and whether they felt supported by the counselor. Nearly all participants described positive interactions with the hotline counselors. Participants described hotline counselors as being *"understanding," "friendly,"* and *"nice."* When describing how they were treated, several participants said that they did not feel judged by the counselor they spoke to.

One participant said, *"[Talking to the counselor] was okay, it was relaxing […] there was no judgement I didn't feel like I was being judged [for] what I was about to do, it was- it was better than I had expected"* (27-years-old).

Several participants also added that they liked the level of confidentiality and privacy provided by the hotline counselors. In addition, some participants also described how the hotline counselor provided emotional support that helped them feel better about themselves and their situation, as one 28-year-old participant said,

"I was treated very well […] I was at first hating myself, I was blaming myself, I was seeing as if it is my fault, but they have very nice counsellors[…] after doing a counselling session with them, I felt I wasn't – I felt so good".

When asked about barriers encountered when contacting the hotline, a few said that they had to call the hotline more than once before reaching a hotline counselor and one participant said they had trouble finding a private place to make the call. A few other participants also mentioned that they had to use their phone credit to make the call to the hotline, which was expensive. Most participants said they did not encounter any challenges or barriers.

Readiness to self-manage the medication abortion process and abortion experience

We asked participants to describe their preparedness to self-manage their abortion after talking with the hotline counselor. Participants described feeling prepared to self-manage their medication abortion after speaking to the hotline counselors, including one participant who said,

"After calling the hotline, I was prepared in that it took me through the procedure and I felt relaxed to carry on with the procedure so I think I was just comfortable, the fear was gone" (36-years-old).

A few participants also described feeling *"scared"* or *"nervous"* about the medication abortion process. Like the participant quoted below, many participants shared that they did not know about safe abortion or medication abortion before interacting with the hotline. However, after contacting the hotline and receiving information about safe abortion, participants felt less afraid and more comfortable with the process,

I didn't know that there was something like safe abortion, but when the counselors spoke to me I got the information that I needed and I went also to do some online research. And then I got comfortable, I was no longer scared. (22-years-old)

In addition, one person described feeling *"doubtful"* about what would happen after they took the pills, however, knowing what to expect throughout the abortion process made her feel prepared to manage any challenges:

If there were difficulties or challenges, I was already prepared—[the hotline counselors] had already prepared me psychologically that this was what was going to happen, so I didn't worry much or I didn't see them as a challenge much because I knew they had told me that this was what was going to happen, so I was psychologically prepared and I felt like, okay yes it is happening now, but I know [what to expect because] I was already told [about] this part of the whole process. (21-years-old)

The majority of respondents said they did not experience any difficulties or challenges during the medication abortion process. However, some participants described challenges related to the physical effects of medication abortion, such as cramping, pain, and bleeding. When asked how they felt after the abortion process, many described positive emotions such as feeling "*happy*", "*relieved*", and "*relaxed*." Only one participant shared feelings of fear and shame after the abortion. All participants reported that their abortion was successful. Most participants considered success to be the termination of pregnancy, which was confirmed either by taking a pregnancy test or through the arrival of their period. A few participants mentioned other components of success, including maintaining confidentiality, feeling happy, and learning about contraceptives.

Preference for self-managed medication abortion

We asked participants to describe why they chose to use self-managed medication abortion over other abortion methods. Reasons for choosing self-managed medication abortion included that the process seemed "easy" and "comfortable". Another participant, who was a student, explained that she decided to use self-managed abortion medication because she perceived it to be a faster recovery process, than surgical abortion, that could allow her to promptly return to school. This participant and others noted that self-managed medication abortion seemed more affordable than in-clinic care:

"*[I] am a student and there are so many things that I have to […] finance myself, so the option of self-medication was cheaper for me."* (21-years-old)

