https://doi.org/10.5281/zenodo.17116523

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DIY Abortion in Context (late 20th – 21st Century)

Abstract: *Reproductive choices are strategic life choices. The decision to continue or interrupt a pregnancy is influenced by personal lifestyle, beliefs, and values, notwithstanding social biases and politics. The choice of the method to achieve an induced abortion might be complex. The national legal context can be crucial to one's decision-making regarding surgical or medical abortion, and in which setting. After the introduction of the abortion pills misoprostol and mifepristone, there has been a steady increase in demand for medical abortion, either with professional assistance or in a do-it-yourself (DIY) way.*

In this article, I will focus on what influences a pregnant person to choose a self-managed medical abortion. I will discuss aspects of the legal, social, and political contexts that favour such a choice, along with the personal motives. Although the state's population policies regarding the availability and access to contraception and abortion impact individual decision-making, the final decision is multifactorial.

We will examine diverse European national contexts concerning abortion and contraception to demonstrate that self-managed medical abortion is supported by women regardless of whether they live in countries with liberal abortion legislation. The historical period under consideration will begin in the late 20th century and continue into the 21st century. The selection of this time frame is based on a series of significant and transformative events that took place during this period, including the demographic repercussions of the Second World War, the introduction of oral contraceptives, the reform of abortion laws, the fall of Communism, and the advent of medical abortion pills.

Keywords: *abortion; self-managed abortion; self-care; self-control; reproductive autonomy; reproductive choices.*

Introduction

In the aftermath of the Second World War, pronatalist policies were implemented in European countries to stimulate population growth by restricting access to abortion and contraception. The ultimate goal was to recover the human losses of the war, rebuild the state, strengthen the workforce, and revive the military sector (Quine, 1996). Inevitably, these policies primarily targeted female bodies and minds,

glorifying motherhood while simultaneously condemning the choice of being childless or having a small family. Population policies reminiscent of Vichy's regime in France, which actively intervened in family life, are an excellent example of pronatalism. Similar eugenic policies originated from the interwar period and flourished in the post-war years (Turda and Gillette, 2014). In a different context, in the Union of Soviet Socialist Republics (USSR), motherhood was deprioritised because the state needed its female human capital to strengthen its workforce. Not surprisingly, the USSR liberalised abortion as early as 1955 (David, 1992; Flood, 2002).

Although the need or desire to terminate a pregnancy has existed for as long as motherhood itself, the right to a safe abortion in a fully equipped state hospital has only been legally permitted in most European countries since the 1970s. The United Kingdom led the shift toward more liberal abortion legislation in 1968. It paved the way to similar reforms in the German Democratic Republic in 1972, followed by Denmark, Sweden, France, Austria, Luxembourg, Italy, the Netherlands, Portugal, Spain, Greece and Belgium by the end of the 20th century (David, 1992).

In countries where abortion was illegal or permitted under exceptional circumstances, often excluding social, psychological or financial reasons, women resorted to self-managed abortion or clandestine surgical abortion due to fear of prosecution. Self-managed abortion has been practised in diverse social and political settings, often posing considerable health risks. Among the range of methods to achieve a self-induced abortion, ingestion of herbal abortifacients has been the most popular (Jerman et al., 2018; Upadhyay et al., 2022). In particular, Delay (2018) notes that Irish women preferred herbal abortifacients, perceived as a 'natural' way to induce abortion. Even though most herbs may not pose significant toxicologic risk, others, such as pennyroyal, blue cohosh, rue, and quinine, can result in adverse clinical events (Feng et al., 2023). Clandestine surgical abortions were a common practice worldwide as well. Predominantly performed by non-licensed obstetrician-gynaecologists, they often resulted in maternal injury and death (Karlin and Joffe, 2023; van den Dungen and Gomperts, 2024).

