A Place for Herbal Abortion in Clinical Herbalism

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Angelica archangelica (angelica)
SOURCE: Pixabay, 2018.

The authors were approached as experts to collaboratively analyze community-led herbal abortion data. Daena Horner is an herbalist, abortion doula, and founder of Holistic Abortions. Molly Dutton-Kenny is a midwife, abortion provider, and educator. Ember Peters is a clinical herbalist and educator. Cheré Suzette Bergeron is an advanced holistic nurse, clinical herbalist, and educator. Amanda Jokerst is a clinical herbalist, Maya Abdominal Therapy practitioner, and fertility awareness and sexual health educator.

Most Western herbalists don't talk about herbal abortion. Herbal abortions exist at the unfortunate intersection of social stigma and criminalization, and the topic remains relatively untouchable in contemporary Western herbal practice with few exceptions (Culpepper 2017; Red Door Collective 2019; Ford 2020). Western herbalists often approach herbal abortions as unsafe, ineffective, or otherwise unnecessary in the context of modern medicine. This attitude negates not only a long, multicultural history of herbal medicine for abortion provision but also a thriving community practice of herbs as primary and adjunct therapies for abortion care outside of the formal medical system. Herbal abortion practices have persisted and remain in use in many communities globally (Netland and Martinez 2000; de Boer 2014), despite the lack of abundant academic reporting and avoidance by Western professional herbal communities.

This paper will discuss a selection of successful herbal-only abortion case results from a first-of-its-kind research project analyzing data from non-medical community abortion providers in the United States and Canada, including clinical herbalists, and safely guided herbal abortions. We hope to show that under skilled guidance, herbal abortions can be a viable abortion option, often sought out and valued by individuals and communities as the first choice for abortion care. We also evaluate perceivable patterns in formulation, dosage, and timing of herbal regimens used in successful herbal abortions and present a selection of three cases for consideration.

Context

People around the world successfully practice varied methods of abortion care without medical oversight (Ciganda and Laborde 2003; Browner 2014; Foster et al. 2017; Gerdts et al. 2018; Moseson et al. 2022). For most of human history, people have relied exclusively on traditional medicines, including herbs, for fertility management, and pregnancy termination (Federici 2004; Schiebinger 2008). It took concerted repression and control efforts from both state and non-state entities to force

Artemisia vulgaris Mugwort, Common wormwood. SOURCE: Wikimedia Commons

abortion care, along with many other aspects of reproductive care, into the exclusive domain of white, male-dominated, gynecology rooted in medical racism and patriarchal violence (Goodwin 2020). In attempts to shift public opinion, extensive campaigns initiated in the 1800s attacked, delegitimized, and criminalized traditional abortion care providers, including midwives, herbalists, and Black, Indigenous, and other racialized community healers (Reagan 1998; Federici 2004; Goodwin 2020).

In June 2022, the United States Supreme Court decided *Dobbs v. Jackson Women's Health Organization*, effectively overturning its previous landmark decision of *Roe v. Wade* and significantly restricting abortion rights and access for the American public (Dobbs 2022; McCammon and Totenberg 2022). Since the *Dobbs* decision, sweeping statements by herbalists (Romm 2022; Funke 2022; Gupta 2022), and members of mainstream media (Dickson 2022) along with social media platforms (Brown 2022; Sass_USA 2022) have perpetuated stigma and fear of herbal abortions. These public claims about the ineffectiveness and danger of herbal abortions are largely made without acknowledging the global practice of herbal abortion or its larger context in society. While self-managed abortion with medication has been widely studied in the United States (Aikin et al. 2022), a lack of reliable data on herbal abortion and the silence of many herbalists along with the potential criminalization of supporting abortion has resulted in a public discussion that is more opinion rather than an informed critique of herbal practice. This dearth of discussion has left many to self-manage and promote misguided or incomplete information on herbal abortions. When people attempt herbal abortions without support and knowledge as to safe and effective practices, they potentially risk their health and safety and are more likely to find themselves frustrated with an incomplete or

ineffective abortion.

Despite the limited knowledge and continued criminalization of non-clinical abortions in the United States, community-driven resources continue to collect the stories of people using herbs for their fertility management. These groups and individuals reveal a multi-faceted narrative that demonstrates how herbal abortions can be safe and effective in some cases (Bennett and Schuler 2011; Zeus 2014; Kress 2022). While there are some herbalists and other providers who discuss and share information about herbal abortion (McGregor 1993; Annwen 2002; Jeunet 2007; Horner 2022), the wider Western professional herbal community does not. Upholding narratives that herbal abortions are always dangerous or that medical professionals or published research are the undisputed experts on every body and every pregnancy serves to erase a long history and the continued lived experience and preference for community-led abortion care.