In addition, many participants expressed that they did not want other people to know that they had an abortion, especially people within their communities and their families, and therefore chose self-managed medication abortion because it felt more private/confidential than surgical abortion or in-clinic medication abortion. Participants emphasized that medication abortion allowed them to decide to whom they wanted to disclose their abortion and avoid potentially stigmatizing interactions, including one participant who said,

"*I […] would do it myself at home, […] cause I don't want so many questions, I just want to be private just on my own cause I don't want people to know about it.*" (25-years-old)

When asked if they would choose to self-manage their medication abortion or go to a clinic or health facility if they needed another abortion, most participants affirmed that they would prefer self-managed medication abortion. Among these participants, reasons for preferring self-managed medication abortion included privacy and avoiding stigmatizing encounters from service providers. For example, one participant explained that she preferred self-managed medication abortion because service providers can be "*judgmental [and] they impose their values on women and girls*" (21-years-old). In addition, another participant said that they preferred the medication abortion because it felt more like *"experiencing menstrual flow"* than they thought a surgical abortion would feel like (21-years-old). A few participants said they would prefer medication abortion in a clinic with the support of health care workers if they needed another abortion. Of these participants, one explained that she would like a health care worker to "*walk her through the process*" while managing their abortion (21-years-old).

When asked if they would recommend self-managed medication abortion to a friend who needed an abortion, nearly all participants, such as the participant quoted below, said that they would recommend self-managed medication abortion to their friends,

"*Of course I would tell them [a friend] about self-management with pills, the safest way to go by, I would not want her to go [through] the other processes*." (25-years-old)

Role of hotlines in providing accurate information and reducing abortion stigma

Participants were asked to describe if and why they thought abortion hotlines should be involved in the abortion process. All participants thought that the abortion hotlines should be involved in the abortion process and detailed reasons such as their ability to relay accessible and accurate information. One participant said,

"Yes [*hotlines should be involved in the abortion process] because it provides correct information that sometimes clinics do not provide*." (28 years-old).

Participants also identified a need for accurate, safe abortion information and services in Kenya, and reflected on the role of hotlines in providing information and services, with specific recommendations for the hotline to increase its outreach efforts, as one participant said:

[…] information is power because most women and girls fear, even in our school we lack quality information, and they end up going to quack services to terminate pregnancies and they lose their lives, so I feel like [the hotline] should reach out to more people outside here and just talk to women and girls because it is an issue that is happening every day. (21-years-old)

Some participants described having negative misconceptions or stigma about abortion prior to contacting the hotline, such as believing that abortion is unsafe, unethical, or illegal. However, a few participants expressed a more positive perception of abortion after contacting the hotline and learning about safe abortion methods, such as medication abortion. Participants learned about the differences between safe and unsafe abortion and the legal context of abortion in Kenya. One participant described how she could share the information she learned from the hotline to help spread awareness about safe abortion:

[…] before [contacting the hotline] I [thought] that abortion is bad, abortion is murder, I never knew that there was anything like safe or unsafe abortion, but I came to understand that there is safe and unsafe abortion and I came to also learn that in Kenya, a woman is allowed to have [an abortion] under certain circumstances and it is information that I can share…and make people understand that abortion is allowed under certain circumstances.(21-years-old)

Lastly, participants suggested more outreach, especially in rural areas, schools, and social media, to increase the accessibility and availability of accurate, safe abortion information. As one participant said,

"*if you come and give us the information, we will be able to save lives*" (22-years-old).

Discussion

Our findings indicate that participants had generally positive experiences interacting with hotline counselors. The majority of participants described receiving clear and accurate information about medication abortion that helped them feel prepared to self-manage the medication abortion process. In addition, our findings shed light on the multitude of reasons why Kenyans may prefer self-managed medication abortion over other methods (including cost, privacy, and safety) and suggest that hotlines can play a role in destigmatizing abortion.