Since their introduction into European pharmaceutical channels, beginning in France in 1988, the medicines misoprostol and mifepristone have been used to induce abortion (Winikoff et al., 2011). Typically, the pregnant person consumes mifepristone, followed by misoprostol 24 to 48 hours later or only misoprostol (Feng et al., 2023). In

countries where abortion pills are legal, women are free to choose this method to terminate an unwanted pregnancy, obtaining them in pharmacies or national clinics.

In contrast, in countries where all methods of abortion are prohibited or permitted only under certain medical conditions, women are often forced to order the drugs online and use them in secrecy, sometimes without any professional assistance (van den Dungen and Gomperts, 2024). However, in today's borderless and interconnected world created by the widespread use of the internet, legal barriers could be overcome by those seeking self-managed abortions. Ordering misoprostol and mifepristone online bypasses legislation and avoids the authorities' control. Furthermore, online orders facilitate access for specific social groups, such as women living in war zones or refugees. The major online supplier of abortion pills is the Canadian non-profit organisation, Women on Web (hereafter WoW). This is a group of people who facilitate access to abortion pills by mailing them free of charge to nearly 200 countries worldwide (Aiken et al., 2021). Even so, their website has been blocked in countries such as South Korea and, until recently, Spain (WoW, n.d.).

Access to family planning information and contraception is essential and should be considered in discussions of abortion. As David (1992) argued, legal abortion is most meaningful when it is included in the state's reproductive healthcare services as part of a family planning program. As will be shown, in countries where both contraception and abortion are banned, illegal abortion is used as a contraceptive method, ultimately resulting in higher abortion rates (Marston and Cleland, 2003). Conversely, in countries with liberal abortion legislation and easy access to contraceptives within a culture that supports reproductive freedom, abortion rates tend to remain low. Notably, maternal deaths due to unsafe, illegal abortions are reduced as well (Hord, 1991; Marston and Cleland, 2003). Indeed, the legal liberalisation of abortion alone is insufficient – the freedom and ability to exercise the right to contraception and abortion are multifaceted. As will be argued, shame and stigma surrounding abortion are social factors that equally impact reproductive freedom. For state population policies to be fruitful and effective, they should be implemented within a social framework of acceptance and solidarity, alongside adequate logistics and healthcare infrastructure coordination. As Vedhuis (2022) correctly points out, the decriminalisation of abortion services does not guarantee their wide-

spread availability. Failing to acknowledge abortion care as a component of standard reproductive care and as part of free family planning services renders its legalisation meaningless.

Research in countries such as Romania, which experienced radical shifts in abortion and contraception policies between the 1960s and the 1990s, reinforces the argument that legislation affects individual decision-making, as reflected in changing abortion and fertility rates. However, the decision not to terminate an unwanted pregnancy was motivated by fear of prosecution rather than by persuasive state messaging. The legalisation of abortion and the subsequent reversal of Romania's total fertility rates demonstrate that personal rationale did not commonly coincide with the state's pronatalist policies (Bradatan and Firebaugh, 2007; Benson et al., 2011). At the same time, the fact remains that no legal restriction has ever eliminated abortions.

This article presents a comparative, cross-cultural study focused on European countries and their approaches toward fertility management, abortion, contraception, and reproductive choices. Its purpose is to identify common incentives for self-managed medical abortion among women in politically and culturally diverse European regions. Since individual reproductive decisions are intertwined with state population policies, we will demonstrate examples of legal, political and socio-cultural contexts which were conducive to abortion in general and self-managed medical abortion in particular.

Although generalisations in such diverse cultural settings would be at best inaccurate, our research identified some shared features. Irrespective of the legal status of abortion, there is a universal tendency to obscure the process from the authorities due to stigmatisation (van den Dungen and Gomperts, 2024). According to the overview data, when possible, women prefer to undergo surgical abortion in a private practice rather than in a public clinic. Furthermore, the fact that self-managed medical abortion can be carried out in complete secrecy gives the pregnant person the power to decide for themselves without conforming to the legal constraints and sociopolitical biases.