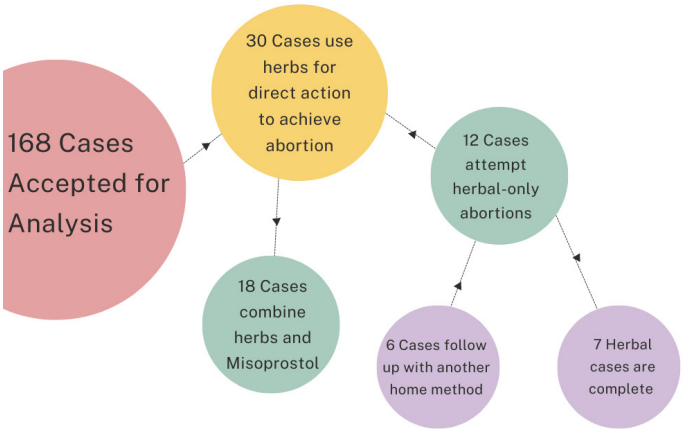
With this article, we begin to fill the current gap in herbal abortion research with scientifically gathered data and case study narratives written and analyzed by experienced herbalists. We examine successful herbal-only abortions to determine overall outcomes, including safety and efficacy. We analyze factors such as gestational age, the synergy of formulation and timing, herbal actions, and the impact of having experienced support. Our hope is by sharing this research, possibilities will expand for future research and community funding opportunities, and Western herbalists may develop a deeper respect and appreciation for herbal abortion methods. Overall we hope it will increase the full range of access and options to safe and effective abortions.

Study Overview

Statistics and case studies on herbal abortions used for this discussion were made available to authors through Community-Based Participatory Research (CBPR) studying community-led abortions in the United States and Canada from 2018-2021 (Dutton-Kenny et al. 2022). This study was approved by the Institutional Review Board of the University of Washington and funded by the Society for Family Planning. Community-led abortion care included direct abortion support and provision by trained individuals and groups without medical licensure or clinical oversight. Documented abortion methods included herbs, medications, vacuum aspirations, and various combinations of methods until achieving complete abortion. Extensive security measures were taken to protect the identities of participants and clients due to the ongoing criminalization of this work. Data was collected through a secure case questionnaire filled out electively by participants after cases met inclusion criteria.

25 anonymous community providers with knowledge and skills in holistic abortion care participated in the research project. Of the 168 at-home abortion cases accepted for analysis, community providers recommended herbs in 30 (18%) cases, either alone or in combination with other methods. Intentional combinations of herbs and misoprostol, a common medication used to induce abortions and miscarriage (Lexicomp 2022), were employed in 18 cases, and 12 clients attempted to use herbs alone as their first choice (Figure 1).

Figure 1. Herbs and community-led abortions



Results and Outcomes

Collected data included 12 attempted at-home abortions with herbs as the sole primary method. Seven of these 12 cases (58%) resulted in a complete abortion with herbs alone on the first attempt. The remaining six cases required continued community care with additional at-home abortion methods; 80% used medication and 20% used at-home extractions for an ultimate 100% complete at-home abortion rate. In this paper, we will narrow our focus on analyzing the results and patterns of the 12 cases attempting to use herbs alone for abortion, and more specifically the patterns in the seven successful herbal-only cases.

Of the seven successful herbal-only abortions, all were started at early gestation. Methods of

reporting gestational age were variably reported, and not every provider specified if the age range was estimated using the last menstrual period (LMP) or from conception. While the formal standardized measurement of gestation is based on LMP and relies on ultrasounds for precise dating, some clients and community providers may have based the estimation of the length of pregnancy from the time of conception. This lack of detail in data collection creates a potential inconsistency in data, resulting in a variation of up to two weeks for each estimated gestational age given. For the sake of data analysis, we used LMP, as this was the measurement most likely used by providers. Expert extrapolation puts all successful herbal-only abortions as begun before six weeks LMP.

Pregnancies were confirmed with home pregnancy tests (83%), ultrasounds (8.3%), and missed menses (58%). The average duration of the herbal-only abortion process from start to finish was 8.8 days, ranging from two to 20 days. All successful herbal-only abortions with a duration of more than seven days took breaks from herbs for one to two days and were able to return to adjusted protocols for completion.

