

Using Paid Sick Days for Medication Abortion

APRIL 2022

Introduction

Everyone needs time to access health care without threatening their economic stability. Paid sick days allow a person to recover from short-term illnesses, access preventive care, undergo a basic medical procedure, or care for a sick child or family member. Yet more than 26 million people — nearly one in four private sector workers¹ — do not have a single paid sick day. Just 33 percent of the lowest-paid workers — those least likely to be able to afford unpaid time away from work — have access to paid sick days.² Moreover, Hispanics, American Indian or Alaska Native, and Black people are less likely to have access to paid sick days, due in significant part to the fact that they are disproportionately concentrated in low-wage jobs.³ For far too many people, then, taking time off from work to attend to their health means putting their jobs and finances at risk.

Paid sick days give people seeking abortion care the time they need to travel to a clinic, receive care, and recover. The benefits of this paid time away from work are especially apparent for people who obtain an abortion via an in-clinic procedure, which more

closely resembles other kinds of in-person or outpatient medical care for which people commonly use paid sick days. Medication abortion care, however, often looks different, as it commonly involves fewer trips to a provider's office and is a process that takes place mostly in one's own home. For many people, it is less intuitive that paid sick days are applicable to this form of care — *but they are*. The availability of paid sick days for medication abortion is an essential component of ensuring that people can access care that best suits their needs and preferences and do so in ways that protect both their health and economic security.

For more information about how paid sick days improve abortion access and strengthen economic security, please see the report and additional resources available [here](#).

Information about the availability of paid sick days in states and local jurisdictions is available [here](#).

Not having access to paid sick days is especially problematic for pregnant people seeking abortion care.⁴ Myriad restrictive abortion laws require people to pay out of pocket for abortion care, travel long distances, take multiple days off work, make multiple medically unnecessary visits to an abortion provider, and spend hundreds or thousands of dollars on travel and procedure-related expenses. When a person lacks paid sick days, getting the care they need may mean not only facing common, persistent challenges like bans on abortion coverage and other harmful abortion restrictions, but also lost wages and possibly job loss. The financial burden, as well as the potential struggles of navigating inflexible work schedules and policies, may delay or even entirely prevent a person's ability to obtain care. The combination of barriers to abortion care and a lack of paid sick days disproportionately affects people with low incomes, people of color, and those living in medically underserved areas, including rural communities.

Paid Sick Days Cover Time Off for Medication Abortion Care

In 14 states and 22 other cities and counties, paid sick days laws ensure workers can earn a baseline amount of paid sick days to seek treatment for and recover from their own illness, access preventive care, or cover for a family member's care.⁵ This leave is usually short in duration, and laws typically allow it to be used in increments from as small as the couple of hours someone may need to go to an appointment with a provider to the few days someone may be sick with a minor illness. In most cases, if a person's absence from work is for three days in a row or less, they do not need to provide documentation to their employer.

For a worker not protected by a paid sick days law, access depends on whether their employer opts to provide paid sick days, and their employer may restrict use of leave. About one in five workers with access to some paid time off say they would not be able to use it to care for a family member.⁶ Some employers discourage workers from taking needed leave through punitive “no fault” attendance policies,⁷ or require a worker to find a replacement in order to take leave. Workers of color are especially likely to face barriers to taking leave; for example, in fall 2020, 28 percent of Black workers reported having requests for leave denied compared to 9 percent of white workers.⁸

