



When Self-Managed Abortion is a Crime: Laws That Put Women at Risk

An Analysis of Massachusetts Law

A Report By:
The National Institute for Reproductive Health

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This report supplements NIRH's initial white paper, "When Self-Abortion is a Crime: Laws that Put Women at Risk," which raises awareness about the harms of criminal bans on self-abortion, with a focus on New York. To read more, please visit <http://bit.ly/NIRHWhitePaper>

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I. Introduction

“Abortion is a fact of life. Women have always had them and they always will.”¹

Throughout history, women² in the United States and around the globe have sought out abortions or induced one themselves when faced with an unintended pregnancy. The law governing their actions, however, as well as the legal consequences for those actions, have changed over time. Abortion was legal and generally available across the United States until the mid-1800s, when every state criminalized the practice. From then until 1973, abortion was generally illegal across the country, but widely practiced at times by medical professionals and lay practitioners alike, as well as by women themselves. Despite its illegality, throughout this period the general consensus was that the woman herself was not a criminal.³ Indeed, only a few states ever enacted statutes specifically prohibiting women from ending their own pregnancy, and those statutes were virtually never enforced.⁴ “Self-induced abortion [was] never . . . treated as a criminal act.”⁵

In the 20th century, this phenomenon was frequently viewed as an unfortunate—and potentially risky—result of lack of access to safe, legal, affordable abortion care from a medical provider.⁶ Although some women have safely and effectively used herbs or

drugs to end their pregnancies, self-managed abortion⁷ has also been associated with serious injury and death.⁸ After *Roe v. Wade* made abortion legal across the United States in 1973, it was widely believed that the resulting arrival of safe and accessible abortion from medical providers would put an end to the conditions that had historically led women to take matters into their own hands.

But 45 years after *Roe*, our country sits at a new crossroads on abortion. Over the past four decades, and with a marked acceleration since 2010, state legislators in many parts of the country have created a patchwork of multiple, often-onerous restrictions on the provision of abortion care, such that while abortion remains technically legal, it is not always accessible or affordable for women who need it. At the same time, there are now methods for self-managing abortion that are safe and effective.⁹

However, even as women may be able to self-manage an abortion without attendant hazards to their health, they may face another serious complication: prosecution and incarceration. In a few states, ending a pregnancy by oneself remains a crime. And,

unfortunately, in states where self-managed abortion is not an explicit crime, including Massachusetts, overzealous prosecutors have stretched other criminal statutes to punish women who act to end their own pregnancies. Arguably, more than at any other time in the complicated legal history of abortion in the United States—from legal to illegal and back to legal again—the prosecution and imprisonment of women for managing their own abortions and for other behavior during pregnancy has become a full-fledged phenomenon, posing a great risk to their health and rights.¹⁰

Last year, we provided a historical perspective on the criminalization of abortion, whether induced by the woman herself or by another, in the United States generally and New York specifically; documented the harm such laws have on the health and lives of women and their families; and suggested some policy approaches that would lead to better health outcomes for women and expand women’s ability to fully exercise their constitutional rights. We now supplement that report with an in-depth profile of the history of criminalization of abortion in Massachusetts—and the ways the state’s laws have been misapplied in recent years to punish women for their pregnancy outcomes. With this report, we hope to educate the public and raise awareness about the harms done to women and families when self-managed abortion is criminalized and the policy approaches that

would better support women in managing all of their reproductive health needs.

II. The Law Governing Abortion

In Massachusetts, the law regulating abortion has a long and complicated history, tied in with English common law and revisions of the statutory criminal law. In order to fully understand Massachusetts’ current law, particularly its possible application to self-managed abortion, it is necessary to understand how the law developed and was implemented and viewed over time.

a. Abortion law up to *Roe*

In the early period in United States history, abortion was not a criminal act until “quickening” (the point at which movement can be felt by the pregnant woman) and was not a crime at any point in pregnancy in some places.¹¹ Rather than being criminalized, under the common law, all women were viewed as having the liberty to terminate a pregnancy.¹²

The first wave of criminal abortion laws was apparently motivated solely by concerns about patient health and not necessarily even particularly related to concerns about abortion. Indeed, the first criminal abortion law in Massachusetts, passed in 1845 and re-codified in 1860, appears to have grown out of concern about surgery in general.

As the Supreme Judicial Court of Massachusetts has observed: “Although the legislative purpose does not appear from the legislative documents in the State Archives, at least one reason for its enactment may have been the desire to protect women from the risks of what was then a dangerous surgical procedure.”¹³ In a footnote, the court further explained: “The statute was passed at a time when the causes of infection (and appropriate precautions to prevent it) were not well understood.”¹⁴

Beginning with the American Medical Association (AMA) in 1859, organized medical societies came to strongly oppose legal abortion and campaigned for restrictive laws that would leave the decision about whether to provide a woman with an abortion strictly in physicians’ hands.¹⁵ Other political forces were at work as well, ranging from anti-immigrant groups that wanted to ensure a higher birth rate among native-born Protestant white women,¹⁶ to some religious groups that entirely opposed abortion based on their beliefs about when life begins, to some female advocates working to advance “social purity” after the Civil War.¹⁷

By the mid-1800s, the confluence of these efforts led to a wave of criminal abortion laws that permitted abortions only in a small set of circumstances and only when performed by a physician, frequently in a

hospital setting, and often requiring approval from a panel of physicians.¹⁸

Yet even then, very few states enacted laws criminalizing the woman’s conduct in inducing her own miscarriage.¹⁹

Furthermore, states that prohibited self-managed abortion also seemed concerned with protecting women’s health rather than intending for women to be prosecuted—“legislators had to find some way to deter women from what seemed to be causing their own destruction.”²⁰

From the mid-1800s until about 1930, there were few criminal abortion prosecutions, and those only in cases where the woman died.²¹ However, across the country, prosecutions of practitioners of illegal abortions ramped up quickly in the 1940s.²² This new effort to prosecute practitioners who violated criminal abortion laws and expose the women who sought abortions appears to have been motivated by some of the latent racist and sexist rationales that animated the original enactment of the laws, including assumptions about women’s roles as mothers and the desire to prevent women from having sex outside of marriage.²³

Abortion-related criminal trials became the focus of sensational press coverage and “transformed abortion from an everyday, if semi-secret, occurrence into a crime.”²⁴ Prosecutors actively tried to “catch women patients” in order to haul them into the court room as witnesses, routinely