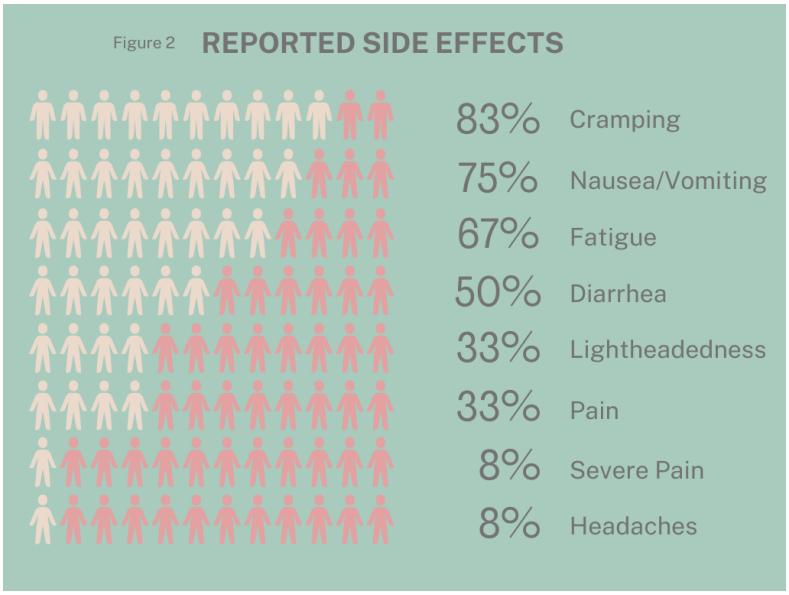


Figure 2. Reported side effects
Reported side effects of cramping, nausea, and fatigue (see Figure 2 for a full list of side effects) with herbal-only abortions were consistent with common side effects from any method of abortion, which also include gastrointestinal upset, cramping, nausea, and fatigue. There were no reported complications with the herbal-only attempts. Complications were defined as requiring outside medical attention for resolution. One case noted "near toxicity" after 10 days of an herbal protocol, though specific symptoms were not outlined. For this case (see Table 4, Client #71 for details of protocol) these unspecified symptoms were managed at home with hydration and taking a break from the protocol for one day, after which the client resumed herbal protocol with adjustments to the formulation and dosage resulting in a complete abortion.

Clients used an average of 4.4 plants per case. Protocols changed and shifted from start to finish in 75% of cases to address side effects or to prioritize different herbal actions at different stages of the abortion process to increase efficacy. Providers employed a range of herbs and varying protocols based on accessibility, regional location, and individual assessments including health histories, the ancestral identity of provider and client, and personal experience with specific plants. The most commonly used herbs were: *Petroselinum crispum* (parsley) leaf pessaries (85%), *Gossypium herbaceum* (cotton) root bark tincture, *Actaea racemosa* (black cohosh) root tincture, infusions of *Artemisia vulgaris* (mugwort) leaf, and decoctions of *Zingiber officinalis* (ginger) rhizome (57%). Table 1 as well as the Case Study Tables 2-4 show detailed doses and preparations. Support was provided in person for 58% of cases and the roles of the provider included consultation about expectations for normal responses to the herbal protocol, emotional and spiritual support, complications management, and vital signs monitoring. Most clients (84.5%) were already connected and in community with herbal providers or came through trusted referrals. In 92% of cases, clients reported having previous experience with herbal medicine. Figure 3 illustrates the motivations of clients seeking the provision of herbal abortion. It clearly shows the choice to use plants or stay at home for abortion has less to do with clinic accessibility, and more about personal preferences.

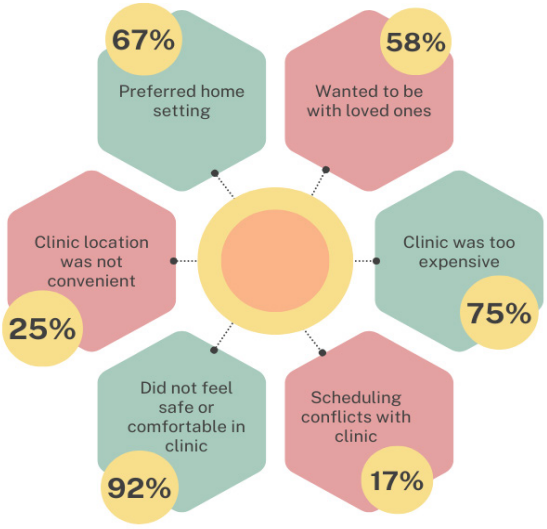


Figure 3. Reasons for seeking community-led herbal abortions

Case Studies

All identifying information, including names, has been changed or omitted. A representative sample of three successful herbal-only abortions were chosen to highlight as case studies. Cases were selected based on the detailed level of data input and because they are most representative of the average duration to completion and types of plants used. The authors intentionally chose to only present successful herbal-only cases as these protocols are rarely reported in academic research and present a unique opportunity for insight into how herbal abortions can work.