One of the reasons people are increasingly opting for medication abortion care is because it can feel less “medicalized”, given that it often involves fewer (or in some cases, no) in-person trips to a health care provider’s office, and the process occurs mostly in the comfort of one’s home. However, the fact that this method of abortion largely occurs at home might mean that people are less likely to realize that their available paid sick days may be used to access medication abortion care — *but they can*. First, a person with paid sick time can take it for any appointments they have with a provider — whether in-person or via telehealth — including any consultation prior to obtaining abortion care, a visit to pick up or take the medication itself, and for any follow-up care. Under post paid sick leave laws, employees do not have to disclose detailed medical reasons for requesting leave.⁹ Second, a person with paid sick days typically may use the time they have earned to stay home as their body goes through the process of terminating the pregnancy, as well as any associated recovery time. This is true even though abortion care is not an “illness” or preventive care (as commonly understood to be covered by paid sick days laws) and even though the side effects from medication abortion are generally very minimal and manageable with common over-the-counter medications like ibuprofen. Using paid sick days in this way can both promote people’s health and well-being while they seek essential reproductive care and simultaneously mitigate some of the risks to their financial stability while doing so.

At the same time — because far too many people still do not have the benefit of such worker protections and live in places with myriad abortion restrictions — policymakers must work urgently to expand and strengthen workers’ access to paid sick days and their access to comprehensive reproductive health care, including medication abortion.

Medication Abortion Care is a Safe, Effective, and Essential Option

Medication abortion is an FDA-approved option for ending a pregnancy up to 10 weeks of gestation with a prescription from a provider.¹⁰ It generally involves the use of two

separate medications, taken in pill form: mifepristone, available under the brand name Mifeprex, and misoprostol.¹¹ The mifepristone is taken first to block progesterone, a hormone essential to the development of a pregnancy. Between 24 and 48 hours later, the misoprostol is taken to trigger a process similar to a menstrual period in which the uterus cramps and sheds its lining so that the pregnancy leaves the person's body. People can also use mifepristone and/or misoprostol to safely and effectively complete a miscarriage. Some states require a person to take the first pill in a clinic or provider's office, and then they can take the second pill at home or wherever they are most comfortable.¹² Other states allow a person to take both pills at home after an in-person or virtual visit, while some states allow for a telehealth visit followed by pills being mailed to the person. All states require people who are seeking a prescription for abortion pills to consult with a health care provider. In addition, follow-up with the provider is done seven to 14 days later,¹³ and may take place over the phone.¹⁴

Evidence shows that medication abortion is extremely safe and effective. A 2018 National Academies of Science, Engineering, and Medicine review of medication abortion care found an overall effectiveness rate of 96.7 percent for gestations up to nine weeks.¹⁵ Other research shows that serious complications requiring hospitalization or transfusion occur in less than 0.4 percent of patients.¹⁶ A 2019 systematic review of telemedicine use for medication abortion also supports the practice: outcomes were similar to in-person care, with high rates of completed abortions, very low rates of complications, and high acceptability on the part of both patients and providers.¹⁷ In addition to its proven safety, medication abortion care may better fit a person's individual circumstances, needs and preferences, for example by offering more control and privacy in the process, or allowing someone to be with loved ones for support during the process.¹⁸ Furthermore, telehealth can reduce barriers to abortion care, including travel, child care, long wait times for an appointment and the costs that result from these obstacles to care.

Self-Managed Abortion and Implications for Paid Sick Days

Self-managed abortion, or ending one's own pregnancy without a doctor or health care provider, is an increasingly common practice.¹⁹ Though self-managed abortion has existed throughout history, the discovery of medication that may be used for abortion makes the practice more accessible than ever.

It is important to acknowledge that some people in the United States have been criminalized for self-managing their abortions,²⁰ and for a range of pregnancy outcomes. Intersecting social, economic, and criminal legal policies²¹ — including those related to reproductive decision-making — disproportionately target and impact individuals and families who are Black, Indigenous, immigrants, queer, trans, low-income, and others. Long standing anti-Blackness and white supremacy are ingrained in our lawmaking and law enforcement systems.

Self-managed abortion is still health care, and still may require time off from work for recovery or healing. Therefore, paid sick days should be available for someone to use to care for themselves in the ways that feel best, including self-managing their own abortion care — much in the way someone might use a paid sick day to manage other self-care (or care of others) on their own.

