Prevalence estimation of self-managed abortion in Argentina: a web-based respondent-driven sampling study

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ABSTRACT

Background Respondent-driven sampling (RDS) is a social network sampling technique used to study hidden behaviours. We used web-based RDS (webRDS) to estimate the prevalence of self-managed abortion (SMA) outside the formal healthcare system in Argentina where abortion was legalised in 2020, but access remains uneven.

Methods A cross-sectional web survey (February–May 2024) among individuals aged 16–49 years, ever pregnant, and residing in Argentina. Our primary outcome was the proportion of SMA occurring outside the formal healthcare system. Estimates were generated using the RDS II estimator.

Results Seven recruitment chains generated 2437 participants (mean of 19.8 recruitment waves, the longest being 51). We filtered for suspected repeat and ineligible participation and generated RDS estimates for the remaining 1340 participants. The estimated personal network size was 4.9; participants knew an average of 2.7 peers with abortion experience. An estimated 17.1% reported ≥1 abortion, ever in life. Among these, an estimated 20.7% (95% CI 14.2 to 28.0) reported an SMA outside the formal healthcare system; 65.3% before and 24.7% after the legal reform. An estimated 42.2% completed the SMA alone. Reported advantages included autonomy in timing and setting, and support person choice. Disadvantages included concerns about pill quality and uncertainties around the process.

Conclusions A substantial proportion of women in Argentina with abortion experience have had an SMA outside the formal healthcare system, including post-legalisation. Our findings highlight the need to better address the preferences and

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Abortion estimates in Argentina and Latin America are based on statistical models using limited data, which affects their accuracy and thus reliable prevalence data is particularly lacking.

⇒ Public data on abortion in Argentina—especially on self-managed abortion (SMA) outside the formal healthcare system—is scarce and largely predates the 2020 legalisation, often reflecting experiences with accompaniment support.

⇒ Web-based respondent-driven sampling (webRDS) has not yet been applied to abortion, presenting a novel opportunity to generate reliable prevalence estimates.

needs of those facing unintended pregnancy and the potential of webRDS to study SMA.

INTRODUCTION

Globally, there is an ongoing shift from the use of unsafe abortion methods to the drugs mifepristone and misoprostol for self-managed abortion (SMA).[1] The WHO recommends the option of self-management in first-trimester abortion[2]; and in many contexts today, women can opt for SMA with support from formal healthcare services. Conversely, in contexts characterised by restrictive abortion legislation and/or pervasive abortion stigma, SMA is predominantly undertaken clandestinely and outside the

WHAT THIS STUDY ADDS

⇒ This study is the first to apply webRDS to estimate the prevalence of SMA outside the formal healthcare system, addressing a hidden and stigmatised practice.

⇒ Our results reveal that one-fifth of those reporting an abortion experience have navigated a SMA without support from or contact with the formal healthcare system—experiences that have been underrepresented in previous research.

⇒ The study demonstrates that webRDS can effectively reach individuals with SMA experiences without necessarily being socially connected/linked through this event, paving the way for broader application in abortion and public health research.

HOW THIS STUDY MIGHT IMPACT RESEARCH, POLICY OR PRACTICE

⇒ Results from this study may inform policy and practice that better respond to the needs and preferences of people with unintended pregnancies in Argentina and similar settings.

⇒ Our results may be used to advance research on SMA occurring outside formal healthcare systems and generate better understanding of this practice and people's experiences with it.

⇒ Methodological insights from this study may be used to generate more reliable abortion estimates in settings like Argentina where individuals with abortion experience are not necessarily socially connected through that experience.

formal healthcare system.[3] In such settings, individuals often do not engage with healthcare services and may instead seek guidance from accompaniment groups, abortion hotlines or informal social networks.[4]

Latin America has historically had some of the strictest abortion laws globally. Recent years have seen decriminalisation in countries like Argentina, Colombia and Mexico.[5] Women in this region often rely on their social networks to obtain information about abortion[6 7] and many access abortion medications and/or information online.[7 8] This is also true for Argentina where, until December 2020, abortion was a criminal offence with exceptions; thereafter, it was legalised to allow for abortion on request up to 14 weeks' gestation. Still, access and quality of care remain uneven,[9] and abortion information and communication flow remain within informal social networks.[10] Available evidence points to SMA outside the formal healthcare system being common,[3 7] but little is known about prevalence and its circumstances.