Table 1. Case Study 1: Beth (Client #15)

Gestational Age: 4 weeks

	Angelica spp.	Mugwort	Parsley	Vitamin C
Day 1		½ c: 1 L H20. Drink ½		1500 mg 6x/day
Day 2		½ c: 1 L H20. Drink ½		1500 mg 6x/day
Day 3		½ c: 1 L H20. Drink ½		1500 mg 6x/day
Day 4		½ c: 1 L H20. Drink ½	Pessary at night	1500 mg 6x/day
Day 5	20 gtts TID	½ c: 1 L H20. Drink ½	Pessary at night	1500 mg 6x/day
Day 6	20 gets TID	½ c: 1 L H20. Drink ½	Pessary at night	1500 mg 6x/day
Results: COMPLETE ABORTION				

At about four weeks gestation, after a positive home pregnancy test, Beth (she/her), age 28, found a community provider to assist remotely with her home abortion. Beth was familiar with using herbal medicines for other health issues, didn't have any significant medical or health history that could impact care, and wanted to try using herbs for her abortion. She had in-person support from her partner and a roommate. After consultation with an experienced herbal provider, they decided to dedicate one week to taking herbs with a plan to administer misoprostol if the herbs did not result in a complete abortion.

Formulation began with a combination of daily mugwort infusions (½c herb: 1L water. Drinking ½c tea six times per day) and Vitamin C (1500mg six times per day) for days one to three. On day three, a fresh parsley pessary was used nightly while sleeping, and on day four, she added 20 drops of black cohosh tincture three times a day. Beth noted side effects including fatigue and diarrhea, but nothing requiring medical attention. Beth used complementary therapies including heat, baths, flower essences (not specified which), and orgasm in hopes to initiate the termination of pregnancy.

On day six Beth experienced a complete abortion, with telltale heavy bleeding and relief of pregnancy symptoms. Beth met with the provider two more times and did not require medical attention.

Table 2. Case Study 2: Marial (Client #31)

Gestational Age: 4 weeks						
	Black Cohosh	Cottonroot Bark	Ginger	Mugwort	Parsley	Vitamin C
Day 1	80 gtts q3hrs	80 gtts q2-3hrs	1 cup Ginger tea 3x/day	1 Tbsp in the 1 cup Ginger Tea, 3x/day	Pessary	6000-8000 mg/ day
Day 2	80 gtts q3hrs	80 gtts q2-3hrs	1 cup Ginger tea 3x/day	1 Tbsp in the 1 cup Ginger Tea, 3x/day	Pessary	6000-8000 mg/ day
Day 3	80 gtts q3hrs	80 gtts q2-3hrs	1 cup Ginger tea 3x/day	1 Tbsp in the 1 cup Ginger Tea, 3x/day	Pessary	6000-8000 mg/ day
Day 4	80 gtts q3hrs	80 gtts q2-3hrs			Pessary	6000-8000 mg/ day
Day 5	80 gtts q3hrs	80 gtts q2-3hrs			Pessary	6000-8000 mg/ day
Day 6	80 gtts q3hrs	80 gtts q2-3hrs			Pessary	6000-8000 mg/ day
Day 7	*break*	*break*	*break*	*break*	*break*	*break*
Day 8	*break*	*break*	*break*	*break*	*break*	*break*
Day 9	80 gtts q3hrs	80 gtts q2-3hrs				
Day 10	80 gtts q3hrs	80 gtts q2-3hrs				
Day 11	80 gtts q3hrs	80 gtts q2-3hrs				
Day 12	80 gtts q3hrs	80 gtts q2-3hrs				
Results: COMPLETE ABORTION						

Marial (she/her), age 17, was raised by an herbalist and was very familiar with herbal medicine. She tracked her period using a phone app and realized immediately her period was late. She confirmed with a home pregnancy test. She had never been pregnant and did not feel the clinic was affordable or safe. It was important for her to be surrounded by loved ones, which the clinic could not accommodate. Marial sought a community provider with herbal experience in her community. They confirmed there weren't any health issues or concerns and together, they formulated a protocol (see Table 2 for exact dosages) including herbal tinctures of black cohosh and cotton root bark, mugwort infusions in ginger tea, a nightly parsley pessary, and Vitamin C. The protocol developed involved taking herbs for six days, followed by two days off, and then four days on again. In the event the protocol was unsuccessful, Marial scheduled a future clinical extraction appointment.