This study aligns with the findings from other countries that have demonstrated how safe abortion hotlines can enable a positive, high-quality abortion experience, reduce risks to people's lives, and promote autonomy among its callers.[13,14] Several participants emphasized the importance of having the information delivered in their native language, which helped them feel prepared to self-manage their own abortion. Participants also reported appreciating how the hotline counsellors provided nonbiased, personalized sexual and reproductive health information. Participants reflected that information they received extended beyond abortion based on their individual circumstances and concerns, such as learning about family planning options. These findings underscore the importance of clear communication and individualized information provision, which has been shown to be associated with positive abortion care experiences and a greater sense of autonomy.[24] While the hotlines strive to mitigate the financial barriers to accessing information about abortion care by offering a toll-free number, further work is needed to address these barriers as represented by the few participants that reported incurring costs in contacting the hotline. In addition, a few participants described having to contact the hotline multiple times; to mitigate this challenge, expanding resources to hotlines to increase their capacity may enable them to field more calls.

Evidence from restrictive settings worldwide shows that when pregnant people seeking abortion cannot access safe abortion services, they often utilize abortion methods that endanger their health and safety.[25,26] However, the advent of self-managed medication abortion means that "illegal" abortions need no longer be equivalent to "unsafe" abortions.[2] Besides the strictly health-related outcomes, safe abortion hotlines also allow pregnant people to reduce social, legal, and economic risks that they may encounter in their trajectories to access abortion. Our findings show that this hotline offered one avenue to "safe abortions" beyond traditional biomedical understandings.[21,27] Importantly, the support of the hotline allowed callers to have control over the decision-making process including whom to share their abortions with and when to do so (i.e. limiting exposure to social stigma and criminalization), minimizing the disruptions in their 'normal' life (i.e. the possibility to continue their education) and limiting exposure to risk (i.e. keep abortion private). Indeed, our findings show participants' preferences for this model of access and the different perceived advantages to self-managed medication abortion.

The participants specifically described how self-managed abortion allowed them to keep their abortions private, which helped them mitigate potentially stigmatizing interactions with their families, communities, and health care workers. This highlights the need for community-based interventions to destigmatize abortion more broadly, as well as policy interventions to decriminalize abortion. While much more work is needed to tackle abortion stigma, our findings show that this hotline may be playing an important role in challenging internal abortion stigma among those seeking care in Kenya, with some participants reporting a much more positive perception of themselves and abortion after contacting the hotline.[27–31] Although experiences were overwhelmingly positive, abortion can elicit complex emotions, as reported by the one participant who said they experienced fear and shame after completing their abortion. Hotlines can

serve as an important resource for those experiencing negative emotions after an abortion, through providing accurate information and vital support to hotline callers.A few participants also identified the need for their community to have high-quality information on safe abortion and one participant acknowledged their own role in disseminating it. Coupled with the change in participants' perception of abortion and themselves, this finding emphasizes the potential of hotlines in normalizing abortion in the public domain.[13] Future research should assess the impact this safe abortion hotline could have on destigmatizing abortion in Kenya.

Limitations

There are limitations to this study. First, interviews were conducted only with people who called into one safe abortion hotline in Kenya and decided to self-manage their abortion with pills. In addition, participants may have had different experiences with abortion prior to contacting the hotline, which could affect their perception of self-managed medication abortion in comparison to other abortion models. Finally, interviews were conducted by staff members of the hotline. Although participants did not speak to the same hotline counselor, there may have been hesitancy to share constructive feedback with other hotline staff.

Conclusion

This paper contributes to building evidence of users' experiences using an abortion hotline and self-managing their abortions with medication. Our findings suggest that, in addition to providing high-quality information and support where abortion is legally restricted, safe abortion hotlines may also play an essential role in destigmatizing and normalizing abortion and building an autonomous model for abortion care that defies the centrality of the legal restrictions and medical power. While more research is needed to further assess the impact of safe abortion hotlines on abortion stigma, our findings provide an important foundation for future studies.

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Authors contribution

YYY and LBP led research ideation, development and writing of the manuscript, SW, SR, YYY led data collection and review of the manuscript; YYY, LBP, MC, IJ, SW, and SR contributed to writing and reviewing the manuscript. YYY, LBP, MC, and SR conducted analyses.