Data on SMA are critical for informing policy and practice aimed at advancing sexual and reproductive health and rights (SRHR). Such data can reveal if and how individuals are accessing abortion care and whether health systems are meeting population needs while upholding human rights obligations. However, population-based data on SMA are largely unavailable; consequently, estimates rely on statistical modelling.[3] This reliance reflects the covert nature of SMA when undertaken outside formal healthcare systems, which poses substantial challenges to study design and sampling.[11] To overcome challenges, scholars have long used social network sampling techniques.[12] Respondent-driven sampling (RDS) is an innovative social network sampling technique developed to generate estimates on populations for which a sampling frame is difficult or impossible to define.[13] RDS combines a modified form of chain referral with a statistical model for weighting the sample to compensate for it not having been drawn as a simple random sample.[14] If the RDS study conforms to methodological assumptions, this sampling technique can provide unbiased estimates of population proportions.[13]

Previous studies using RDS to study abortion are few, conducted in sub-Saharan Africa and mainly focused on incidence and safety.[15–19] These studies have used standard, in-person RDS. An alternative approach is web-based RDS (webRDS), in which participants can respond anonymously using a secure, online system. This renders webRDS faster compared with traditional sampling and standard RDS—it may allow for representative sampling of hidden groups without geographical limits and potentially generate larger samples.[20] WebRDS has generated reliable prevalence estimates for different health behaviours such as drug use and risky sexual behaviours among men who have sex with men[21 22] and has been proposed as an opportunity to address knowledge gaps on SMA.[11] In this article, we aimed to generate prevalence estimates on SMA occurring outside the formal healthcare system in Argentina using webRDS.

METHODS

We conducted a self-administered, cross-sectional survey using webRDS. Findings from our formative research phase, published in part in 2024, informed the study design.[10] This article follows Strengthening the Reporting of Observational Studies in Epidemiology (STROBE)-RDS guidance.[23] RDS relies on four elements: a coupon system, participants' social network size, recruitment tracking and mutual recognition.[13] Sampling begins with seeds who complete the survey and recruit peers using unique invitation coupons, forming recruitment waves. Data collection continues until 'equilibrium'—when key variable estimates stabilise across waves. Participants' network sizes are used to weight their influence on probability estimates. If assumptions are met (networked population, random recruitment, accurate reporting of personal network size, mutual recognition, etc.), sample proportions reflect population characteristics, independent of seed traits.[20] See box 1 for information on commonly used terms in webRDS.

> **Box 1   Summary box: Common terms used in webRDS**
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> Invitation coupon: A digital token used by participants to recruit peers from the same target population into the study. Each coupon typically has a unique identifier for tracking recruitment.
> Equilibrium: The point at which the sample composition stabilises and becomes independent of the initial seeds, indicating that recruitment has reached a steady state.
> Mutual recognition: Recruiters and recruits know each other from the same target population.
> Personal network size: The number of eligible individuals within the target population that a participant knows (and who knows them) and could potentially recruit.
> Recruitment chains: Sequences of participants linked through successive recruitment, starting from seeds and extending through multiple recruitment waves.
> Recruitment waves: Generational layers of recruitment, where each wave consists of participants recruited by individuals from the previous wave.
> Seeds: Purposefully selected participants to start the recruitment process.

Our formative research indicated that women may not disclose their abortion, consistent with previous research.[24] However, they knew and could report how many of their friends had been pregnant. Considering our study aim and that RDS relies on networked individuals, we chose to sample broadly among ever pregnant persons aged 16–49 years in Argentina.

The RDS software was developed by the Karolinska Institutet (Sweden), the University Medical Center Utrecht (The Netherlands) and the National Institute for Public Health and the Environment (The Netherlands). Study information was available as text and video. After consenting and confirming eligibility, participants completed the survey. All questions except for those on eligibility, SMA experience and personal social network included a *"Don't want to answer"* option. The personal network size question asked: *"How many persons do you know between ages 16–49, in Argentina, who have ever been pregnant? 'To know' means someone who you would talk to about issues such as pregnancy and abortion, and who would share such information with you"*. The survey took <10 min to complete using a smartphone, laptop or a tablet, in the Spanish or English language. The system was piloted and refined before launch; no changes were made after data collection began.