“put[t]ing their abortions on display for judge, jury and journalist.”²⁵ Yet, prosecutions were still not aimed at the women themselves.²⁶

With more prosecutions and fewer physicians comfortable providing the care, mortality and morbidity associated with abortion began to grow. Indeed, the proverbial clothes hanger became a symbol of self-managed abortion because women often resorted to violent and sometimes life-threatening methods of ending a pregnancy.²⁷ The lack of access to safe abortion, whether legal or not, disproportionately affected women of color, and black women in particular, as white women typically had access to safer illegal abortions or to hospital review boards, while black women were forced to find less safe providers.²⁸

By the early 1960s, it was clear to many in the medical and legal fields that the law surrounding abortion was no longer functioning. In 1962, the American Law Institute (ALI), an influential independent scholarly organization that aims to clarify and improve American law, finalized and published a new model law on abortion focused on protecting abortion providers from prosecution when performing abortions for those women facing a substantial physical or mental health risk, fetal abnormality, or pregnancy due to rape or incest.²⁹ The AMA also changed its posture on abortion, revising its position in 1967 and again in 1970. The 1967 revision

proposed allowing legal abortions by a licensed physician in an accredited hospital with the written approval of two other consulting physicians, in select cases: “to safeguard the health or life of the patient, or to prevent the birth of a severely crippled, deformed, or abnormal infant.”³⁰ By 1970, the AMA approved a dramatically different proposal, concluding that abortion should be regulated like any other medical procedure and that the “Principle of Medical Ethics of the AMA does not prohibit a physician from performing in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.”³¹ Neither statement addressed self-induced abortion or the criminal prosecution of women.

Advocates publicly vowed to break the law and help women find safe abortions, including the Citizen’s Advisory Committee on the Association for the Study of Abortion³² and the Clergymen’s Consultation Service on Abortion.³³ The general public was also in favor of reform, including a large proportion of Roman Catholics.³⁴

States all over the country were beginning to reform their abortion laws, adopting the ALI’s model recommendation: Between 1962 and 1972, thirteen states amended their laws to allow for abortion in cases of rape, health risk to the pregnant woman, and fetal anomalies.³⁵ In Massachusetts, however, reform did not occur until

prompted by the U.S. Supreme Court’s historic decision in *Roe v. Wade*.

By 1971, the Supreme Court had taken its first abortion cases to be decided on the merits, *Roe v. Wade* and *Doe v. Bolton*.³⁶ These lawsuits challenged the abortion laws of Texas and Georgia, respectively, which were emblematic of the two distinct types of abortion statutes in the United States at the time—the more restrictive laws that were virtually unchanged since the 1800s and a more recent “reformed” group of laws that contained exceptions for situations such as rape and incest.³⁷ Neither the Texas law nor the Georgia law criminalized or prohibited self-managed abortion.

After reviewing the relevant case law, the Court held that the right of privacy “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”³⁸ The decisions in *Roe v. Wade* and *Doe v. Bolton* ultimately suspended the existing abortion laws in 44 states.³⁹

b. Massachusetts’s 1974 abortion law

Until the mid-19th century, abortion was a crime at common law in Massachusetts only after quickening of the fetus.⁴⁰ The state’s first criminal abortion law was codified in the General Laws in 1845 under the title, *An Act to punish unlawful attempts to cause Abortion*.⁴¹ It was then re-codified in 1860 under the title *Unlawful attempts to procure miscarriage*.⁴² That statute, though generally viewed as unconstitutional and

unenforceable following *Roe*,⁴³ has never been repealed and remains on the books with virtually identical language today.⁴⁴

Instead, after *Roe*, the Massachusetts legislature drafted a new law governing abortion that was intended to comply with the constitutional limits set by the U.S. Supreme Court.⁴⁵ Despite the stated intent, Governor Francis Sargent vetoed the measure, citing concerns that it went beyond ensuring that abortion be performed in a safe and proper manner by regulating the abortion decision itself and that its parental consent provision was constitutionally infirm.⁴⁶ However, the legislature overrode his veto and passed the bill into law on August 2, 1974.⁴⁷

The measure allows abortion prior to 24 weeks if it is “in the best medical judgment of a physician...necessary under all attendant circumstances.”⁴⁸ After 24 weeks, an abortion may only be performed to save the life of the pregnant woman or protect her physical or mental health from “a substantial risk of grave impairment.”⁴⁹ In addition, it requires that any abortion, regardless of gestational age, be performed by a physician; and both parents consent to an abortion for an unmarried minor.⁵⁰

Despite this advancement over the pre-*Roe* statute, the reform law left open the possibility that abortions outside of these situations could still be a crime and that any self-managed abortion by a woman without the involvement of a physician, at any point

in pregnancy, could potentially be prosecuted. While some “physician-only statutes” have explicit exemptions for pregnant women who terminate their own pregnancies,⁵¹ the Massachusetts law does not.

That said, nothing in the legislative record supports the conclusion that, by including a physician-only requirement in the 1974 law, the legislature intended to criminally penalize a woman who ends her own pregnancy. First, the topic does not seem to have arisen during any documented legislative debate.⁵² Second, Massachusetts courts have “long held that a statutory repeal of the common law will not be lightly inferred; the Legislature’s ‘intent must be manifest.’”⁵³

Nineteenth century cases interpreting the 1845 miscarriage statute consistently held that a woman “could not [be] indicted as a participator in the offence” nor could she be charged as an accomplice.⁵⁴ Similarly, at common law, “it was not an offense [for a pregnant woman] to so treat her own body, or to assent to such treatment from another It was in truth a crime which, in the nature of things, she could not commit.”⁵⁵

Given that the 1974 Act includes no language explicitly abrogating the common law protections that exempted a pregnant woman from criminal liability in procuring or assisting with her own abortion,⁵⁶ it would be a gross misinterpretation of the

modern abortion statute to read its physician-only provision as imposing a criminal prohibition on a woman who ends her pregnancy without medical assistance or supervision. Unfortunately, that has not stopped some overzealous prosecutors from twisting state laws to serve their own political agenda.