Abortion is a strategic life choice that primarily concerns the pregnant person; as such, its gendered dimensions cannot be ignored. This analysis focuses on women who get pregnant, decide to terminate their pregnancy, and opt for self-managed medical abortion. The methods used may vary, but the underlying desire for self-care and self-control remains the same.

Methodology and Sources

Given that self-managed medical abortion can be carried out in secrecy and anonymity, reliable demographic data are rare or non-existent. In addition, even when there is data on the sales of misoprostol and mifepristone, there is no guarantee that an abortion has occurred. A woman might change her mind and, ultimately, decide not to terminate her pregnancy. There is also the possibility of taking the medication after 12 weeks of gestation, when the process may fail (WHO, 2022). As a result, research on self-managed medical abortion is primarily based on published fieldwork studies, rather than official statistics.

In this context, the use of anonymised data provided by the Google platform has gained traction among researchers studying self-managed medical abortion. Some publications are almost exclusively based on Google Analytics, as it offers a way to capture the global or national trends in the demand for self-induced abortion (Jerman et al., 2018; Upadhyay et al., 2022). Following this methodology, non-academic publications in lay journals and newspapers have also emerged. The fact that the number of Google searches for abortion pills increases is alarming (Butterly et al., 2018). Findings showed that people primarily search for abortion pills, information about abortion, potential implications, and how to access abortion care (Pizzarossa and Nandagiri, 2021). Anonymised data coming from the WoW platform is also valuable for researchers. To a certain extent, data from Google and WoW is a method to overcome the unreliability of official data and help capture the real position of self-induced abortion within the broader spectrum of abortion choices.

Although studies based on Google Analytics and the WoW platform statistics have been used in this article as secondary sources, the core methodological approach and sources are based on a bibliographical review. The bibliography includes published scholarship in medical humanities, gender studies, demography and legal studies. Although the article focuses on the European context, relevant qualitative and demographic studies from other parts of the world are also considered. The following sections outline key aspects of the historical trajectories of abortion and contraception from the post-war period to the 21st century, intending to elucidate the social, political and legal factors that influence individual reproductive choices. The particularities of the COVID-19 pandemic will also be addressed due to its effects on the rise of telemedicine and DIY abortion at home.

Definition of the Process and Access to Abortion Pills

The process of terminating one's pregnancy outside a formal clinical setting or healthcare institution is commonly referred to as Do-It-Yourself or self-managed abortion (Moseson et al., 2020; Pizzarossa and Nandagiri, 2021; Hoggard et al., 2024). As previously mentioned, historically, attempts at self-managed abortion involved the use of herbal abortifacients or other non-medical means (Delay, 2018; Feng et al., 2023). In this article, however, I will focus on self-managed medical abortion. Depending on a woman's preference and accessibility, there are two main types of medical abortion: a clinical one, which involves a healthcare professional – either a gynaecologist or lay healthcare professionals – and an autonomous one with no medical assistance. In the former case, abortion can be initiated or completed in a clinical setting or remotely via telemedicine. In the latter, the woman may complete the process independently or with support from non-medical staff (Vedhuis et al., 2022).

As a non-surgical method, medical abortion allows women to avoid the health risks associated with surgical intervention. It is seen as a more 'natural' way to induce abortion, as it resembles a miscarriage (Delay, 2018; Moseson et al., 2020). Not to mention, self-managed medical abortion is much cheaper than surgery or even free of charge in countries where the medication is state-subsidised and prescribed by a physician. However, self-managed medical abortion might fail if the gestational age is more than 12 weeks, in which case a surgical abortion becomes necessary (Moseson et al., 2020; WHO, 2022).

Determined by the legal context, access to abortion pills can be obtained in a clinic or pharmacy in countries with liberal laws, by online order in countries where abortion is restricted, or by travelling to a country where abortion pills are legal. Medical tourism for abortion, either to have it in a clinic or to buy the pills, has been done for many years. In Europe, notable examples are women travelling from Northern Ireland and Malta to England and from Poland to Germany (Delay, 2018; Dibben et al., 2023; Kuźma-Markowska and Kelly, 2022).