References

1. Moseson H, Herold S, Filippa S, Barr-Walker J, Baum SE and Gerdts C. Self-managed abortion: A systematic scoping review. *Best Pract Res Clin Obstet Gynaecol*. 2020;63:87-110. doi:10.1016/j.bpobgyn.2019.08.002
2. Moseson H, Shaw J, Chandrasekaran S. Contextualizing medication abortion in seven African nations: A literature review. *Health Care Women Int*. 2019;40(7-9):950-980. doi:10.1080/07399332.2019.1608207
3. Raymond EG, Tan YL and Comendant R. Simplified medical abortion screening: a demonstration project. *Contraception*. 2018;97(4):292-296. doi:10.1016/j.contraception.2017.11.005
4. Rocca CH, Puri M and Shrestha P. Effectiveness and safety of early medication abortion provided in pharmacies by auxiliary nurse-midwives: A non-inferiority study in Nepal. Vermund SH, ed. *PLOS ONE*. 2018;13(1):e0191174. doi:10.1371/journal.pone.0191174
5. Sjöström S, Dragoman M, Fønhus M, Ganatra B and Gemzell-Danielsson K. Effectiveness, safety, and acceptability of first-trimester medical termination of pregnancy performed by non-doctor providers: a systematic review. *BJOG Int J Obstet Gynaecol*. 2017;124(13):1928-1940. doi:10.1111/1471-0528.14712
6. Winikoff B and Sheldon W. Use of Medicines Changing the Face of Abortion. *Int Perspect Sex Reprod Health*. 2012;38(03):164-166. doi:10.1363/3816412
7. World Health Organization. *Abortion Care Guideline: Executive Summary*. World Health Organization; 2022. Accessed May 4, 2022. https://apps.who.int/iris/handle/10665/352342
8. Hyman A, Blanchard K, Coeytaux F, Grossman D and Teixeira A. Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. *Contraception*. 2013;87(2):128-130. doi:10.1016/j.contraception.2012.10.020
9. Chemlal S and Russo G. Why do they take the risk? A systematic review of the qualitative literature on informal sector abortions in settings where abortion is legal. *BMC Womens Health*. 2019;19(1):55. doi:10.1186/s12905-019-0751-0