Survey questions on abortion are listed in online supplemental Table 1. Participants were asked: *"How many times have you had an abortion? Note: This includes any attempt to end a pregnancy even if it did not work"* (range: 0–20). This wording aimed to capture different scenarios, including abortions that began as self-managed but were later completed in-clinic. Those reporting an abortion using pills were asked if they self-managed any part of the process (eg, assessed pregnancy length, obtained pills, took pills at home, assessed outcome) without contacting a healthcare facility/provider. Participants with more than one pill-based abortion answered these questions for one experience. Those meeting criteria for SMA outside the formal healthcare system (see rbelow) were asked for details about that experience.

Our primary outcome was the prevalence of SMA outside the formal healthcare system, defined as an abortion where a person has obtained abortion pills and taken them at home, without contact or help from formal healthcare services. This definition includes abortions for which a person has sought care from a healthcare facility/provider pre- or post-abortion, informed by the WHO definition of SMA.[2] Secondary outcomes included prevalence of abortion (any method) and details of SMA experiences. This covered the year of the SMA, comparing those conducted before and after the legal reform (any time before and after December 2020), available support, perceived advantages and disadvantages.

Seeds were individuals who met the inclusion criteria, with large social networks and the ability to recruit others from the same target population. We recruited seeds through women's groups and non-governmental organisations. Participants were asked to recruit up to three peers (ever pregnant, aged 16–49 years, with mutual recognition) via WhatsApp or by sharing a survey link. Each invitation link contained a unique auto-generated code. If a mistake occurred, links could be clicked up to three times, with an option of generating a fourth invitation link. When a new participant accessed the survey, a new code was generated so that recruiters could not view their contacts' codes. We used the unique codes to track recruitment and to create social network trees. Participants who spent >5 min completing the survey could receive a US$5.00 compensation for their time, to their mobile wallet account (Mercado Pago) or their urban travel card (SUBE), and US$5.00 per successful peer recruitment. Mercado Pago is a widely used mobile payment application, linked to a telephone number that may be shared within households. SUBE is a travel card used in major cities, reloadable at subway stations or online, including via Mercado Pago. Compensation and peer recruitment were explicitly optional. No reminders were sent out.

Considering our broad sampling strategy, we assumed a sample size of around 2000 participants. Post hoc, we estimated that a sample size of n=1925 would be required for a marginal error of 0.05 with design effect D=5. We monitored recruitment in real time and assessed equilibrium using predefined variables (age, education and employment). We stopped recruitment when we had achieved equilibrium and reached a sample of 2000. We used the RDS II estimator to

estimate the population proportions—this weights/adjusts the sample proportion or numeric mean to account for homophily[25] and is expressed in this article with the letter "w". We present sample proportions and RDS estimates with a 95% CI. To corroborate the reliability of our estimates, we compared our sample characteristics (age and education) with 2022 census data (https://www.indec.gob.ar/) using Pearson's correlation coefficient (r). Analyses and plots/visualisations were conducted in R version 4.41, Gephi 0.10.1 and Matlab R2019a.

In webRDS it is standard to assess repeat participation, which may indicate insincere responses. We examined the use of compensation numbers, survey completion time and the interval between survey completion and recruited peer link activation. We considered the use of the same compensation number by >5 participants, as suspected repeat participation. Sharing of IP addresses was expected and not considered indicative of a repeat participant. We conducted a sensitivity analysis using different cut-offs for suspected repeat participation and compared RDS estimates across variables.

Patient and public involvement

Patients and the public were not involved in co-designing the research. However, to ensure feasibility, we engaged study target population members and consulted key informants in Argentina during the formative phase. Post-publication, we plan to involve stakeholders in dissemination through local, regional and international networks.