Recent data speaks to the safety and efficacy of self-managed abortion with pills, with at least one study noting that self-managed abortion at nine weeks' gestation and earlier is equally as effective as clinically managed abortion.²² However, it is important to note that self-managed abortion is not the same as telemedicine abortion. Telemedicine abortion does give someone the opportunity to have part of their abortion experience at home, but they are working with a licensed health care provider to guide the abortion and prescribe the medication.²³ While recent changes in FDA regulations open possibilities for telemedicine abortion, people who self-manage continue to face unjust criminal prosecutions, sometimes using the exact same medications in the exact doses prescribed by health care providers.²⁴

There are many reasons someone may choose to self-manage their own abortion, including factors that push people toward this method, and factors that pull people toward this method.²⁵ Push factors include: legal restrictions on abortion that make clinical and telemedicine abortion inaccessible; financial barriers; threat of public exposure or fear of protestors; lack of culturally or experientially responsive care; and distrust of the conventional health care system, particularly for patients who regularly experience discrimination such as people of color, people with disabilities, people deemed "overweight", LGBTQ people, immigrants, and people living in poverty. Pull factors include: practicing agency to end one's own pregnancy in an affirmative way; the appeal of having an abortion in the privacy and comfort of one's own home, on one's own time; cultural or personal values systems that prioritize or normalize self-directed care; and increased comfort or familiarity with self-directed care.

Despite Persistent Restrictions, Use of Medication Abortion is Growing

Because of the numerous benefits that medication abortion can offer, more and more people are opting for this form of care. Medication abortion accounted for more than one-third of all abortions in the United States in 2017 (the most recent year for which this data is available), which is a 25% increase from 2014.²⁶ Medication abortion also accounted for an estimated 60% of all abortion care prior to 10 weeks.²⁷

The COVID-19 pandemic has only accelerated usage of medication abortion, as people sought to maximize their ability to stay at home, as several states moved to deny abortion as essential health care, and as many states and providers offered rapid changes in how care was provided, including via telehealth.²⁸ For example, TelAbortion, a pilot study in the U.S. that allows people seeking an abortion to have video consultations with certified providers and then receive the medication abortion pills by mail, found about twice as many people had abortions through the program in March and April 2020 compared to January and February.²⁹ Moreover, in a span of three weeks from late March into April 2020, more than 3,300 people in the United States requested help from Aid Access, a European organization that helps pregnant people access mifepristone and misoprostol by mail, increasing by more than a quarter from pre-COVID levels.³⁰

A growing body of research demonstrates that the protocol used to provide medication abortion care during the pandemic is equally as safe as in-person care, and that people are highly satisfied with the care they have received.³¹ In March 2022, the World Health Organization published new guidelines that, for the first time, provided recommendations for the use of telemedicine for abortion care and cited it as a successful intervention that improves quality access to reproductive health care.³²

Even though medication abortion has proven to be a safe, effective, and essential form of care, restrictions on its availability and use continue to persist. At the federal level, in 2011, the Food and Drug Administration (FDA) issued a restriction on medication abortion, placing mifepristone under the Risk Evaluation and Mitigation Strategy (REMS). Mifepristone's REMS required, among other things, that individual prescribing providers be certified and that the pill be distributed only in person, in a health care facility by or under the supervision of a certified prescriber.³³ In April 2021, as a response to the extenuating circumstances and risks involved in the coronavirus pandemic, the FDA announced it was suspending the in-person dispensing requirement for the duration of the public health emergency.³⁴ Then, in December 2021, the FDA announced that, after reviewing the science and evidence on the safety and efficacy of medication abortion, it would permanently lift this in-person requirement, enabling

people to get mifepristone by mail from certified prescribers or pharmacies.³⁵ This change is a significant step forward that will improve medication abortion access for many people.