Since the 1990s, abortion medications have been approved in several European countries, beginning with France in 1988, followed by Great Britain and Sweden in 1992, and then Belgium, Denmark, Finland, the Netherlands and Germany in 1999 (Winikoff et al., 2011). Medication abortion became officially available more widely after the World Health Organisation declared it safe in 2005. According to the latest 2022 list of nationally authorised medicinal products, misoprostol

is authorised in Austria, Poland, Belgium, Denmark, Spain, Finland, Greece, Ireland, Iceland, Italy, Luxembourg, Netherlands, Norway, Portugal and Sweden (European Medicines Agency, 2022). As of the latest 2024 list, mifepristone is authorised in Finland, Lithuania, Iceland, Bulgaria, Romania, Estonia, Cyprus, Greece, Netherlands, Spain, Austria, Czech Republic, Denmark, France, Ireland, Norway, Finland, Germany, Sweden, Slovenia, Croatia, Portugal, Latvia, Italy, Belgium, Luxemburg (European Medicines Agency, 2024).

The Legal, Social and Political Context of Abortion and Contraception

Specific periods in modern European history have influenced reproductive health, placing it at the centre of health policies and public concern. These were the aftermath of the Second World War (1950s), the introduction of oral contraceptives (1970s), and the fall of Communism (1990s). These periods coincided with urbanisation, the resurgence of feminism, and advances in biomedicine and technology.

In the 1950s, the political situation in Europe was still unstable. Seeking social and political stability, most European countries were in the process of reconstruction of infrastructure, policy-making, and population management. To recover from the significant losses of the war, widely disseminated pronatalist policies promoted big and healthy families that would restore the number of workers and soldiers (Quine, 1996). As a result, we witnessed the resurgence of eugenics in many European countries during the post-war period (Bashford and Levine, 2010; Barmpouti, 2019). In the name of demographic growth, abortion laws became stricter, and access to contraceptives was often banned. Subsequently, in the 1960s, many Western European countries, such as France, faced overpopulation during the so-called ‘baby boom’ (Brée, 2017), while Southern European countries experienced a high number of illegal abortions (David, 1992; Sedgh et al., 2007).

In the late 1960s, the arrival of ‘the pill’, the first hormonal oral contraceptive, marked a groundbreaking change to the long-standing insecurity of traditional contraceptive methods. This so-called modern contraceptive offered reliability and reassurance to the user. Its widespread use in some countries resulted in a gradual decline in abortion rates (Marston and Cleland, 2003). The link between abortion and contraception is demonstrated in the pattern suggesting that in countries where contraceptives are readily available, abortion rates are lower. In reality, this rule is often complicated by factors such as the cost and

type of contraceptives available and the prevailing national attitudes toward contraception. Accordingly, in low-income countries, where 'modern' hormonal oral contraceptives and intrauterine devices (IUDs) are too expensive to buy or in short supply, poorer couples use traditional, less reliable contraceptive methods, such as condoms or withdrawal, which can result in unwanted pregnancy. During Căușescu's regime in Romania, for instance, wealthier women could afford to buy contraceptives illegally or bribe doctors to perform abortions under the guise of a life-threatening condition. At the same time, poorer women risked their lives and freedom by undergoing backstreet abortions (Haliliuc, 2013). In Bulgaria, modern contraceptive methods were not introduced until 1975. In line with the above-mentioned correlation between abortion rates and effective contraception, Bulgaria witnessed a decline in abortion in the late 1980s and 1990s – a pattern similarly observed in Denmark and the Netherlands (Marston and Cleland, 2003).