After three days of the protocol, Marial discontinued the mugwort and ginger infusion due to nausea. On day six, as planned, she took a break from the tinctures and decided to eliminate Vitamin C because of loose bowels and continued nausea.

Mentha pulegium (pennyroyal) in bloom. CREDIT: Javier Martin SOURCE: Wikimedia Commons

She experienced spotting, and her two-day break (days seven and eight) from the herbal protocol allowed space to focus on adjunct therapies like meditation, rest, ceremony, heat, steams and baths, flower essences (not specified which), and touch therapy.

On the eighth day of following the protocol, she resumed taking black cohosh and cotton root bark at the same dosage as previously, with fewer side effects, and on day 10 began bleeding. She continued these herbs for two days and ceased when the bulk of tissue passed, and pregnancy symptoms subsided. Completion was confirmed with a negative pregnancy test and return of the menstrual cycle. Marial met with her provider for two more visits and shared that despite the duration and side effects she would consider using herbs to support pregnancy termination in the future.

Gestational Age: 4 weeks						
	Ginger	Mugwort	Motherwort	Pennyroyal	Parsley	Vitamin C
Day 1	1 qt fresh Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	Pessary changed 2x/day	
Day 2	1 qt fresh Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	Pessary changed 2x/day	
Day 3	1 qt fresh Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	Pessary changed 2x/day	2 tsp Ascorbic Acid
Day 4	1 qt fresh Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	1 Tbsp in Ginger tea*	Pessary changed 2x/day	2 tsp Ascorbic Acid
Results: COMPLETE ABORTION					** frequency of dosage not specified*	

Table 3. Case Study 3: Amal (Client #16)

Amal (she/her), age 30, began experiencing fatigue and tender breasts at the time her menses was due and suspected she could be pregnant. A home test confirmed this to be the case and, based on calendar data she was keeping, she knew she was four weeks out from her last menstrual period.

Amal knew she did not want to be pregnant, but a clinical abortion was problematic for her for several reasons: it wasn't a convenient location, it was too expensive, she couldn't get a clinic appointment soon enough or at a time that didn't interfere with work, and she didn't feel safe or comfortable in a clinical setting. She had no ongoing or historic health issues of concern and had attempted a successful self-induced herbal abortion before, but she wanted to have the additional input and support of a knowledgeable care provider for this termination. A friend referred her to a trusted provider in their community. Amal reported if she hadn't found access to a home provider, she would have attempted to end the pregnancy on her own using herbs.

Amal used a combination of mugwort, *Mentha pulegium* (pennyroyal), *Leonurus cardiaca* (motherwort), and ginger (see Table 3 for details on exact dosing) as an infusion along with Vitamin C. She began by drinking a liter of this mixture

throughout the day for several days. After four days of this regimen, she planned to add black cohosh root and cotton root bark tinctures. She also used a fresh parsley leaf pessary, changed twice daily. After four days of taking the herbal infusion formula and using the parsley pessary, she started having some cramping and bleeding, and by the end of the next day, her abortion was complete. Ultimately it wasn't necessary for Amal to use the black cohosh or cotton root bark tinctures. Amal experienced no complications from the protocol and went on to have a normal period the next month.

Discussion

Although the data presented here represent a small sample size, the results are potent. The cases represent a glimpse into safe, effective, community-led herbal abortion protocols. They demonstrate that herbal abortions could be considered a legitimate option to support termination in early pregnancy, especially with herbal practitioner guidance, and for those who have an existing practice of using herbal medicine. Further, the data show perceivable patterns in gestational age, formulation, dosage, and duration as they relate to successful outcomes.

Gestational age appears to be a key factor in the success of herbal-only abortions. Herbal protocols and dosages were relatively consistent between the successful and unsuccessful herbal abortions, revealing gestational age to be the most consistent factor of success. The data (highlighted in Figure 4) clearly show the earlier someone starts an herbal abortion, the more likely it is to be successful. All herbal-only protocols started by the expected time of menses (four weeks LMP) were complete. Of the nine clients who started an herbal protocol by six weeks LMP, 78% were effective. Of the three clients who started an herbal protocol between seven to nine weeks LMP all required an additional method for completion. Notably, clinical abortion care, including medications and extractions, often has a minimum gestational age by which clients qualify for clinical care, typically after six weeks LMP when a gestational sac can be reliably located and dated on ultrasound. Herbal abortions appear to be most effective in gestations pre-dating six weeks LMP, potentially closing a gap in abortion care for clients aware of their pregnancies very early and who do not want to wait to begin their abortion care.