III. Post-*Roe* criminalization and prosecution

Although *Roe* recognized women’s constitutional right to terminate a pregnancy prior to viability, the statutes on the books in 1973 that were inconsistent with that holding were not eliminated. Instead, in many states, as in Massachusetts, parts of the pre-*Roe* statutes co-exist with the post-*Roe* legal system, so that the two must be read together to determine the law in any given state. As noted above, the pre-*Roe* Massachusetts statute prohibiting “unlawful” attempts to procure a miscarriage was never repealed, despite being inconsistent with *Roe* by imposing a criminal ban on abortion at any stage of pregnancy.

And while a few states have had statutes explicitly criminalizing self-managed abortion since the mid-19th century, although not in Massachusetts, they were considered a “dead letter” as late as 1967, having sat unused for over a century.⁵⁷ Only

now, in the 21st century, are women being targeted directly and specifically by criminal prosecutors.⁵⁸ For instance, New York’s criminal laws prohibiting “self-abortion” throughout pregnancy have actually been used, with at least five women charged in the last thirty years.⁵⁹

Even though no such statute exists in Massachusetts, the state’s unlawful miscarriage statute has been used to justify charges against an immigrant teenager for ending her own pregnancy with abortion pills. In 2007, an 18-year-old named Amber Abreu was arrested on charges of procuring a miscarriage.⁶⁰ The District Attorney originally considered bringing homicide charges as well but ultimately chose not to do so, citing the difficulty of proving viability at 25 weeks.⁶¹

Abreu admitted to taking three Cytotec pills (the brand name for misoprostol) in the days before giving birth to an infant who died four days later.⁶² Held in a maximum-security state prison for three days until her family was able to secure the \$15,000 required for her bail,⁶³ she was eventually sentenced to probation and counseling.⁶⁴

The Abreu case in Massachusetts and others around the country demonstrate clearly that, in the post-*Roe* world, women themselves, and low-income women and women of color in particular, are at more risk of criminal prosecution for abortion and other pregnancy outcomes than at any other point in history.⁶⁵ Though some women have been specifically charged with

inducing their own abortions,⁶⁶ in the majority of cases nationwide, criminal prosecutions of pregnant women deal with the opposite side of the reproductive decision coin—the decision to carry a pregnancy to term.⁶⁷ There have been a number of efforts to prosecute women for drug use or a variety of other acts or omissions believed, often erroneously, to have affected a pregnancy.⁶⁸

Indeed, in Massachusetts, women have been prosecuted for involuntary manslaughter of their child after ingesting cocaine or simply giving birth at home.⁶⁹ In the latter case, Allissa Pugh was initially convicted of involuntary manslaughter for continuing a medically-unassisted home birth after realizing the baby was in a breech position and “applying significant force to various parts of his body,”⁷⁰ thereby “inflicting fatal injuries on a viable and near full term fetus during the birthing process.”⁷¹ In issuing the conviction, the lower court explicitly relied on the state’s abortion statutes noting that “the defendant’s conduct in this case transgresses the public policy of the Commonwealth,” in particular the state’s restrictions on abortion after 24 weeks and the requirement that an abortion be performed by a physician in a clinic or hospital setting.⁷²

Although Pugh’s conviction was reversed on appeal and the appellate court made clear that no woman could be prosecuted for giving birth at home,⁷³ the court

underscored the “defendant is not charged with intending to self-abort” and left open the door to such prosecutions in the future.⁷⁴

IV. How Criminalizing Self-Managed Abortion Hurts Women and Families

While the availability of medication abortion may have made self-managed abortion safer and more effective than it used to be, new risks are created by the recent push to punish women for ending a pregnancy themselves⁷⁵—with increased monitoring and prosecution opening the door to a range of negative outcomes for women, families, and communities.

Fear of prosecution makes it more difficult to share or acquire accurate, reliable information about the safer methods of self-managed abortion, including medications like mifepristone and misoprostol. It also makes it more difficult to obtain safe methods—often women have to turn to less secure sources for drugs, such as flea markets or the internet.⁷⁶ Finally, the fear of prosecution limits women’s ability to seek the health care they may need after attempting to end a pregnancy or even simply after a spontaneous miscarriage—in rare cases, women may experience serious health complications or even death due to their

inability to seek out medical care.⁷⁷

This fear can also come from the complicated relationship between the medical community and the criminal justice system in the United States. In one survey of more than four hundred cases of arrests and forced interventions on pregnant women, 53% of the cases were reported to police by a health care provider or social worker, and another 17% were reported by a health care provider to child protective services who then reported to the police.⁷⁸ Indeed, in the Abreu case, it was a hospital social worker who called the police after Abreu sought care at a hospital.⁷⁹

In some cases, women who had recently gone through birth, a miscarriage, or were suspected of self-managing an abortion have been subjected to bedside interrogations, leading to “humiliating police questioning about intimate details of their lives while lying, and sometimes dying, in their hospital beds.”⁸⁰ Furthermore, any actions a woman takes that could potentially increase the likelihood of miscarriage, including common daily activities like riding a bike, could be used as evidence of harmful intent or even criminalized.⁸¹

Low-income women and women of color in the United States are particularly vulnerable to this type of prosecution, as they have less access to affordable legal abortion as well as other health care services, are more vulnerable to government monitoring, and

are also more likely to be targets of prosecution by law enforcement.⁸² Black women, in particular, are more likely to be reported to government authorities by health care professionals.⁸³

When women are jailed for self-managed abortion, their health and well-being and that of their family suffer as well.

“Significantly, detention in health and correctional facilities has not meant that the pregnant women (and their fetuses) received prompt or appropriate prenatal care.”⁸⁴ Incarceration also separates women from their children, frequently pushing their children into the foster care system and placing them at increased risk for a variety of problems.⁸⁵ Moreover, many women may be at risk for deportation if they are arrested for any reason, particularly in the current political climate.⁸⁶

As access to abortion decreases and women turn to self-managed abortion, the state’s interest in protecting health and safety is not advanced by discouraging women from finding medically accurate information before attempting to end a pregnancy themselves, seeking out medical assistance afterwards if needed, or making miscarriage a potentially suspicious pregnancy outcome in any situation.