10. *Right to Life*. Vol 4.; 2010.
11. Moseson H, Bullard KA, Cisternas C, Grosso B, Vera V and Gerdts C. Effectiveness of self-managed medication abortion between 13 and 24 weeks gestation: A retrospective review of case records from accompaniment groups in Argentina, Chile, and Ecuador. *Contraception*. 2020;102(2):91-98. doi:10.1016/j.contraception.2020.04.015
12. Braine N and Velarde M. Self-Managed Abortion: Strategies for Support by a Global Feminist Movement. *Womens Reprod Health*. Published online January 10, 2022:1-20. doi:10.1080/23293691.2022.2016142
13. Gill RK, Cleeve A and Lavelanet AF. Abortion hotlines around the world: a mixed-methods systematic and descriptive review. *Sex Reprod Health Matters*. 2021;29(1):75-89. doi:10.1080/26410397.2021.1907027
14. Drovetta RI. Safe abortion information hotlines: An effective strategy for increasing women's access to safe abortions in Latin America. *Reprod Health Matters*. 2015;23(45):47-57. doi:10.1016/j.rhm.2015.06.004
15. Pizzarossa LB, Maziwisa M, and Durojaye E. Self-Managed Abortion in Africa: The Decriminalization Imperative in Regional Human Rights Standards. *Health Hum Rights*. 2023;25(1):171-183.
16. Gerdts C and Hudaya I. Quality of Care in a Safe-Abortion Hotline in Indonesia: Beyond Harm Reduction. *Am J Public Health*. 2016;106(11):2071-2075. doi:10.2105/AJPH.2016.303446
17. Katz AJ, Ramirez AM, Bercu C, Filippa S, Dirisu O, Egwuatu I, Nmezi S, Palmer L, and Baum SE. "I just have to hope that this abortion should go well": Perceptions, fears, and experiences of abortion clients in Nigeria. Owolabi OO, ed. *PLOS ONE*. 2022;17(2):e0263072. doi:10.1371/journal.pone.0263072
18. Berro Pizzarossa L and Nandagiri R. Self-managed abortion: a constellation of actors, a cacophony of laws? *Sex Reprod Health Matters*. 2021;29(1):23-30. doi:10.1080/26410397.2021.1899764
19. Braine N. Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action. *Health Hum Rights*. 2020;22(2):85-97.
20. Nandagiri R and Berro Pizzarossa L. Transgressing biomedical and legal boundaries: The "enticing and hazardous" challenges and promises of a Self-Managed Abortion multiverse. *Womens Stud Int Forum*. 2023;100:102799. doi:10.1016/j.wsif.2023.102799
21. Assis MP and Larrea S. Why self-managed abortion is so much more than a provisional solution for times of pandemic. *Sex Reprod Health Matters*. 2020;28(1):1779633. doi:10.1080/26410397.2020.1779633
22. Marler I and Platero DM, Anumo F. Reclaiming culture, resisting co-optation: young feminists confronting the rising right. *Gend Dev*. 2018;26(3):515-532. doi:10.1080/13552074.2018.1523274
23. Alhojailan MI. THEMATIC ANALYSIS: A CRITICAL REVIEW OF ITS PROCESS AND EVALUATION. *West East J Soc Sci*. 2012;1.
24. Cotter SY, Sudhinaraset M, Phillips B, Seefeld CA, Mugwanga Z, Golub G and Ikiugu E. Person-centred care for abortion services in private facilities to improve women's experiences in Kenya. *Cult Health Sex*. 2021;23(2):224-239. doi:10.1080/13691058.2019.1701083
25. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE and Shah IH. Unsafe abortion: the preventable pandemic. *The Lancet*. 2006;368(9550):1908-1919. doi:10.1016/S0140-6736(06)69481-6
26. Marlow HM, Wamugi S, Yegon E, Fetters T, Wanaswa L and Msipa-Ndebele S. Women's perceptions about abortion in their communities: perspectives from western Kenya. *Reprod Health Matters*. 2014;22(43):149-158. doi:10.1016/S0968-8080(14)43758-3
27. Mohamed D, Diamond-Smith N and Njunguru J. Stigma and agency: exploring young Kenyan women's experiences with abortion stigma and individual agency. *Reprod Health Matters*. 2018;26(52):128-137. doi:10.1080/09688080.2018.1492285
28. Wollum A, Huerta SG, Uribe OL, Garnsey C, Gaddis SM, Baum SE and Keefe-Oates B. The influence of feminist abortion accompaniment on emotions related to abortion: A longitudinal observational study in Mexico. *SSM - Popul Health*. 2022;19:101259. doi:10.1016/j.ssmph.2022.101259
29. Atienzo EE, Cruz V, Garduño S, Lomelí S, Meza M, Zurbriggen R, Carbone SL and Wollum A. Safe abortion in Latin America: a look at abortion accompaniment collectives from the perspective of their activists. *Cult Health Sex*. Published online July 28, 2023:1-17. doi:10.1080/13691058.2023.2233589
30. Erdman JN, Jelinska K and Yanow S. Understandings of self-managed abortion as health inequity, harm reduction and social change. *Reprod Health Matters*. 2018;26(54):13-19. doi:10.1080/09688080.2018.1511769
31. Bornstein M, Young YY, Pizzarossa LB, Cohen MJ and Maina J. Documenting activism and advocacy around medication abortion in Central, East, and West Africa. *Afr J Reprod Health*. 2023;27(1):84-94. doi:10.29063/ajrh2023/v27i1.8.