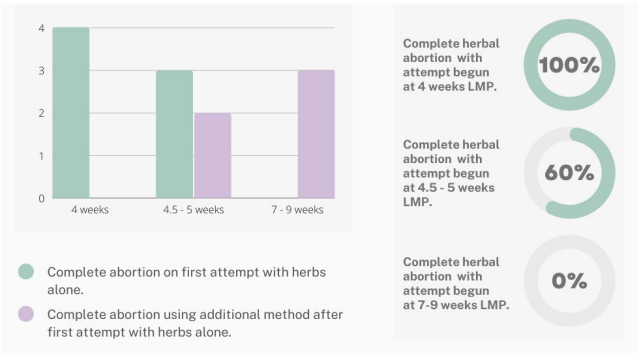


Figure 4. Outcomes and Gestational Age

Duration of use is another key factor. In four of the six cases where abortion was not completed on the first attempt, the client discontinued the herbs after four or five days. The average duration from start to finish was 8.8 days, with most of the successful cases requiring 11-20 days of dosing herbs for the contents of the uterus to be fully expelled. Effective herbal abortion seems to rarely be a quick process and is most effective with sustained use and consistent dosing.

Formulation varied from case to case and provider to provider, yet mechanisms of action and dosage appeared to have some consistent strategies. (See Table 4 for details on herbs and formulations for all twelve cases.) Each effective herbal protocol included abortifacient herbs to accomplish a set of actions in the body, including:

- Inhibiting progesterone production in the body
- Increasing available oxytocin
- Stimulating uterine contractions
- Cervical softening (in all but one case)

These actions work in synergy to terminate early pregnancy. When the corpus luteum forms in the first week of gestation, it begins producing progesterone, an essential hormone for fetal development. Progesterone causes the cells in the uterine lining to divide rapidly to prepare a fertile bed for the embryo inside the uterus. Disrupting available levels of progesterone reduces the ability of pregnancy to continue. Cervical softeners seem to help encourage the release of uterine contents. Cervical softeners are used in midwifery to prepare for birth, soften the cervical tissue, and dilate the cervical os (the opening in the cervix that creates passage between the uterus and vagina). Herbs that increase the availability of the hormone oxytocin can stimulate regular uterine contractions. Some abortifacient or emmenagogue herbs increase blood circulation to the pelvic area and irritate the uterus due to the presence of volatile oils. All of these actions can interrupt the continuation of early pregnancy by impacting the environment, physiology, and viability of the embryo. Many of the herbs used in these formulas are effective due to a synergy of these abortifacient actions (Tiamat 1994; Annwen 2002; Sage-femme Collective 2008; Red Door Collective 2016). Many cases presented in this research demonstrated skilled formulations aimed at specific synergistic bodily actions to terminate a pregnancy.

There is a long-held belief amongst herbalists and holistic reproductive healthcare providers that herbal abortions are successful at ending and expelling a