V. Why the State Has No Sufficient Interest to Justify the Criminalization of Self-Managed Abortion

As described in detail in our earlier report, *When Self-Abortion is a Crime: Laws That Put Women at Risk*, women who choose to manage their own pregnancies do so for a range of reasons and have a range of experiences.⁸⁷ Criminal laws do not deter women from ending their own pregnancies but may endanger their health if they do, causing them to fear the medical community and deterring them from seeking care. Although in the 1800s, the first wave of criminal abortion laws may have been, as in Massachusetts, motivated by concerns about women’s health as a result of the surgical standards of the time, those concerns have long since disappeared. With them, whatever state interest there once may have been in criminalizing self-managed abortion has also disappeared.

Given the constitutional rights at stake, the intimacy of the decisions involved, and the health considerations for women, it is surprising that laws criminalizing self-managed abortion remain on the books in a handful of states and that laws like the ones in Massachusetts have been used to prosecute women for ending their own

pregnancies. The state interests that underlie the criminalization of self-induced abortion are not easily ascertained; few laws make such actions a crime and the legislative intent has rarely been documented. What documentation exists provides only criticism of such laws, not support.

Professor Cyril Means, who wrote an authoritative history on New York abortion law until 1968 and dealt specifically and critically with the issue of criminalization of self-managed abortion, once criticized such laws as meaningless, surmising that such laws were never intended to be and could never be enforced.⁸⁸

Similarly, when the ALI released the MPC in 1962, its committees had carefully considered whether and to what extent either self-managed abortion or aiding a woman in self-managed abortion should be criminalized.⁸⁹ In examining state abortion statutes, the ALI found that “liability [for a woman in the case of self-induction] would appear to be precluded by the phrasing of the statute in terms suggesting that the legislature regarded her as a victim of criminal behavior, rather than its perpetrator.”⁹⁰ The implied exemption was “especially true of statutes which provide[d] for aggravated penalties where the woman dies,”⁹¹ given that naturally a woman who had died could not be prosecuted. Indeed, the ALI identified Massachusetts as one of the states that had a statute that provided such penalties in the case of a woman’s

death.⁹²

Both Means and the ALI also raised concerns about jury nullification—the phenomenon of a jury refusing to convict because it finds the law too harsh or immoral—as well as abuse of prosecutorial discretion, noting that “district attorneys and other responsible officials should not face the problem of the mother’s liability as one of discretion”⁹³ and:

Criminal liabilities which experience shows to be unenforceable because of nullification by prosecutors or juries should be eliminated from the law. Such nullification usually points to a situation of divided community opinion. Also, “dead letter” laws, far from promoting a sense of security in the community, which is the main function of penal law, actually impairs that security by holding the threat of prosecution over the heads of people whom we have no intention to punish.⁹⁴

Indeed, Chief Justice Burger had raised the same concern about selective enforcement in his concurring opinion in *Roe v. Wade*, arguing that one reason to strike down criminal abortion statutes in general is because they were only selectively enforced.⁹⁵

As other courts have noted, including the Supreme Judicial Court of Massachusetts, investigations into the ways that

pregnancies progress and end may veer so closely into state control over women’s every move during pregnancy that laws authorizing those investigations trespass on women’s constitutional rights.⁹⁶ In addition, laws that criminalize self-managed abortion run the risk of criminalizing every miscarriage and interposing the state’s criminal law into physician-patient interactions, as was documented during the years where abortion was widely illegal.⁹⁷ Moreover, such prosecutions are likely to target low-income women and women of color the most, as those groups are most likely to encounter or to be reported to law enforcement in a number of circumstances.⁹⁸

Thus, while the risks to women from these laws are clear, the benefits, as noted earlier, are nonexistent. While the U.S. Supreme Court has, since *Roe*, upheld a number of restrictions on abortion, its most recent decision, *Whole Woman’s Health v. Hellerstedt*, made clear that abortion laws must actually benefit women’s health, rather than impose arbitrary burdens, and that courts assessing those laws may not simply “infer that the legislature sought to further a constitutionally acceptable objective.”⁹⁹ Under the Massachusetts Constitution, the right to abortion may be even more strongly protected.¹⁰⁰

Whatever state interest there once may have been in criminalizing self-managed abortion—at best an interest in protecting the woman’s life and health in the days

when surgery was dangerous—has long since disappeared. Based on the constitutional standards that have been made clear over the last forty-five years, even though self-managed abortion may, depending on the method, carry some risks for the woman,¹⁰¹ the state does not have a sufficient enough interest in protecting the woman’s health in those circumstances to justify both intruding upon her own constitutional rights in her pregnancy outcome and doing so in the most extreme manner, namely criminal prosecution and incarceration.¹⁰²

VI. Better Approaches for Protecting Women’s Health and Safety

Law, policy, and medicine related to abortion have all changed radically since the first criminal prohibition was enacted in Massachusetts in 1845. In 2018, abortion is both common and safe. In fact, it is one of the safest medical procedures available in the country today.¹⁰³ Nonetheless, women still face barriers to care and, in some cases, still induce their own abortions. Allowing the criminal law in Massachusetts to be used against women who have ended their own pregnancies serve no reasonable state purpose, but may cause great harm to women, particularly low-income women and women of color, who are most likely to encounter or be reported to law

enforcement.

If policymakers want to consider solutions to address both the lack of access to care and the harm to women that comes from criminal prohibitions, there are several policy options that could be pursued:

Decriminalize self-managed abortion: A first step would be to ensure that there are no criminal penalties associated with women ending their own pregnancies using medications or any other means. In Massachusetts, where the law does not explicitly allow for these criminal penalties in the first place, this could mean repealing the pre-*Roe* miscarriage statute that has been misused and/or amending the 1974 law to explicitly exempt the pregnant woman. It might also involve enacting new legislation to ensure that prosecutors do not use other, non-specific criminal laws to prosecute women who end their own pregnancies. Any measures should also ensure that no other people are prosecuted in these situations, including friends, family, or advocates who may help a woman access information, the means to end a pregnancy, or related medical assistance.

Increase access to clinical abortion care: Because most women who self-manage abortions appear to do so as a result of barriers to accessing abortion in a medical setting, proposals to increase access to abortion, including medication abortion, should be pursued. Specific proposals could include reviewing the state's abortion laws and ensuring that they fully enable broad

access to care, including ensuring public and private insurance coverage for abortion care and repealing laws that prohibit that coverage, like the federal Hyde Amendment. This is not a barrier in Massachusetts, which already covers abortion through the state's Medicaid plan. However, in Massachusetts, that could include repealing the law that allows only a physician, rather than any qualified health care provider, to provide abortion care, and supporting policies that advance telemedicine for medication abortion, a technological advance that holds great promise in expanding access to abortion care for rural women.