RESULTS

Between 7 February and 17 May 2024, 2437 individuals completed the survey, including ten seeds—seven of whom actively recruited peers. Seeds resided in Buenos Aires and Santa Fe, two of Argentina's largest provinces. We began with five seeds and added five more when recruitment slowed. The maximum number of recruitment waves was 51, with an average number of recruitment waves across the sample of 19.8. The three most successful seeds with the longest recruitment chains comprised a total of 1966, 329 and 121 participants, respectively. Figure 1 illustrates the recruitment chains, with a unique colour representing each of the seven active seeds for the full sample (n=2437). Figure 2 illustrates the recruitment chains for the full sample and highlights participants reporting ≥1 abortion (green) and 0 abortions or ineligible participants (black).

The sample composition stabilised (ie, reached equilibrium) for our selected key variables, with the changes of estimation for the last 200 participants at 3.5% for mean age, 1.1% for occupation, 0.4% for education, 1.5% for mean number of pregnancies and 0.5% for the proportion of participants with abortion experience (online supplemental figure 1). For
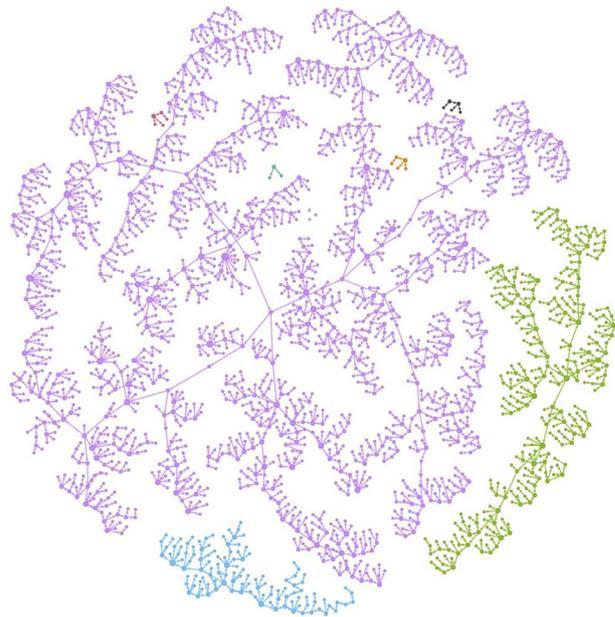
Figure 1 Recruitment chains: each colour represents one recruitment chain initiated by a total of seven seeds.

the RDS estimation relating to our primary outcome, we excluded ineligible participants, for example, those aged <16 or >49 years (n=37), reporting 0 pregnancies (n=763), suspected repeat participants (n=248) and those reporting a personal network size of 0 (n=211). We generated RDS estimates for the remaining sample (n=1340). Our sensitivity analysis showed that the RDS estimates for selected variables did not change significantly when comparing the different cut-offs for suspected repeat participation (online supplemental table 2). Both the sample proportions and estimates had a strong positive correlation
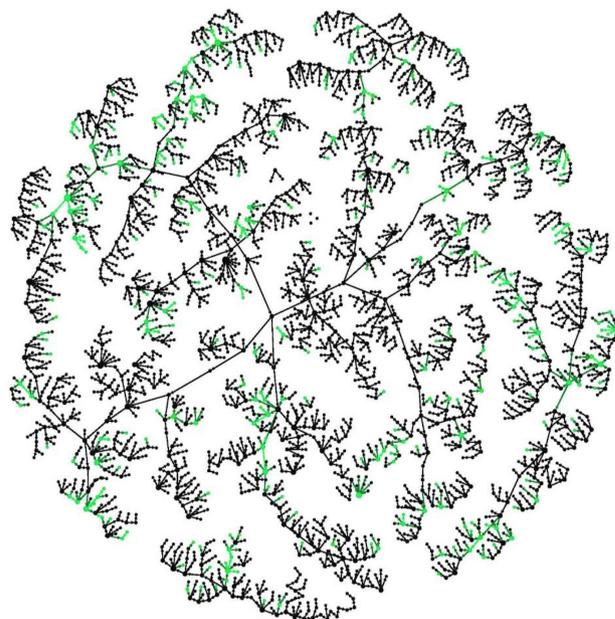
Figure 2 Recruitment chains: ≥1 abortion (green) and 0 abortions/ineligible participant (black).

with the latest census data from 2022 (online supplemental figure 2). RDS estimates (eg, weighted means and proportions) are preceded by the letter "w" in the Results section.