Table 4. Formulation, dosage, and outcome

	Client 15	Client 16	Client 23	Client 28	Client 31	Client 70	Client 71
Angelica spp. (Angelica, Dong Quai)	20gtts TID; started Day 4		60-70 gtts q4hrs; Days 1-2			4 mL q4hrs; Days 5-7, 9-12, 2mL q4hrs Days 13-14	2-4 mL q2-3hrs; Days 5-9, 15-17
Actaea racemosa (Black Cohosh)				*unknown amount in blend. 30-60 gtts q4hrs	80 gtts q3hrs; Days 1-6, 9-12*		1-2 mL q2-3hrs; Days 1-9
Gossypium herbaceum (Cottonroot Bark)			60-70 gtts q2-3hrs; started Day 2		80 gtts q2-3hrs; Days 1-6, 9-12*		1-2 mL q2-3hrs; Days 1-9, 11-14, 16
Zingiber officinalis (Ginger)		1 qt fresh Ginger tea		*unknown amount in blend. 30-60 gtts q4hrs + fresh Ginger tea	1 cup Ginger tea 3x/day; Days 1-3*		2 oz rhizome: 8-12 ounce water; Days 10, 17-20
Lobelia inflata (Lobelia)				*unknown amount in blend. 30-60 gtts q4hrs			
Artemisia vulgaris (Mugwort)	½ c: 1 L H20. Drink ½; Days 1-6	1 Tbsp in Ginger tea		*unknown amount in blend. 30-60 gtts q4hrs	1 Tbsp in the 1 cup Ginger Tea, 3x/ day; Days 1-3*		
Leonurus cardiaca (Motherwort)		1 Tbsp in Ginger tea		*unknown amount in blend. 30-60 gtts q4hrs			
Petroselinum crispum (Parsley)	Pessary at night; started Day 3	Pessary changed 2x/ day			Pessary*; Days 1-6*	Pessary; Days 1-7, 9-12	Pessary; Days 1-4
Mentha pulegium (Pennyroyal)		1 Tbsp in Ginger tea					
Rosa spp. (Rose)				*unknown amount in blend. 30-60 gtts q4hrs			
Ascorbic Acid (Vitamin C)	1500 mg 6x/ day; Days 1-6	2 tsp Ascorbic Acid			6000-8000 mg/ day; Days 1-6*	6000-8000 mg/ day; Days 1-7, 9-12	(unspecified amount); Days 1-13
Gestational Age (LMP)	**4 weeks**	**4 weeks**	**5 weeks**	**4 weeks 4 days**	**4 weeks**	**2.5 weeks**	**4 weeks**
RESULTS	**6 days: Complete Abortion**	**4 days: Complete Abortion** Frequency of consumption unspecified.	**2 days: Complete Abortion** started bleeding after second dose of CRB.	**Complete Abortion:** unspecified timeline Combination tincture blended at undocumented amounts.	**12 days: Complete Abortion** Discontinued infusion after 3 days. Discontinued Vit C after 6 days. Rested and hydrated for 2 days. Came back to the tincture dosage. Released in an additional 4 days. *dosed through the night as well	**11 days: Complete Abortion** Takes a break at Day 7. Comes back to protocol and begins bleeding on Day 11.	**18 days: Complete Abortion** Day 6 complete rest & cessation of protocol. Day 7-8 returns to protocol; halves tincture dosage. Day 10-16 alternates herbs. Day 15 spots. Day 18 begins to bleed.

pregnancy by essentially poisoning the body with unsafe amounts of herbal extracts. Many herbs, including abortifacients, can be dangerous if taken without proper administration or with certain pre-existing conditions, which providers from this study screened for. However, herbs taken at the optimal time in synergistic combination and appropriate doses can be both safe and effective, even in the context of herbal abortion. Believing the only way herbs can terminate a pregnancy is through "poisoning" the body (and thus the embryo) is outdated and misleading. Recommended dosages analyzed and outlined in the above case studies were in line with therapeutic dosing for other health concerns using the

Table 5. Typical Herb Dosages vs. Dosages in Study

Herb	Typical Dosage Range	Dosage Range Used in Study
Angelica spp. root	10–20 ml per day (Bone & Mills 2013); 2–4 ml tid (Easley & Horne 2016); 3–5 ml tid (Romm 2010); 10–60 gtts qd–qid (Tilgner 2019)	20 gtts–4 ml up to 5 times per day*
Black cohosh root	3 –7.5 ml per day (Bone & Mills 2013); 2–4 ml tid; 0.1–1 ml tid (Easley & Horne 2016); 0.4–2 ml per day (Romm 2010); 10–40 gtts qd–qid (Tilgner 2019)	2–2.5 ml up to 5 times per day*
Cotton root bark	2–4 ml qd–tid (Easley & Horne 2016); 2–4 ml bid (Romm 2010); 20–60 gtts every 20–30 minutes (Tilgner 2019)	2–2.5 ml up to 5 times per day*
Ginger root	Fresh root 500–1,000 mg tid (Bone & Mills 2013); 1 Tbsp grated fresh root per cup tid–qid (Romm 2010); 2–3 cm fresh root per cup of water (Tilgner 2019)	1 Tbsp–2 oz fresh root in 1 cup water, taken up to 3x/day
Motherwort leaf	Standard infusion, 2–4 oz qd–qid (Easley & Horne 2016); 2–4 g tid (Romm 2010); 1 Tbsp per cup, qd–qid (Tilgner 2019)	1 Tbsp per quart water, 4 cups per day
Mugwort leaf	1–3 g bid (Romm 2010); 1 tsp per cup, qd–qid (Tilgner 2019)	1 Tbsp–1/2 cup per quart water, 2-4 cups per day
Pennyroyal leaf	Weak infusion, 4–8 oz qd–qid (Easley & Horne 2016); 1 Tbsp per cup, qd–qid (Tilgner 2019)	1 Tbsp per quart water, 4 cups per day

*Data unclear if client continued dosing throughout the night, so dosing may be up to 8 times per day.

same plants. (Table 5) No provider recommended unusually high amounts.