Provide public education about abortion: Another barrier to abortion access that may lead women to self-manage abortion is a lack of information about the legality and availability of abortion. Access to this information is further impeded by stigma associated with abortion, which makes it harder for women to get this information from their friends and family. Policymakers could fund a public education campaign to promote information about abortion, including how to access it, via printed materials, billboards, and referrals, among other tools. For example, policymakers could fund a pilot project to put up billboards and posters in English, Spanish, and other relevant languages for targeted populations saying "Abortion is safe and accessible in your community, find out more at [state web address].gov," which could then refer to local abortion providers. Further, policymakers could ensure that

grants or funding under such programs are given directly to community-based organizations in the communities most likely to benefit from the campaigns.

Expand access to contraception:

Unintended pregnancy is a primary reason people seek abortions. Increasing women’s ability to control when they become pregnant by improving access to contraception is a key part of reducing unintended pregnancy and therefore the need for abortion, self-managed or otherwise. Various administrative and legislative proposals exist to advance access to contraception, including maintaining no co-pays for contraception; expanding the types of contraception covered by insurance, whether available by prescription or over-the-counter; and increasing the amount of covered medication that can be provided at one

time.

VII. Conclusion

The complicated history of self-managed abortion in the United States leaves one fact entirely clear: Women have always ended their own pregnancies when the situation requires it, and criminalizing their conduct does nothing but create risks for women and their families. Instead of maintaining these criminal laws in Massachusetts and elsewhere, policymakers should consider creating policies that support all women’s access to comprehensive reproductive health care, in the manner and setting of their choosing, and that enable all women to have meaningful options in choosing whether and when to become a parent.

¹ Shirley Chisholm, UNBOSSSED AND UNBOUGHT 117 (1972).

² Throughout this document, we use the term “women” but recognize and intend to include both cisgender women and other people who can become pregnant.

³ See, e.g., Cyril C. Means, Jr., *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411, 488 (1968).

⁴ See JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY 145 (1978) (noting that in the first wave of criminal laws, between 1840 and 1860, only three states “struck the immunities traditionally enjoyed by American women in cases of abortion”). *But see id.* at 227 (noting that more states criminalized the women seeking abortion in the 1870s).

⁵ SARAH WEDDINGTON, A QUESTION OF CHOICE 97 (1993).

⁶ See Rickie Solinger, *Introduction to ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000* 4 (Rickie Solinger ed., 1998).

⁷ Although historically “self-induced abortion” has been the term most commonly employed to describe a woman ending her own pregnancy, reproductive health advocates are increasingly using the term “self-managed abortion” given that abortion pills have made it easier for a woman to manage the process of terminating a pregnancy herself if she has access to accurate information about how to do so. *See infra* note 9.

⁸ See Waldo L. Fielding, *Repairing the Damage, Before Roe*, N.Y. TIMES, June 3, 2008, <http://www.nytimes.com/2008/06/03/health/views/03essa.html> (last visited June 3, 2017) (“The familiar symbol

of illegal abortion is the infamous ‘coat hanger’—which may be the symbol, but is in no way a myth. In my years in New York, several women arrived with a hanger still in place. Whoever put it in—perhaps the patient herself—found it trapped in the cervix and could not remove it.”).

⁹ Some international studies have shown that self-managed abortion with medication can be safe and effective when taken according to evidence-based recommendations. See WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 23 (2012), available at

http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1. The World Health Organization has recognized that women can manage using the combined regimen of mifepristone and misoprostol without direct supervision of a health care provider when they have accurate information and access to a health care provider should they need or want it at any stage of the process. *Id.* at 23, 46. The World Health Organization has also stated that when mifepristone is not available, misoprostol alone can be a safe and effective method to end a pregnancy. *Id.*

¹⁰ See, e.g., Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

¹¹ See *Roe v. Wade*, 410 U.S. 113, 132–36 (1973) (holding modified by *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833 (1992)); Means, *supra* note 3, at 420.

¹² Means, *supra* note 3, at 430.

¹³ *Commonwealth v. Brunelle*, 277 N.E.2d 826, 830 (Mass. 1972).

¹⁴ *Id.* at 830 n.9.

¹⁵ ROSALIND P. PETCHESKY, ABORTION AND WOMAN’S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM 79 (1985) (citing MOHR, *supra* note 4, at 157); ALEXANDER SANGER, BEYOND CHOICE: REPRODUCTIVE FREEDOM IN THE 21ST CENTURY 26 (2004) (citing MOHR, *supra* note 4, at 161).

¹⁶ “The decline of native fertility was alarming some Protestants, particularly in light of the very high fertility of the vast number of immigrants who poured into America beginning with the 1840s. Fears of ‘race suicide’ and Catholic domination arose in the minds of some Protestants, and, since abortion was seen to be a major factor in the decline of Protestant fertility, the suppression of abortion was one logical remedy for Protestant fears.” R. Sauer, *Attitudes to Abortion in America, 1800-1973*, 28 POPULATION STUD. 53, 59 (1974); see also MOHR, *supra* note 4, at 207 (quoting Ohio legislators in 1868: “Do [our native women] realize that in avoiding the duties and responsibilities of married life, they are, in effect, living in a state of legalized prostitution? Shall we permit our broad and fertile prairies to be settled only by the children of aliens?”).

¹⁷ PETCHESKY, *supra* note 15, at 80; SANGER, *supra* note 15, at 28-29.

¹⁸ Means, *supra* note 3, at 451.

¹⁹ MOHR, *supra* note 4, at 22; see *Abele v. Markle*, 342 F. Supp. 800, 806 (D.Conn. 1972) (Newman, J., concurring) (“Prior to 1860, it was not a crime in Connecticut for a woman to cause her own miscarriage.”).

²⁰ MOHR, *supra* note 4, at 125.

²¹ See Leslie J. Reagan, *“About to Meet Her Maker”: Women, Doctors, Dying Declarations, and the State’s Investigation of Abortion, Chicago, 1867-1940*, 77 J. OF AM. HIST. 1240, 1247 (1991); Means, *supra* note 3. Moreover, there is some evidence that even these prosecutions were not generally successful at obtaining convictions: “Jurors were hard to mobilize to convict a physician who had done exactly what the patient had asked him to do, even where her death had ensued, even where no more than seven years’ imprisonment could be imposed.” Means, *supra* note 3, at 476.