The sample proportions and means for participants' characteristics and social networks (n=1340), along with weighted population proportions and means and CIs, are reported in table 1. Mean age of participants was w30.4 years and most were either cohabiting (w42.7%) or single (w23.2%). The sample included participants from 12 of Argentina's 23 provinces, but most resided in the Province of Entre Ríos (w75.0%). The estimated personal network size was w4.9 and participants reported knowing an average of w2.7 peers who had had an abortion.

Pregnancy and abortion are presented in table 2. An estimated w17.1% reported ≥1 abortion, and among those w72.4% had used pills. Among participants reporting ≥1 abortion (n=214), the estimated proportion of SMA outside the formal healthcare system was w20.7%. An estimated w10.6% had an SMA without engaging with formal healthcare services at any stage.

Of 52 participants reporting an SMA outside the formal healthcare system, 46 provided responses about their most recent experience (online supplemental table 3). An estimated w65.3% occurred in 2020 or earlier, and w24.7% in 2021 or later. A total of w42.2% reported having no support. Common reasons for choosing SMA included secrecy (w21.3%), lack of alternatives (w13.1%) and perceiving it to be safe and effective (w13.9%). Frequently cited advantages were maintaining secrecy (w20.8%) and choosing time and place (w17.7%), and support person(s) freely (w12.1%). Others noted avoiding judgement and stigma from healthcare providers (w11.3%) and the community (w8.1%). Common disadvantages were uncertainty about drug quality (w22.2%) and not knowing what to expect (w18.7%).

DISCUSSION

Our results indicate that SMA outside the formal healthcare system continues to coexist alongside other pathways to abortion in Argentina. Further, the results suggest that a significant proportion of women who undergo an abortion do so entirely on their own, without support or engaging with healthcare services. These experiences have not been fully captured in previous work on SMA and have, most likely, not been included in previous abortion estimates.

Uncertainties about pill quality and what to expect after taking them are a commonly mentioned disadvantage of SMA in our study. Notwithstanding legalisation, the lack of public information campaigns about abortion in Argentina persists.[10] This creates a vacuum for other actors to fill, and a risk of misinformation seeping into online spaces, further eroding trust in public institutions.[26] In Colombia, a recent study revealed how online retailers of abortion pills

sometimes provided inaccurate or contradictory instructions.[27] Combined with poor availability of quality-assured abortion medications and high costs, this greatly undermines the safety of SMA.[28] Seeing that access to accurate medical information is a basic human right[29] and critical during an abortion along with access to good-quality drugs,[2] there is an urgent need to expand public abortion campaigns and adapt messages to ensure safe and positive SMA experiences.

Our study, capturing SMA experiences before and after the law reform, suggests that perceived benefits of SMA coupled with limited trust in healthcare institutions contribute to the prevalence of SMA outside the formal healthcare system. Similar motivations were reported among abortion hotline users in this setting.[30] Studies have documented progress in implementing legal abortion within healthcare institutions, while emphasising the need to improve service quality.[9 31] At the time of data collection for this study, the newly elected government was outspokenly anti-abortion, and while the abortion law remains unchanged, reductions in funding for SRHR programmes jeopardise access to care. In this context, our findings emphasise that the practice of SMA outside the formal healthcare system is likely to persist. This presents an opportunity for health entities to integrate new models of care, including digital models, that enable SMA according to women's own terms and preferences.

We intentionally used a broad target population, which has both advantages and disadvantages. For instance, individuals with a single undisclosed pregnancy and abortion may be less likely to be recruited under our inclusion criteria. However, since RDS requires sufficiently large personal networks to sustain recruitment, and our participants knew relatively few peers with abortion experience,[14] we speculate that narrower sampling would not have yielded the long recruitment chains we observed. Of note, recruitment waves do not usually exceed 30,[21] with few exceptions.[32] Our study's network composition illustrates how participants with abortion experience were embedded in broader networks. This pinpoints a potential advantage of wedRDS over traditional RDS—namely its ability to reach individuals with abortion experience, without necessarily being connected by that experience or limited by geography. This opens up new applications of webRDS in abortion research, which merit further exploration.

