
Introduction

In summer 2022, pro-choice protesters gathered around the United States to express shock, outrage, and defiance at the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*. The Court declared in *Dobbs* that abortion was no longer protected by the Constitution and could be banned altogether by any state that wished to do so. Some states banned abortion within hours of the decision, shuttering clinics immediately, while others committed to passing bans in the following weeks or months. As they marched, the protesters held up signs with slogans about choice, bodily autonomy, and health. They also held up signs with a familiar image of pro-choice protests: the coat hanger. In the decades before legal abortion, death from self-induced abortion with unsafe methods was so common that American coroners trained with medical textbooks that listed the dozens of ways women induced abortion: what they inserted, what they ingested, how they harmed themselves.¹ We won't go back to unsafe methods like the coat hanger, the protesters announced after *Dobbs*.

For all the political and emotional resonance of those coat hanger signs, which evoke a visceral horror at the dangers of self-induced abortion, they depict the past and not the present or future of illegal abortion. Self-managed abortion after 2022 will not be the same as it was before 1973, when the constitutional abortion right was established in *Roe v. Wade*. Abortion pills, developed in the 1980s, offer an alternative to surgical abortion and make safe abortion easier to obtain outside a clinical context. They have permanently changed the landscape of abortion care across the world, in countries with

and without legal abortion. To understand the future of abortion in the United States after *Dobbs*, we must reckon with the impact of abortion pills in other countries where they have transformed the safety and availability of clandestine abortions.

What if abortion were as simple as ordering a small package of pills online and taking them in your home? What if your abortion could happen at the time and place of your choosing, without traveling to a clinic and without a doctor judging your reasons? What if it could happen without paying hundreds of dollars? Without legislators and courts deciding if, when, and how your abortion should proceed? Abortion would look radically different.

Governments and courts are rolling back abortion rights in the United States, Poland, El Salvador, and other countries. They are making it difficult—or impossible—to obtain a legal abortion. In spite of their efforts, the practicalities of abortion have been transformed by medication abortion, increasing the safety and availability of abortion for people who live in places with restrictive laws. It has also changed the way that restrictive abortion laws operate. Historically, laws governing abortion were written to regulate the conduct of doctors, and governments depended on doctors' cooperation to enforce those laws.² When people can safely self-manage abortion without medical supervision, with medication they can obtain online, they can bypass this system of oversight.³ As a consequence, greater access to safe, self-managed abortion challenges governments' efforts to impose, enforce, and maintain restrictive abortion laws. Self-managed abortion is on the rise, but it is by no means universally available. If, how, and where a person can obtain a medication abortion depends on a complex mix of legal, political, geographic, economic, and social factors.

Abortion Pills Go Global is a book about medication abortion (MA). It follows MA across borders, asking how it changes the politics and geography of abortion when it enters countries with restrictive abortion laws. My analysis is focused on four countries in the midst of seismic shifts on abortion: the United States, Poland, Ireland, and Northern Ireland. While Ireland and Northern Ireland have recently moved from near-total abortion bans to relatively liberal abortion laws, the United States and Poland have moved in the opposite direction. Poland's already restrictive abortion law has recently been tightened. And fifty years after abortion was declared a constitutional right

in the United States, this precedent has been overturned and constitutional protections on abortion have been eviscerated. Millions of Americans now live in states where they can obtain abortion only when it is necessary in order to save life, and, in practice, they might not even be able to obtain abortion in that circumstance. The United States and Poland are out of step with the global trend toward more progressive abortion laws, but they are by no means the only places in the world where clandestine abortion is a lifeline. Around the world, people have safe but illegal abortions, accompanied by community providers and lay activists who support them remotely.

Despite their differences, these four countries and their experiences with medication abortion suggest significant trends that we might expect to see in other places in the future. That being said, this book offers no predictions. It is a work of social science scholarship, drawn from abortion research in geography, politics, and law. A geography of abortion might sound puzzling at first, but understanding abortion's spatial arrangement is essential for thinking about access, care, and equality. Abortion travel—domestic and international—is a regular feature of abortion access around the world. What is unavailable at a local hospital might be available at a hospital in a neighboring city, just as what is illegal in one country might be legal across the border. Medication abortion technology challenges us to think more creatively about the geography of abortion and the kinds of mobility that are involved in obtaining it. What is illegal in one country might be easily obtained over the internet from a vendor in another country. In places where neighboring states have vastly different abortion laws, as in the United States after *Dobbs*, borders and jurisdiction will become “the central focus of the abortion battle.”⁴ As I illustrate in later chapters, borders are also sites of opportunity for medication abortion activists.

This book develops four key arguments. First, MA activism as a movement prioritizes practical accessibility of abortion in the short term as a means to achieve longer-term social and political change. Second, MA is able to transgress social and political boundaries because it challenges prevailing ideas about what abortion is, where it takes place, and who does it. Third, MA travels the globe in ways that make it difficult for authorities to block because it is part of globalized medicine flows that cross borders (sometimes illicitly). Fourth and finally, self-management of abortion with pills makes it very difficult for authorities to enforce restrictive anti-abortion laws because it is difficult to monitor, detect, and prevent but also because criminalizing

individuals for obtaining abortions is politically unpopular. I preview each of these arguments in more detail below, after a brief discussion of some key concepts and terminology.