In the absence of contraceptives, safe reproductive control relied heavily on repetitive abortions. A 1969 demographic field study in Greece found that abortion was considered and used both as a contraceptive and as a remedy for an unwanted pregnancy (Barmpouti, 2015). Couples interviewed for the study categorised abortion alongside other contraceptive methods (Valaoras et al., 1969). Similarly, in the context of the USSR, where both abortion and contraception were legal, the availability of contraceptives was low. Factors, such as cost, logistics and availability, could be crucial to the access and consistent use of contraceptives. In addition, given the vast geography of the USSR, not all regions had healthcare facilities capable of providing contraception or performing abortions, despite both being legal. As a result, abortion was frequently used as a contraceptive, raising its incidence in the country (Marston and Cleland, 2003). In terms of the socio-political environment, Marxist ideas and values emphasised intense labour, materialism, and atheism, framing women's roles more as workers than as mothers. As Flood explicitly put it, 'legalised, state-funded abortion was a way to encourage women to devote their energies to build socialism, not families' (Flood, 2002: 191). Romania and Poland followed the same route, legalising abortion in the 1950s (Flood, 2002).

Romania, only a decade after legalising abortion, shifted to stricter legislation on abortion and contraception (Bradatan and Firebaugh, 2007). In 1966, Ceaușescu's regime passed a law that made abortion illegal for women under forty or those with fewer than four

children. Creating large families became a national duty (Haliliuc, 2013: 113). After Ceaușescu's overthrow, the government of Romania liberalised abortion legislation again (David, 1992). The change of regime impacted broader family planning policies. Former communist countries, including Bulgaria, Hungary and Romania, embraced a more pro-natalist perspective, thus restricting access to both abortion and contraception (Flood, 2002).

European legal frameworks commonly permit abortion when the life of the mother or the fetus is at risk, except Iceland, which was the first country to introduce the concept of medicosocial indications, followed by the United Kingdom, Denmark, and Sweden (David, 1992). During the post-war period, when pronatalist policies were widely disseminated, the emotional and psychological health of the mother was often neglected. As mentioned earlier, a global trend toward liberalising abortion laws emerged only after 1975. The majority of European countries replaced their strict abortion regulations with new laws permitting broader grounds for terminating a pregnancy, including socio-economic reasons (UN, 2002). This wave of legalisation at the end of the 20th century acknowledged the psychological, social and financial burdens of an unwanted pregnancy and provided greater protections for the pregnant person.

A striking exception was the Republic of Ireland, which legalised abortion as recently as 2018. The anti-abortion movements that formed in the second half of the twentieth century played a key role in limiting social acceptance of abortion and sustaining abortion stigma. In 2020, Poland saw a significant legislative shift when abortion for foetal defects and abnormalities became illegal. Kuźma-Markowska and Kelly's (2022) research showed that anti-abortion activism was decisive in this respect.

Between 1996 and 2003, several Eastern European countries – Bulgaria, the Czech Republic, the Russian Federation, Hungary, and Slovakia experienced a decline in abortion rates, most probably due to increased use of modern, safe contraceptives. Nevertheless, these countries still report the highest abortion rates in Europe (Sedgh et al., 2007). David (1992) attributes high abortion rates to persistent taboos around sexuality, even if these countries implemented liberal laws on abortion long before oral contraceptives. In contrast, he argues that open attitudes toward sexuality and the introduction of sexual education in early school years have been critical factors for the low abortion rates in the Netherlands and the Scandinavian countries (David, 1992). During the

same period, abortion rates in Northern, Western and Southern Europe remained relatively stable except in the Netherlands, where the rate increased by 31%. This was mainly due to women seeking abortions from ethnic minority groups (Sedgh et al., 2007). Demographic research has shown that maternal mortality rates have dropped significantly following the adoption of liberal abortion laws. Culturally diverse countries such as Sweden and Hungary witnessed the same sharp decline in maternal deaths after legalising abortion in the 1970s (Marston and Cleland, 2003).

It is undeniable that women undergo abortions everywhere, regardless of legal context, but illegal abortions carry a high risk of maternal mortality. According to Hord, nearly 87% of maternal deaths during Ceaușescu's regime were the result of unsafe abortions (Hord, 1991; Marston and Cleland, 2003; Haliliuc, 2013). Maternal deaths tend to decrease significantly when abortion is performed in a safe environment by trained professionals (Benson et al., 2011). Furthermore, self-managed medical abortion is safer than clandestine surgical abortion in countries with restrictive laws (Aiken et al., 2017; van den Dungen and Gomperts, 2024).