Despite herbal abortions statistically being less effective at ending and expelling a pregnancy than their counterpart methods of medications and extractions, client satisfaction and person-centered care should remain a focus when discussing the spectrum of abortion options. Just as people may choose which form of birth control to use based on what most closely aligns with their lifestyle and values rather than reported effectiveness, people may also decide how to terminate their pregnancies using a similar rationale (Egarter 2013). For many, the ability to choose and to have greater agency in their care decisions makes their experience more positive, more empowering, and less traumatic (Raifman et al. 2021). Client-centered care is a practice approach shared by many herbalists, which prioritizes individual goals, desires, barriers, and capacities. In the context of abortion, a client-centered approach allows space for the person seeking an abortion to choose their methods, the role of herbs, and their care team in personally meaningful and important ways.

While medication and procedural abortion methods, (both in-clinic and outside-of-clinic) are well-researched and demonstrate a high efficacy (98%+), herbal abortions cannot be dismissed outright. They *appear to be effective for some people at some times*, with attention to the right herbs, appropriate timing, and skilled guidance. Data from this study show herbal abortion can be safe when co-managed with a community provider or trained herbalist and could provide an effective option in early pregnancy at a time when clinical care is often postponed or when clients are unable or unwilling to seek formal medical care. Further study is necessary to explore themes and patterns of why some herbal protocols are successful while others are not. Clients inquiring about herbal abortion deserve informed consent and a full range of options on which to base their personal health decisions.

Within the CBPR study, of the data accepted for analysis, 17.8% of clients wanted to use herbs in their abortion in some way. Experienced providers were able to inform clients of options, including a clear depiction of efficacy, and many, particularly with an estimated gestation of more than six weeks LMP, chose to combine herbs with medication (60%) with a success rate on the first attempt at 89%. In cases of incomplete herbal-only abortion attempts, providers employed other methods with a home abortion success rate of 100%. Herbs were also integrated as adjunct support, for cervical softening with home extractions, to manage complications, and, in one case, to complete an abortion initiated with medication.

Future Research

This specific data set provides much more material for analysis that could be used to increase access and

information resulting in more abortion options with higher success. Within the twelve cases attempting to manage abortion with herbs alone, an in-depth look at materia medica, with consideration of phytochemical properties could prove helpful. Additionally, the 30 cases that used a combination of herbs and varying dosages and administrations of misoprostol have the potential to inform providers of ways to combine methods to improve outcomes and manage side effects. For future data collection, we advise consistency around reporting gestational age, specific formulation, tincture ratios, and dosing protocols.

Conclusion

Herbal abortions exist on the spectrum of abortion options, as they have for millennia. Far from a solely historic practice, herbal abortions remain relevant and in demand today. Herbalists and other knowledgeable community health care providers have the potential to fill a crucial gap in abortion care for clients in very early pregnancy or offer holistic care to those desiring abortion support. Like any other abortion method, safety and efficacy are dependent on understanding when and how a particular method is best applied. Careful analysis of synergistic actions in the body may shed light on how, when, and for whom some herbal abortions work. Herbal practitioners enthusiastically provide support for all other aspects and phases of reproductive care, including pregnancy, miscarriage, birth, and postpartum. Abortion exists within the continuum of reproductive health (WHO 2022) and notwithstanding the various legal restrictions leading to criminalization, can be safely adopted into the scope of practice of herbalists and others committed to learning about this topic and providing this type of care in their communities. By openly discussing cases, protocols, and specific herbs and their mechanisms of action, safety, and contraindications, herbalists can rewrite the dominant narrative about herbal abortions.

Herbalists can improve holistic, full-spectrum reproductive and abortion care by integrating herbs into the abortion process, no matter the method. We can re-learn, teach, and share the related skills and knowledge necessary, trusting the choices clients make about their bodies. Herbalists can expect to be called on by their communities for herbal abortion knowledge and support. In this precarious time of limited abortion access and increasing restrictions on bodily autonomy, more options and more knowledge are needed. Those who carry knowledge and skill in the practice of herbal abortion need to be protected and embraced by reproductive justice advocates, medical professionals, and the wider professional Western herbal community.

“Herbalists and other knowledgeable community health care providers have the potential to fill a crucial gap in abortion care for clients in very early pregnancy or offer holistic care to those desiring abortion support.”

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