²² Loretta J. Ross, *African-American Women and Abortion*, in ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000 161, 173 (Rickie Solinger ed., 1998).

²³ See *id.*; Rickie Solinger, *Pregnancy and Power Before Roe v. Wade, 1950-1970*, in ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000 15, 18 (Rickie Solinger ed., 1998).

²⁴ Solinger, *supra* note 23, at 18.

²⁵ LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND THE LAW IN THE UNITED STATES, 1867-1973 161 (1998).

²⁶ See *id.*

²⁷ *People v. Belous*, 458 P.2d 194, 201 (Cal. 1969) (“The Los Angeles County Hospital, alone, for example, in 1961 admitted over 3,500 patients treated for [criminal] abortions.”); SANGER, *supra* note 15, at 29; WEDDINGTON, *supra* note 5, at 40; *id.* at 15 (“Before abortion became legal in California in 1967, the county hospital in Los Angeles had a ward called the IOB (infected obstetrics) ward. It had about sixty beds for women suffering the results of

botched abortions, and sometimes abortions they had performed themselves. Doctors and nurses who worked at public hospitals in the days when abortion was illegal remember women who died in their arms.”); *see also* Reagan, *supra* note 21, at 1245-46.

²⁸ *See* Ross, *supra* note 22, at 161; Linda J. Greenhouse, *Constitutional Question: Is There a Right to Abortion?*, N.Y. TIMES, Jan. 25, 1970, at 30 (“More than 90 percent of the legal abortions in New York City hospitals [before 1970 were] performed on white women, while nonwhite women account for a large proportion of the deaths from bungled, illegal abortions.”).

²⁹ American Law Institute, *American Law Institute Abortion Policy, 1962*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT’S RULING* 24, 25 (Linda Greenhouse & Reva Siegel eds. 2010). While the ALI policy ultimately led 12 states to reform their abortion laws, it would not survive past 1973, when Georgia’s ALI-style law was struck down in *Doe v. Bolton*, the companion case to *Roe v. Wade*. *Doe v. Bolton*, 410 U.S. 179 (1973).

³⁰ Committee on Human Reproduction, *AMA Policy on Therapeutic Abortion*, 201 JAMA 544, 544 (1967).

³¹ American Medical Association, *American Medical Association Policy Statements, 1967 and 1970*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT’S RULING* 25, 28 (Linda Greenhouse & Reva Siegel eds. 2010).

³² Martin Gansberg, *Marchers Favor Abortion Reform*, N.Y. TIMES, Mar. 12, 1967, at 40; Martin Tolchin, *Defiance Pledged on Abortion Law*, N.Y. TIMES, Mar. 12, 1967, at 81.

³³ Edward Fiske, *Clergymen Offer Abortion Advice*, N.Y. TIMES, Mar. 22, 1967, at 1; *see also* Sarah McCammon, *50 Years Ago, A Network Of Clergy Helped Women Seeking Abortion*, NPR, May 19, 2017, <http://www.npr.org/2017/05/19/529175737/50-years-ago-a-network-of-clergy-helped-women-seeking-abortion> (last visited June 19, 2017).

³⁴ Sydney Schanberg, *Rockefeller Asks Abortion Reform*, N.Y. TIMES, Jan. 9, 1968, at 1.

³⁵ Judith Bourne, James Kahn, S. Beach Conger, & Carl Tyler Jr., *Surveillance of Legal Abortions in the United States, 1970*, 1 J. OBSTETRIC, GYNECOLOGICAL, & NEONATAL NURSING 17 (1972).

³⁶ WEDDINGTON, *supra* note 5, at 105, 131.

³⁷ *Id.* at 81.

³⁸ 410 U.S. 113, 153 (1973).

³⁹ WEDDINGTON, *supra* note 5, at 169; *see* Katherine Grainger et al., *What if Roe Fell?* CTR. FOR REPROD. RIGHTS (Nov. 2007), available at https://www.reproductiverights.org/sites/default/files/documents/Roe_PublicationPF4a.pdf (describing the impact on various state laws if *Roe* were overturned, given that some were repealed, others left on the books, and others partly or entirely enjoined by other courts).

⁴⁰ *Commonwealth v. Parker*, 50 Mass. 263, 265–66 (1845). British common law at the time, by contrast, held it to be a misdemeanor for a woman to ingest any substance intending to induce an abortion. *R v. Russell*, (1832) 168 Eng. Rep. 1302.

⁴¹ 1845 Mass. Acts 406.

⁴² MASS. GEN. LAWS ch. 165, § 9 (1860).

⁴³ *See, e.g.*, NARAL PRO-CHOICE AMERICA, STATE LAWS: MASSACHUSETTS, available at <https://www.prochoiceamerica.org/state-law/massachusetts/> (last visited Sept. 3, 2017).

⁴⁴ *See* MASS. GEN. LAWS ch. 272 § 19 (2017).

⁴⁵ 1974 Mass. Acts 713.

⁴⁶ Gov. Francis Sargent, VETO LETTER: MASS. HOUSE BILL NO. 6502 (Aug. 1, 1974); *see also* Rachele Patterson, *Sargent Vetoes Bill to Control Abortions*, BOSTON GLOBE, Aug. 2, 1974, at 1.

⁴⁷ Rachele Patterson, *Abortion Veto is Overridden by Huge Margin*, BOSTON GLOBE, Aug. 3, 1974, at 1.

⁴⁸ MASS. GEN. LAWS ANN. ch. 112, § 12L (Enacted 1974; Last Renumbered 1977).

⁴⁹ *Id.* § 12M.

⁵⁰ The two-parent consent requirement was later struck down under the state constitution. *Planned Parenthood League of Massachusetts, Inc. v. Attorney General*, 677 N.E.2d 101 (Mass. 1997). The statute also required any abortion past 13 weeks be performed in a hospital, but that is also assumed to be unconstitutional as it conflicts with Supreme Court caselaw and is unenforceable. *See* *Matter of Moe*, 25 Mass. App. Ct. 931, 517 N.E.2d 170 (1987).

⁵¹ *McCormack v. Hiedeman*, 694 F.3d 1004, 1011–12 n.3 (9th Cir. 2012) (listing state statutes with express exemption of liability for the pregnant woman).