Judging by the long recruitment chains and achievement of equilibrium, our use of webRDS was successful. Still, our study is not without limitations. Although our analyses showed strong positive correlation with census data, we cannot say with certainty that our sample is representative of the underlying population. Further, it is not possible to decipher if ineligible participants were due to mistakes when completing the survey or if they were in fact ineligible. Though not uncommon

Table 1 Participants' background characteristics and social networks (n=1340)

Item	Sample n (%)	RDS weighted estimates (95% CI)
Age (years), mean (SD)	31.5 (8.54)	30.4 (29.57 to 31.27)
16–19	112 (8.4)	11.1 (6.6 to 16.9)
20–29	494 (36.9)	41.1 (33.5 to 48.9)
30–39	469 (35.0)	30.4 (23.1 to 41.1)
40–49	265 (19.8)	17.3 (13.1 to 22.2)
Education		
Never attended school	4 (0.3)	0.1 (0.0 to 0.3)
Incomplete primary school	31 (2.3)	3.3 (1.3 to 6.5)
Complete primary school	98 (7.3)	9.2 (5.3 to 13.4)
Incomplete secondary school	272 (20.3)	22.8 (18.5 to 27.7)
Complete secondary school	515 (38.4)	38.2 (32.5 to 44.0)
Started and/or completed tertiary/university education	414 (30.9)	25.4 (18.6 to 31.9)
Don't want to answer	6 (0.4)	0.9 (0.0 to 2.5)
Relationship status		
Currently married	174 (13.0)	12.7 (8.4 to 17.6)
Cohabiting	595 (44.4)	42.7 (37.2 to 48.3)
Currently in a relationship but not cohabiting	184 (13.7)	13.4 (9.1 to 17.7)
In a casual relationship	90 (6.7)	6.6 (3.9 to 10.8)
Single	282 (21.0)	23.2 (17.2 to 29.1)
Don't want to answer	15 (1.1)	1.4 (0.4 to 3.2)
Occupation*		
Housewife	508 (31.1)	32.81 (27.90 to 37.91)
Student	181 (11.1)	13.58 (9.64 to 17.68)
Employed (formal employment)	233 (14.3)	11.92 (8.14 to 16.17)
Employed (informal employment)	263 (16.1)	17.88 (13.09 to 22.72)
Self-employed	261 (16.0)	13.72 (9.98 to 17.87)
Unemployed	134 (8.2)	7.25 (5.33 to 9.42)
Other	27 (1.7)	1.17 (0.37 to 2.54)
Don't want to answer	26 (1.6)	1.47 (0.53 to 3.12)
Province of residence†		
Autonomous City of Buenos Aires	38 (2.8)	2.9 (0.7 to 6.3)
Buenos Aires Province	110 (8.2)	6.5 (3.1 to 11.2)
Catamarca	4 (0.3)	0.5 (0.0 to 1.4)
Chubut	2 (0.1)	0.2 (0.0 to 0.7)
Córdoba	7 (0.5)	0.3 (0.0 to 1.3)
Corrientes	3 (0.2)	0.3 (0.0 to 2.0)
Entre Ríos	952 (71.0)	75.0 (51.5 to 85.8)
Formosa	1 (0.1)	0.0 (0.0 to 0.0)
Mendoza	3 (0.2)	0.2 (0.0 to 1.1)
Neuquén	1 (0.1)	0.0 (0.0 to 0.1)
Río Negro	6 (0.4)	0.4 (0.0 to 1.8)
Santa Fe	211 (15.7)	13.0 (5.2 to 36.4)
Don't want to answer	2 (0.1)	0.7 (0.0 to 2.8)
Social network questions		
Personal network size, mean (SD)	12.2 (16.37)	4.92 (4.40 to 5.43)

Table 1 Continued

Item	Sample n (%)	RDS weighted estimates (95% CI)
Number of friends who have had an abortion, mean (SD)	3.4 (3.42)	2.72 (2.52 to 2.93)
Relationship with recruiter		
Friend	647 (48.4)	43.4 (37.8 to 49.3)
Acquaintance	151 (11.3)	12.4 (8.8 to 17.0)
Family member	518 (38.7)	41.6 (35.6 to 47.8)
Stranger	19 (1.4)	2.4 (0.9 to 4.7)
Mutual friend	1 (0.1%)	0.1 (0.0 to 0.4)
Other	2 (0.1)	0 (0.0 to 0.1)