ABORTION IN MEDICINE AND LAW

Restrictive abortion laws do not end the need for abortion, nor do they prevent people from obtaining abortions. They do mean, however, that a greater proportion of abortions are carried out in unsafe conditions.⁵ Abortion has its own geography, occurring at higher rates in places where there is greater poverty, less access to quality healthcare, and more restrictive anti-abortion laws.⁶ Regardless of the law, many people have abortions. Just under half of all pregnancies worldwide are unintended; of these unintended pregnancies, 56 percent end in abortion. Every year, twenty-five million unsafe abortions occur globally. These unsafe abortions are the product of political choices: they are overwhelmingly concentrated in countries with the most restrictive laws.⁷

Advances in abortion methods have contributed to a decline in injury and death from unsafe abortion. The most important of these advances is the subject of this book: medication abortion. Abortion pills are used in hospitals and clinics around the world where abortion is legally available, but they are also widely used for self-managed abortion, in which a person “performs their own abortion without clinical supervision.”⁸ Safe self-managed abortion with pills has been an especially important innovation in places with very restrictive abortion laws, where it is difficult or impossible to access abortion care in a medical facility. In fact, medication abortion has transformed the safety and accessibility of abortion outside formal medical settings to the extent that new categories have been introduced to conceptualize it. Instead of seeing all self-managed abortions as unsafe, the World Health Organization (WHO) now categorizes abortions as safe, less safe, and least safe, according to whether they are done with a safe method and a trained provider. A self-managed abortion with pills is not the equivalent of the “dangerous and invasive” secret surgical abortion that many people call to mind when they imagine an illegal abortion.⁹

The legal status of abortion is also important for understanding its safety. The prevailing way of understanding illegal abortion—what scholars call the medico-legal paradigm—assumes a certain relationship between the legality and the safety of abortion. It assumes that only places with legal protections

for abortion can provide safe conditions for it to take place and that abortion will almost always be unsafe in places where it is illegal.¹⁰ However, the equation of legality with safety, and illegality with danger, has been upended by self-managed abortion with pills.¹¹ A safe but illegal medication abortion may not carry the physical risks we associate with earlier generations of illegal abortion, but it still presents challenges: many people lack access to accurate information about how to safely self-manage abortion, are unable to afford medication abortion or do not know where to obtain it, and risk criminalization if their abortion is discovered by state authorities.

Abortion language is always politicized, but even among proponents of medication abortion, there is some confusing terminology and blurring of concepts. For this reason, I cover a few key definitions at the outset. Medication abortion usually involves two drugs: mifepristone, followed twenty-four to forty-eight hours later by misoprostol. Mifepristone blocks the hormones that sustain a pregnancy; misoprostol induces uterine contractions that expel the pregnancy. Mifepristone and misoprostol together are the most effective, but misoprostol on its own is highly effective (and is much easier to obtain and therefore is widely used by itself). Mifepristone and misoprostol together have been shown to result in an abortion without further medical intervention in 95 percent of first trimester pregnancies, compared to 87 percent for misoprostol alone.¹² Because this book deals with medication abortion and self-managed abortion, it is primarily concerned with early abortion, that is, abortion during the first trimester. Medication abortion is also used at later stages of pregnancy, but WHO only recommends self-management of abortion with pills up to twelve weeks into a pregnancy. It is much less safe to self-manage abortion later in pregnancy, because later abortions often require greater medical intervention and clinical capacity.¹³ Nonetheless, many people self-manage abortions after the first trimester in places where legal or local abortion care is lacking.

In this book, I use the term “medication abortion” or “MA” to refer to abortion by means of mifepristone and misoprostol. When I want to emphasize the material qualities of these medications, I refer to them as abortion pills, and when I want to emphasize the nonclinical context of an abortion, I use the term “self-managed abortion.” Medication abortion is not the same as emergency contraception, although they are frequently confused.¹⁴ It is also important to differentiate between the abortion methods used during the first trimester: medication abortion uses pills to make the body expel the

pregnancy, whereas vacuum aspiration (commonly known as surgical abortion) uses suction to empty the uterus.¹⁵ Although widely used, “surgical abortion” is not an accurate label as this kind of abortion involves no cutting or suturing, which is usually associated with a surgical procedure.¹⁶ Despite these technical caveats, I speak about medication abortion and surgical abortion in the book for the sake of consistency and clarity.¹⁷

Self-managed abortion with pills includes a range of ways to end a pregnancy outside of clinical settings or without direct clinical supervision.¹⁸ It is better understood as a category rather than a specific procedure. Sometimes self-managed abortion involves elements of telemedicine, meaning the provision of remote clinical services like a telephone or email consultation with a doctor. Self-managed abortion might be legal, illegal, or somewhere in between, depending on the country in which it takes place. It is best to imagine the different models of self-managed abortion on a continuum, with some points of overlap:¹⁹