⁵² See Mass. House J. 3-7 (Aug. 2, 1974) (veto override debate regarding House Bill 6502).

⁵³ Lipsitt v. Plaud, 994 N.E.2d 777, 783 (Mass. 2013) (quoting *Comey v. Hill*, 438 N.E.2d 811, 817 (Mass. 1982)); see also *Jennings v. Commonwealth*, 34 Mass. 80, 82 (1835) (“unless [the intent of the legislature] is manifest, the repeal by implication cannot be inferred.”).

⁵⁴ *Commonwealth v. Boynton*, 116 Mass. 343, 345 (1874). See also *Commonwealth v. Wood*, 77 Mass. 85, 90 (1858); *Commonwealth v. Folloansbee*, 155 Mass. 274, 277 (1892).

⁵⁵ *State v. Carey*, 56 A. 632, 636 (Conn. 1904) (interpreting common law and citing statutory history in Massachusetts).

⁵⁶ In addition, the only mention of “self-induced” abortion that appears in proposed legislation in Massachusetts—and was then rejected—relates to the duties of the medical examiner. Since 1945, state medical examiners have been charged with investigating deaths that are supposedly the result of abortion. 1945 Mass. Acts 669 (“When any person in the commonwealth is supposed to have died by. . . abortion . . . it shall be the duty of any person having knowledge of such death immediately to notify the medical examiner . . .”). Beginning in 1966 and repeating nearly every year for a decade, the legislature introduced a bill that would alter the language to include “deaths due to criminal abortion, whether apparently self-induced or not.” See, e.g. H.B. 2612, 164th Gen. Court Sess. (Mass. 1966). However, that language was never adopted and the medical examiner was only ever given the duty to investigate “death following an unlawful abortion.” MASS. GEN. LAWS ANN. ch. 38, § 3 (West). The implication is that the legislature did not wish to categorize self-managed abortion as criminal or unlawful.

⁵⁷ Means, *supra* note 3, at 488.

⁵⁸ See generally Roberts, *supra* note 10.

⁵⁹ See Anemona Hartocollis, *After Fetus is Found in Trash, a Rare Charge of Self-Abortion*, N.Y. TIMES (Dec. 2, 2011), <http://www.nytimes.com/2011/12/02/nyregion/self-abortion-charge-after-fetus-found-in-trash-in-washington-heights.html>; NBC4, *Self-Abortion Charges Dropped in Case of Fetus Left in Trash* (Jan. 3, 2012), <http://www.nbcnewyork.com/news/local/Self-Abortion-Fetus-Trash-Charges-Dropped-136608803.html>.

⁶⁰ Brian R. Ballou & Raja Mishra, *Alleged bid to abort leads to baby’s death*, BOSTON GLOBE, Jan. 25, 2007, at A1.

⁶¹ Raja Mishra, *DA Declines to seek murder charges in abortion case; Woman accused of using pills to end pregnancy*, BOSTON GLOBE, March 29, 2007, at B5. (“‘The baby was 25 weeks, and you can’t prove viability beyond a reasonable doubt at 25 weeks,’ said Steve O’Connell, a spokesman for the [DA’s] office.”).

⁶² Ballou & Mishra, *supra* note 60.

⁶³ Eileen McNamara, *Bad Choices All Around*, BOSTON GLOBE, Jan. 28, 2007, at B1.

⁶⁴ Jennifer S. Lee and Cara Buckley, *For Privacy’s Sake, Taking Risks to End Pregnancy*, NEW YORK TIMES, Jan. 4, 2009, at A15.

⁶⁵ Jill E. Adams & Melissa Mikesell, *And Damned If They Don’t: Prototype Theories to End Punitive Policies Against Pregnant People Living in Poverty*, 18 GEO. J. GENDER & L. 283, 323-24 (2017).

⁶⁶ See, e.g., *McCormack v. Hiedeman*, 694 F.3d 1004 (9th Cir. 2012); *Bei Bei Shuai v. State*, 966 N.E.2d 619 (Ind. Ct. App. 2012); THE SIA LEGAL TEAM, *ROE’S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL* (2018).

⁶⁷ Roberts, *supra* note 10, at 1432.

⁶⁸ *Id.*

⁶⁹ *Commonwealth v. Baker*, No. 98-912 (Mass. Super. Ct. Hampden County May 6, 1998); *Commonwealth v. Pugh*, No. CR2007-1323, 2009 WL 890988 (Mass. Super. Jan. 26, 2009), *rev’d*, 969 N.E.2d 672 (Mass. 2012).

⁷⁰ *Pugh*, at *4.

⁷¹ *Id.* at *6.

⁷² *Id.*

⁷³ *Pugh*, 969 N.E.2d at 686 (holding that “[w]hat constitutes reasonable conduct during labor defies ready articulation” and that “competent women who are pregnant may weigh [childbirth] risks themselves and make decisions about the course of their own pregnancies and childbirths.”).

⁷⁴ *Id.* at 683.

⁷⁵ *Id.* at 321-332.

⁷⁶ Phoebe Zerwick, *The Rise of DIY Abortion*, GLAMOUR (May 31, 2016, 9:00 AM), <http://www.glamour.com/story/the-rise-of-the-diy-abortion> (“Pills bought online or through a nonmedical source can be fake or contaminated, and it’s impossible to confirm the dose. ‘One patient ordered pills online – she thought they had worked, but they had not,’ a provider in the South told *Glamour*. ‘I saw her when she was in her second trimester. Instead of a simple early abortion, she needed a more complex procedure.’”).

⁷⁷ April L. Cherry, *Shifting Our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 J.L. & HEALTH 6, 24 (2015).

⁷⁸ Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 311 (2013).

⁷⁹ Eleanor J. Bader, *A Miscarriage of Justice for Dominican Immigrant*, <https://indypendent.org/2007/04/a-miscarriage-of-justice-for-dominican-immigrant/> (last visited March 8, 2017).

⁸⁰ *Id.* at 328.

⁸¹ Lawrence J. Nelson, *A Crisis for Women's Rights? Surveying Feticide Statutes for Content, Coverage, and Constitutionality*, 6 U. DENV. CRIM. L. REV. 63, 91 (2016) ("Common activities could possibly cause a miscarriage: working (e.g., as a law enforcement officer or fire fighter), playing sports, strenuous hiking or climbing, skiing, undergoing medical treatment dangerous to the unborn (e.g., chemotherapy), and driving. Pregnant women should be able to engage in activities like these without fear that doing so could turn them into criminals if the unborn they carry happens to die.").