*Multiple choice question.
†In the remaining provinces there were 0 participants.
RDS, respondent-driven sampling.

issues in webRDS research,[21] we took a conservative approach in our prevalence estimation and our sensitivity analysis indicated that repeat participation was not a serious issue. Additionally, the inclusion of participants reporting zero pregnancies, while unexpected, revealed meaningful connections to eligible participants, which may have important implications for study design. Future

webRDS research on abortion should consider refinements in seed selection strategy to allow for a wider geographical spread and modifications to reduce ineligible participants. Finally, the estimated abortion prevalence may include individuals who attempted but did not successfully terminate a pregnancy. However, based on survey piloting, we expect such cases to be rare and unlikely to bias

Table 2 Pregnancy, abortion and self-managed abortion estimates (n=1340)

Item	Sample n (%)	RDS weighted estimates (95% CI)
Pregnancy and abortion estimates (n=1340)		
Pregnancies, mean (SD)	2.1 (1.3)	2.0 (1.87 to 2.16)
Births, mean (SD)	1.6 (1.3)	1.5 (1.36 to 1.66)
Miscarriages, mean (SD)	0.4 (0.70)	0.4 (0.34 to 0.49)
Abortions*, mean (SD)	0.2 (0.47)	0.2 (0.15 to 0.24)
Abortions*, n (%)	214 (16.0)	17.1 (13.3 to 21.4)
Methods used for abortion (n=214)		
Surgery	49 (20.5)	18.1 (11.0 to 25.5)
Pills	150 (62.8)	64.2 (63.4 to 61.1)
Self-managed at least one component	142 (94.6)	92.5 (84.7 to 98.3)
Self-assessed the gestational age	93 (62.0)	50.9 (39.6 to 62.9)
Obtained pills without contacting or visiting a healthcare provider or clinic	55 (36.7)	33.1 (23.6 to 43.5)
Self-administered pills at home/someone else's home	129 (86.0)	83.7 (73.8 to 92.1)
Self-assessment of the abortion outcome	107 (71.3)	65.9 (53.9 to 77.4)
Injection	8 (3.3)	2.5 (0.7 to 4.7)
Herbs	4 (1.7)	1.3 (0.0 to 3.6)
Drank something	6 (2.5)	3.1 (0.7 to 6.1)
Sharp object	0	0
Don't want to answer	22 (9.2)	10.7 (5.3 to 17.1)
SMA outside the formal healthcare system among participants reporting abortion experience (n=214)		
Obtained pills and took them at home; may include contact with a healthcare provider/clinic pre- or post-abortion	52 (24.3)	20.7 (14.2 to 28.0)
Self-managed the entire abortion process without engaging with a healthcare provider or clinic at any stage	28 (13.1)	10.6 (6.0 to 15.7)

*Number of abortions (ever in life).
RDS, respondent-driven sampling; SMA, self-managed abortion.

our results, particularly given the large sample size. Importantly, the broader framing of SMA allowed us to capture SMA experiences comprehensively, illustrating the diverse ways in which people self-manage, and highlighting how common such practices are in Argentina today.

CONCLUSIONS

A significant number of individuals in Argentina self-manage their abortions without engaging with the formal healthcare system. Our results underscore the potential of digital interventions such as webRDS in contexts where abortion is stigmatised and historically restricted by legislation. Healthcare systems must intensify efforts to ensure positive SMA experiences and services that align with the needs and preferences of those facing unintended pregnancy.

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Patient consent for publication Consent obtained directly from patient(s).

Ethics approval This study involves human participants. The project received ethical approvals from the WHO Ethics Review Committee (A66017), Investigación y Reflexión Bioética (www.irbioetica.com) and RESPIRE, Argentina. This study was also submitted to the Swedish Ethics Review Authority (2023-03332401) to ensure alignment with ethical standards, although this organisation does not formally approve studies conducted outside Sweden. Participants gave informed consent to participate in the study before taking part.

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Data availability statement No data are available. Participant data will not be shared; however, data collection materials are available upon reasonable request.

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