At the same time, the impact of this change is severely blunted by the fact that, as of March 2022, 19 states have laws that nevertheless require the clinician providing a medication abortion to be physically present when the medication is administered, thereby prohibiting the use of telemedicine to prescribe medication for abortion or mail to deliver it.³⁶ Additional state laws aimed at undermining the availability of medication abortion are also proliferating; for example, Texas has prohibited medication abortion after seven weeks of pregnancy, despite FDA approval for use up to 10 weeks.³⁷ Since the start of the 2022 state legislative sessions, legislators in at least 20 states have proposed laws that would ban or restrict access to medication abortion.³⁸

Recommendations for Policymakers

Access to both paid sick days and to medication abortion are critical to people's health, well-being, economic security, and ability to thrive. Consequently, policymakers at the federal level must enact:

- The **Healthy Families Act**, which would establish a national paid sick and safe days standard and allow workers to earn up to seven paid, job-protected sick days each year;
- The **Equal Access to Abortion Coverage in Health Insurance (EACH) Act**, which would ensure abortion coverage to pregnant people who receive health care or insurance through the federal government; and
- The **Woman's Health Protection Act (WHPA)**, which protects the right to access abortion free from medically unnecessary restrictions and bans on abortion.

Additionally, policymakers at the municipal and state level must enact:

- Paid sick and safe days laws that allow all workers to earn job-protected paid sick days;
- Laws that would enhance abortion access by requiring insurance coverage for abortion care, including ensuring that state funds are used to provide abortion care for Medicaid enrollees;

- Laws like the Whole Woman’s Health Act that build upon the precedent set by the U.S. Supreme Court in *Whole Woman’s Health v. Hellerstedt* and help protect pregnant people and abortion providers from medically unnecessary regulations;
- Laws repealing antiquated criminal abortion offenses; and
- Laws to protect people who self-manage their own abortions — and those who help them — from criminalization.

¹ U.S. Bureau of Labor Statistics, National Compensation Survey: Employee Benefits in the United States, March 2021 (Table 33 and Appendix Table 2), accessed September 29, 2021, <https://www.bls.gov/ncs/ebs/benefits/2021/employee-benefits-in-the-united-states-march-2021.pdf>

² See note 1.

³ Institute for Women’s Policy Research, Paid Sick Days Access and Usage Rates Vary by Race/Ethnicity, Occupation, and Earnings, accessed March 14, 2022, <https://iwpr.org/wp-content/uploads/2020/08/B356-paid-sick-days.pdf>.

⁴ In this brief, we use gender neutral language in recognition of the fact that not all those who can get pregnant or who seek abortions are cisgender women. However, when citing studies or works, we use language congruent to the terms used in those studies.

⁵ National Partnership for Women & Families, Paid Sick Days Statutes, last modified July 2021, <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-sick-days/paid-sick-days-statutes.pdf>.

⁶ U.S. Bureau of Labor Statistics, Access to and Use of Leave -- 2017-2018: Data from the American Time Use Survey (Table 3), August 29, 2019, <https://www.bls.gov/news.release/pdf/leave.pdf>.

⁷ Dina Bakst, Elizabeth Gedmark, and Christine Dinan, A Better Balance, Misled & Misinformed: How Some U.S. Employers Use “No Fault” Attendance Policies to Trample on Workers’ Rights (And Get Away With It), June 2020, https://www.abetterbalance.org/wp-content/uploads/2020/06/Misled_and_Misinformed_A_Better_Balance-1-1.pdf.

⁸ Jessica Mason and Paula Molina Acosta, National Partnership for Women & Families, Called to Care: A Racially Just Recovery Demands Paid Family and Medical Leave, March 2021, <https://www.nationalpartnership.org/our-work/economic-justice/reports/called-to-care-a-racially-just-demands-paid-family-and-medical-leave.html>.

⁹ Drew Lewis, New Federal Paid Sick Leave Rights (2022): The Ultimate Guide for Employees, last modified February 9, 2022, <https://drewlewis.law/federal-paid-sick-leave-rights-for-employees>.

¹⁰ Kaiser Family Foundation, The Availability and Use of Medication Abortion Care, last modified October 21, 2021, <https://www.kff.org/infographic/the-availability-and-use-of-medication-abortion-care>.