- ♦ Traditional, in-person care: Appointments with a doctor take place in person. All consultations and tests are done in person. Medicines are prescribed and dispensed in person, and the medications might be taken in the clinic in front of the abortion provider. This model is only available in countries with legal abortion.
- ♦ Partial telemedicine: Tests are carried out in person at a nearby medical facility that is not an abortion clinic. The consultation with the abortion provider is done remotely via telephone or video. Medications are dispensed in person or by mail. This model is only available in countries with legal abortion.
- ♦ “No touch” or full telemedicine: All consultations with the abortion provider are carried out remotely, and medications are dispatched by mail directly to the person’s home or somewhere safe where they can be collected later, for example, a post office box. This model is only available in countries with legal abortion. It has become much more widespread since COVID-19.
- ♦ Self-managed abortion with remote support from online feminist networks: There are no home tests, only a remote email consultation with a doctor or other support person. Medications are dispatched by mail. This model is available throughout the world, though it is illegal in many places. It is available, for example, through the organizations Women on Web and Women Help Women.

- ♦ Self-managed abortion without support: Some people obtain abortion pills through local networks or online pharmacy vendors. They may use these pills to self-manage an abortion without the support of a doctor, lay activist, or community health worker. People who self-manage abortion without support are especially vulnerable to criminalization.

Dividing abortion care into these categories shows the range of services available, but it provides only a rough guide because services are tailored to the geographic context where they operate. In addition, it is common for a few of these models to coexist in the same country at the same time, as in countries where it is difficult or expensive to access legal abortion care and cheaper and easier to access abortion pills through online networks or in the local informal market.

SOCIAL DECRIMINALIZATION BEFORE LEGAL DECRIMINALIZATION

There are many activist movements advocating for access to abortion across the world. They are a large and heterogeneous group, often working in domestic movements to lobby for reforms and facilitate greater local abortion access. There is also a transnational abortion activist movement of people—most of them women—who work to expand access to MA. Sometimes they do this by advocating legal change, but just as often they work outside of legal and political institutions to provide abortion medications and practical information on their safe use. MA activists are skeptical about prioritizing law as a tool to create access, instead working according to the principle that on-the-ground access leads to legal change. They engage with scientific authorities and lawmakers, but they do so by drawing on evidence generated over years of facilitating clandestine abortion.

MA activism operates according to a radical theory of change, probably most akin to what social movement scholars call “prefigurative” politics.²⁰ This means that rather than protest unjust institutions, activists focus on enacting change immediately, building their own institutions and embodying the changes they want to see. This is a helpful framework for understanding MA activism. It welcomes law reform—especially abortion decriminalization—but it is opposed to modes of activism that concentrate on law at the expense

of the practical availability of abortion. The activist networks discussed in this book are engaged in years-long efforts to build sophisticated organizations to obtain MA, supply it, increase awareness of it, provide reliable information about how to use it, and eventually change its legal status. MA activists believe that everyday social acceptance of self-managed abortion runs ahead of legal change. As a Polish activist explained to me, “We don’t believe that law creates access—we believe that access creates law.”²¹ MA activists argue that the informal social decriminalization of abortion pills that is generated by widespread clandestine use can contribute to formal decriminalization and abortion law reform.

Changing abortion’s social status is the key goal here. Activists do this by running campaigns to break the silence surrounding abortion, sharing personal stories of abortions, and fighting stigmatizing narratives that claim abortion is traumatizing and shameful. Where abortion is legal but taboo, someone who speaks publicly about having an abortion might risk being harassed or shunned, but they do not risk imprisonment. Where abortion is illegal, speaking publicly about it is another matter entirely. Latin American feminists call this process “social decriminalization”: changing abortion’s social status among the public and persuading them that it is unacceptable to jail people for having abortions even while it remains criminalized by the state.²² This strategy has several different aspects. It employs public defiance of abortion laws and facilitates access to safe self-managed abortion with pills.²³ It promotes campaigns to bring abortion into the public conversation and to persuade the public that abortion is a common procedure and a human right.²⁴ Campaigners counter stigma with empathetic narratives about the prevalence of abortion to persuade the public that abortion exists regardless of the law, and therefore the secrecy in which it is shrouded should end.²⁵ Social decriminalization combines small everyday activities with spectacular moments of protest and interventions in public institutions.²⁶ Public defiance of criminal abortion bans is a high-risk strategy in some places, and there are Latin American countries like El Salvador that have been willing to imprison individuals for suspected abortions.²⁷ Generally, however, there has been little political will among Latin American governments to enforce the criminal abortion bans that they have installed.²⁸

Social decriminalization of abortion works on parallel tracks: it provides clandestine abortions regardless of abortion’s legal status while mobilizing public opinion against restrictive abortion laws. It does not wait for law to