⁸² Roberts, *supra* note 10, at 1422; Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POLICY REVIEW 70, 74 (2015); see also KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RADICALIZATION* 41 (2011), reprinted in MELISSA MURRAY & KRISTIN LUKER, *CASES ON REPRODUCTIVE RIGHTS AND JUSTICE* 155-59 (2015) ("[T]he pregnant women who decide to attempt prenatal care with state assistance find themselves . . . most decidedly within the reach of the disciplinary, regulatory and biopolitical state.").

⁸³ Roberts, *supra* note 10, 1432.

⁸⁴ Paltrow & Flavin, *supra* note 78, at 332.

⁸⁵ Nicholas Freudenberg, *Adverse Effects of US Jail and Prison Policies on the Health and Well-Being of Women of Color*, 92 AM. J. PUB. HEALTH 1895 (2002); see also Tamar Kraft-Stolar, *Reproductive Injustice: The State of Reproductive Healthcare for Women in New York's Prisons*, N.Y. CORR. ASSOC. WOMEN IN PRISON PROJECT (2015), <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf>.

⁸⁶ See, e.g., Tara Culp-Ressler, *Immigrant Woman Could Face Deportation After She Tried to Go To the Doctor*, SLATE, Sept. 14, 2015, available at <https://thinkprogress.org/immigrant-woman-could-face-deportation-after-she-tried-to-go-to-the-doctor-50cc535f3ba6>; NAT'L LATINA INST. FOR REPROD. HEALTH, PRESS RELEASE: THE NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH CONDEMNS NATIONWIDE ICE RETALIATION AND INTIMIDATION (February 10, 2017), available at <http://www.latinainstitute.org/en/national-latina-institute-reproductive-health-condemns-nationwide-ice-retaliation-and-intimidation>.

⁸⁷ National Institute for Reproductive Health, *When Self-Abortion is a Crime: Laws That Put Women at Risk*, 3-7 (June 2017), available at <https://www.nirhealth.org/wp-content/uploads/2017/06/Self-Abortion-White-Paper-Final.pdf>.

⁸⁸ Means, *supra* note 3, at 488.

⁸⁹ MODEL PENAL CODE § 201.11(3) (AM. LAW INST. 1962).

⁹⁰ MODEL PENAL CODE § 207.11 cmt. 9 n.35 (AM. LAW INST., Tentative Draft No. 9, 1959).

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.* § 207.11 cmt. 9.

⁹⁴ *Id.* § 207.11 cmt. 1(D).

⁹⁵ See *Roe v. Wade*, 410 U.S. 113, 208 (1973) (Burger, C.J. concurring).

⁹⁶ *Commonwealth v. Pugh*, 462 Mass. 482 (Mass. 2012). In the context of a woman being prosecuted for the death of her newborn after giving birth without medical assistance in her own bathroom, the Massachusetts Court held:

Although the vast majority of women elect hospital births, medically unassisted births continue to take place by choice and by necessity. "Children are born of unattended mothers on trains, in taxis, and in other out of the way places, and we fear to open up a field for unjust prosecutions of actually innocent women." Unassisted childbirth has always been a legally recognized alternative to medically assisted childbirth. All births, regardless of venue, carry inherent risks; in the ordinary course, competent women who are pregnant may weigh these risks themselves and make decisions about the course of their own pregnancies and childbirths.

Id. at 505-06 (quoting *State v. Osmus*, 276 P.2d 469 (Wyo. 1954)). “Pregnancy presents a unique circumstance because ‘anything which a pregnant woman does or does not do may have an impact, either positive or negative, on her developing fetus.’” *Id.* at 508 (quoting *Stallman v. Youngquist*, 531 N.E.2d 355 (Ill. 1988)).

⁹⁷ See *Reagan*, *supra* note 21, at, 1255.

⁹⁸ *Roberts*, *supra* note 10, at 1422; *Rowan*, *supra* note 82, at 74.

⁹⁹ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016); see also *Means*, *supra* note 3, at 453 (writing in 1968, “it is a matter for serious consideration whether the invocation of this recognized chief purpose of the police power of the State (citizens’ health and life) and no other (e.g., morals, population promotion, etc.) renders abortion statutes today . . . vulnerable to constitutional attack. Women have been deprived of an ancient common-law liberty in the name of health.”).

¹⁰⁰ *Moe v. Sec’y of Admin. & Fin.*, 417 N.E.2d 387, 400 (Mass. 1981) (holding that the state’s Medicaid program must cover medically-necessary abortion, noting that “[w]e think our Declaration of Rights affords a greater degree of protection to the right asserted here than does the Federal Constitution as interpreted by *Harris v. McRae*”).

¹⁰¹ See WORLD HEALTH ORG., INFORMATION SHEET: SAFE AND UNSAFE INDUCED ABORTION: GLOBAL AND REGIONAL LEVELS IN 2008, AND TRENDS DURING 1995–2008 (2012), available at http://apps.who.int/iris/bitstream/10665/75174/1/WHO_RHR_12.02_eng.pdf (describing the characteristics and occurrence of unsafe abortion, including many methods and types of self-managed abortion); Teresa A Saultes, Diane Devita & Jason D. Heiner, *The Back Alley Revisited: Sepsis after Attempted Self-Induced Abortion*, 10 WEST J. EMERG. MED. (2009). But see Daniel Grossman, *The New Face of Self-Induced Abortion*, HOUSTON CHRONICLE, Jan. 21, 2016, <http://www.houstonchronicle.com/opinion/outlook/article/Grossman-The-new-face-of-self-induced-abortion-6775378.php> (last visited June 19, 2017) (“This is the new face of self-induced abortion - in the U.S. and the world over. It’s rare that women use coat hangers. Now women are more likely to use misoprostol, a very safe and effective medication, to end an early pregnancy without additional intervention.”).

¹⁰² See generally *Roberts*, *supra* note 10.

¹⁰³ GUTTMACHER INST., FACT SHEET: INDUCED ABORTION IN THE UNITED STATES, (Jan. 2017), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states> (last visited June 19, 2017).