¹¹ U.S. Food & Drug Administration, Mifeprex (Mifepristone) Information, last modified December 16, 2021, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information>.

¹² Guttmacher Institute, Evidence You Can Use: Medication Abortion, last modified February 2021, <https://www.guttmacher.org/evidence-you-can-use/medication-abortion>; Guttmacher Institute, State Laws and Policies: Medication Abortion, last modified March 1, 2022, <https://www.guttmacher.org/state-policy/explore/medication-abortion>.

¹³ U.S. Food and Drug Administration. “Mifeprex (Mifepristone) Information,” February 5, 2018, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information>.

¹⁴ U.S. Food & Drug Administration, Summary Review, Center for Drug Evaluation and Research, accessed March 14, 2022, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020SumR.pdf; Rachel K. Jones and Heather Boonstra, “The Public Health Implications of the FDA’s Update to the Medication Abortion Label,” *Health Affairs* (June 30, 2016), 10.1377/forefront.20160630.055639.

¹⁵ National Academies of Sciences, Engineering, and Medicine, The Safety and Quality of Abortion Care in the United States, accessed March 14, 2022, <https://www.nap.edu/read/24950/chapter/1>; Melissa J. Chen and Mitchell D. Creinin, Mifepristone with Buccal Misoprostol for Medical Abortion: A Systematic Review, *Obstetrics and Gynecology*, 126, no. 1 (July 2015), 12-21, Pubmed ID: 26241251, <https://escholarship.org/uc/item/0v4749ss>.

¹⁶ Elizabeth G. Raymond, Caitlin Shannon, Mark A. Weaver, and Beverly Winikoff, First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review, *Contraception* 87, no. 1 (January 2013): 26-37, doi: 10.1016/j.contraception.2012.06.011.