Not surprisingly, DIY abortion is more common in countries where relevant legislation restricts or entirely forbids abortion anywhere in the country, even within healthcare institutions. In such contexts, both the pregnant woman and the healthcare professional who assists with the abortion face prosecution and incarceration. In Malta, for example, a woman who induces abortion risks three years in prison, while the healthcare provider who assists her risks four years of imprisonment and, if they are a physician, the loss of their medical license. As a result, self-managed abortion or travelling to another country remains the only option for those facing unwanted pregnancies. The main difference between the two options is that when travelling abroad, the home country has no legal jurisdiction; on the contrary, if self-medication abortion is discovered, the woman will face prosecution. Dibben's research on Maltese abortion seekers indicated an ongoing shift toward self-managed medical abortion, particularly following the COVID-19 travel restrictions (Dibben et al., 2023).

Incentives for Self-managed Medical Abortion

Paradoxically, research shows that even in countries with liberal legislation, there is a trend to choose at-home abortion. Hospital care is often rejected by women who prefer to undergo an induced abortion in

the comfort of their own space. Just as some women choose to give birth at home, to be with their partner and relatives, they may decide to undergo a self-induced medical abortion at home with their loved ones, even when the country they live in permits abortion at a clinic (Moseson et al., 2020; Hoggart, 2024).

The recent COVID-19 pandemic exacerbated this trend while demonstrating the safety and effectiveness of self-managed medical abortions. The fear of infection during the COVID-19 pandemic heightened demand for abortions outside of clinical settings, promoting DIY abortions. To avoid potential infection, pregnant women and healthcare practitioners choose self-medication abortion at home, often supported by online guidance and physicians via telemedicine (Aiken et al., 2021; Pizzarossa and Nandagiri, 2021). Before the pandemic, England, Wales, and Scotland had already incorporated the procedure into medical protocols, allowing women to take mifepristone in a clinic and misoprostol at home. Therefore, during the COVID-19 pandemic, women and physicians in these countries were already familiar with self-managed medical abortion at home. According to Hoggard et al. (2024), this was not the case for their neighbours in Northern Ireland, where the legislation continued to restrict abortions even during the pandemic. That self-managed medical abortion proved to be safe and effective was then more widely recognised, particularly due to the widespread use of abortion pills during this period (Fay et al., 2023). According to the World Health Organisation (WHO), when self-managed medical abortion is performed according to the guidelines and particularly with the aid of a healthcare professional, it carries minimal risk (WHO, 2022).

Combining data on abortion rates and the growing acceptance of medication abortion suggests that the availability of abortion pills has not increased the overall incidence of abortion (Sedgh et al., 2007). Medical abortion partly replaced surgical abortion, mainly due to shifting attitudes toward reproductive issues. Abortion has been socially and individually reassessed in light of modern values, beliefs and lifestyles. Women have taken their reproductive decisions out of the hands of physicians and politicians and into their own, exercising reproductive freedom alongside rights to self-care, self-control, and autonomy. A pregnant person takes control of their life because an unintended pregnancy may disrupt life plans, including education or career goals, not to mention the financial burden of raising a child (Pizzarossa and Nandagiri, 2021; van den Dungen and Gomperts, 2024).

Recent scholarship suggests that the freedom to exercise reproductive autonomy and self-care is the leading incentive for self-managed abortion, followed by the emotional safety and comfort of home, and the ability to undergo the process with a partner or family, or all alone (Pizzarossa and Nandagiri, 2021; Feng et al., 2023; van den Dungen and Gomperts, 2024). Furthermore, it allows for complete secrecy and anonymity, which may be necessitated by legal constraints but may also stem from social stigma or personal choice. A pregnant person is entitled to end a pregnancy without disclosing it.