-
- ¹⁷ M. Ender, A. Lavelanet, A. Cleeve, B. Ganatra, R. Gomperts, and K Gemzell-Danielsson, Telemedicine for Medical Abortion: A Systematic Review, *BJOG: An International Journal of Obstetrics and Gynaecology* 126, no. 9 (August 2019): 1094-1102, doi: 10.1111/1471-0528.15684.
- ¹⁸ Stephen L. Fielding, Emme Edmunds, and Eric A. Schaff, Having an Abortion Using Mifepristone and Home Misoprostol: A Qualitative Analysis of Women's Experiences, *Perspectives on Sexual and Reproductive Health* 34, no. 1 (January-February 2002): 34-40, <https://doi.org/10.2307/3030230>.
- ¹⁹ Megan K. Donovan, Guttmacher Institute, Medication Abortion and the Changing Abortion Landscape, last modified September 2019, <https://www.guttmacher.org/article/2019/09/medication-abortion-and-changing-abortion-landscape>.
- ²⁰ If/When/How, Roe's Unfinished Promise, accessed March 29, 2022, <https://www.ifwhenhow.org/resources/roes-unfinished-promise>.
- ²¹ Ella Baker Center for Human Rights, Who Pays? The True Cost of Incarceration on Families, September 2015, <http://whopaysreport.org/who-pays-full-report>.
- ²² Heidi Moseson, Ruvani Jayaweera, Ijeoma Egwuatu, Belen Grosso, Ika Ayu Kristianingrum, Sybil Nmezi, Ruth Zurbriggen, Relebohile Motana, Chiara Bercu, Sofia Carbone, and Caitlin Gerdts, Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls, *Lancet Global Health* 10, no. 1 (November 18, 2021), [https://doi.org/10.1016/S2214-109X\(21\)00461-7](https://doi.org/10.1016/S2214-109X(21)00461-7).
- ²³ Repro Legal Helpline, Self-Managed Abortion FAQ, accessed March 14, 2022, <https://www.reprolegalhelpline.org/sma-faq>.
- ²⁴ If/When/How: Lawyering for Reproductive Justice, Roe's Unfinished Promise: 2019 Update, accessed March 15, 2022, <https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update>.
- ²⁵ If/When/How: Lawyering for Reproductive Justice, Real People Have Real Reasons, accessed March 15, 2022, <https://www.ifwhenhow.org/resources/real-people-have-real-reasons>.
- ²⁶ Rachel K. Jones, Elizabeth Witwer, and Jenna Jerman, Abortion Incidence and Service Availability in the United States, 2017, last modified September 2019, <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.
- ²⁷ See note 26.
- ²⁸ Abigail R.A. Aiken, Jennifer E. Starling, Rebecca Gomperts, Mauricio Tec, James G. Scott, and Catherine E. Aiken, Demand for Self Managed Online Telemedicine Abortion in the United States During the Coronavirus Disease 2019 (COVID-19) Pandemic, *Obstetrics & Gynecology* 136, no. 4 (October 2020), <http://doi.org/10.1097/AGG.0000000000004081>.
- ²⁹ Pam Belluck, "Abortion by Telemedicine: A Growing Option as Access to Clinics Wanes," *The New York Times*, April 28, 2020, <https://www.nytimes.com/2020/04/28/health/telabortion-abortion-telemedicine.html>.
- ³⁰ See note 28.
- ³¹ Erica Chong, Tara Shochet, Elizabeth Raymond, Ingrida Platais, Holly A. Anger, Shandhini Raidoo, Reni Soon, Melissa S. Grant, Susan Haskell, Kristina Tocce, Maureen K. Baldwin, Christy M. Boraas, Paula H. Bednarek, Joey Banks, Leah Coplon, Francine Thompson, Esther Priegue, and Beverly Winikoff, Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic, *Contraception* 104, no. 1 (July 2021): 43-48, doi: 10.1016/j.contraception.2021.03.019.
- ³² World Health Organization, WHO issues new guidelines on abortion to help countries deliver lifesaving care, last modified March 9, 2022, <https://www.who.int/news/item/09-03-2022-access-to-safe-abortion-critical-for-health-of-women-and-girls>.
- ³³ U.S. Food and Drug Administration, Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200mg, accessed March 15, 2022, https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifepristone_2019_04_11_REMS_Full.pdf.
- ³⁴ U.S. Food and Drug Administration, letter to American College of Obstetricians and Gynecologists, April 12, 2021, <https://www.aclu.org/letter/fda-response-acog-april-2021>.
- ³⁵ U.S. Food and Drug Administration, Questions and Answers on Mifeprex, last modified December 16, 2021, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>.
- ³⁶ Guttmacher Institute, State Laws and Policies: Medication Abortion, last modified March 1, 2022, <https://www.guttmacher.org/state-policy/explore/medication-abortion>.
- ³⁷ Kevin Reynolds, "Texas Law Restricting Access to Abortion Medications Goes Into Effect Dec. 2 After Governor Signs Bill," *Texas Tribune*, September 24, 2021, <https://www.texastribune.org/2021/09/24/texas-abortion-medication-law-abbott>.
- ³⁸ Christine Vestal, Pew Charitable Trusts, As Abortion Pills Take Off, Some States Move to Curb Them, last modified March 16, 2022, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/16/as-abortion-pills-take-off-some-states-move-to-curb-them>.



If/When/How: Lawyering for Reproductive Justice transforms the law and policy landscape through advocacy, support, and organizing so all people have the power to determine if, when, and how to define, create, and sustain families with dignity and to actualize sexual and reproductive wellbeing on their own terms. Learn more: [IfWhenHow.org](https://ifwhenhow.org).



**NATIONAL NETWORK OF
ABORTION FUNDS**

The National Network of Abortion Funds builds power with members to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice. Learn more: [AbortionFunds.org](https://abortionfunds.org).



The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. Learn more: [NationalPartnership.org](https://nationalpartnership.org).

© 2022 National Partnership for Women & Families. All rights reserved.