In addition to the feeling of safety and security, women may prefer self-managed medical abortion because they consider it better for their health and well-being than surgical abortion (Aiken et al., 2017). Medical abortion is perceived as less invasive than a surgical one (Delay, 2018; Moseson et al., 2020).

In terms of the patient-doctor relationship, self-managed medical abortion can be interpreted as a way of resisting medical paternalism (Pizzarossa and Nandagiri, 2021; Karlin and Joffe, 2023; Hoggart, 2024). Doctors' authority often influences women's attitudes and final decisions. In addition, self-managed medical abortion is a way to overcome the reluctance or objection of health professionals to perform an abortion on moral grounds (David, 1992). Ultimately, as Karlin and Joffe argued, self-managed medical abortion challenges medical authority by contributing to the 'demedicalisation' of abortion. The process involves ingesting pills which are accessible online, thus making the physician's involvement optional (Karlin and Joffe, 2023). Nevertheless, professional involvement in assessing one's medical history and counselling is deemed essential for the procedure's safety.

Furthermore, self-managed abortion is often free of charge, whereas the operation, particularly in private practice, can be costly. In rural areas, access to surgical abortion may involve travel to a clinic, time off work, travel and accommodation costs, or even the need for childcare if the pregnant person already has children (Upadhyay et al., 2022; Feng et al., 2023). Therefore, it is crucial to recognise the financial aspect, which encourages women to prefer medical to surgical abortion.

It is important to note that not all people think and feel the same way about abortion. There is no single profile of an abortion seeker, but many. They may be single women who want to avoid or delay the birth of a child for medical, personal or social reasons. Moreover, couples may choose abortion to space or end childbearing. Generally, desired

family size depends on socioeconomic status, individual aspirations, or medical reasons (Marston and Cleland, 2003). Undeniably, women have multiple roles, and society expects them to manage all of them optimally. As discussed in the context of pronatalist policies, giving birth has been a unique mission as it is subject to familial, social and political pressures. Legislation, social shame and stigma frequently determine decision-making (van den Dungen and Gomperts, 2024).

Anti-abortion legislation often reflects anti-abortion sentiments of a given society (van den Dungen and Gomperts, 2024). Stigmatisation is reinforced by anti-abortion activism, which has recently been revived in the US and now influences Europe (Kuźma-Markowska and Kelly, 2022). Furthermore, in countries where the Christian Church is powerful, such as the Catholic Church in Ireland and Poland and the Orthodox Church in Greece, having an abortion is highly stigmatised and condemned as it is equated with murder. The Church's condemnation of abortion does not necessarily mean that all citizens are practising believers or strongly influenced by its moral teachings. However, it is indisputable that religion plays a vital role in a society's culture. Particularly in countries such as Greece and Ireland, where a dominant religion is officially recognised, its teachings exert direct or indirect influence on abortion seekers (Valaoras et al., 1969; Barmpouti, 2015; Kuźma-Markowska and Kelly, 2022).

Conclusion

The transformative events of the mid-20th to early 21st centuries reshaped both population policies toward abortion and contraception and individual reproductive choices. Self-managed medical abortion is not simply one method among others. It can be understood as a means of exercising reproductive autonomy and self-care. The introduction and dissemination of abortion pills challenged ideas regarding reproductive issues, reduced social stigma and lowered the cost of the procedure. It has been shown that this form of abortion is increasingly accepted by women, particularly after the WHO confirmed its safety when performed under the guidelines. It seems a reasonable choice in countries with strict abortion legislation, yet recent research shows it is increasingly preferred in countries with liberal legislation, too. As discussed, the incentives behind the preference for self-managed medical abortion over surgical abortion are rooted in the desire to exercise self-control and reproductive autonomy and the physical and emotional comfort it encompasses.

All in all, self-managed medical abortion offers precisely what its name implies: the ability of the pregnant person to manage their condition in a way that feels dignified, comfortable and safe. It succeeded in protecting women from social biases, legal prosecution and stigma, simultaneously giving them the freedom to terminate their pregnancy in a way that aligns with their attitudes, lifestyles and values.

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