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Safe and Subversive: Medication Abortion's Potential to Reshape Patterns of Access and Power

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Medication Abortion's Potential to Reshape Patterns of Access and Power

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Introduction

"You can't hold back scientific progress… You can't put it back in the drawer,"[1]

—Dr. Etienne-Emile Baulieu (1989)

The development of medication abortion (MA) in the 1980s was the first advance to significantly affect how abortion care is provided and received since the vacuum aspiration method was introduced in the 1950s. It uses two types of pills to terminate a pregnancy, starting with mifepristone and followed by misoprostol at least 24 hours later. Prior to that breakthrough, nearly all abortion techniques available to medicine had been known since antiquity.[2] How is it that for a practice as old and routine as abortion, medical innovation has been so incredibly slow to advance? The issue lies not with researchers, who depend on funding from sources willing to be associated with abortion, but is instead wrapped up in the political, moral and ethical debates surrounding the issue. Since the day it was discovered that mifepristone (RU-486) could be used to end early pregnancy, its fate has been governed by politics rather than science.

In France, where mifepristone was first synthesized by Dr. Etienne-Emile Baulieu and colleagues in 1980 and approved for use in 1988, anti-abortion groups initially succeeded in pressuring the drug's manufacturer, Roussel Uclauf, to take it off the market. "Side effects were in no way a problem," said Arlette Geslin, director of medical relations for Roussel, "The problem was that there were protests, letters threatening to boycott, and demonstrations in front of our headquarters. We didn't want to get into a big moral debate."[3] On the same day the company withdrew mifepristone, nearly 10,000 physicians and researchers were gathered in Rio de Janeiro for the World Congress of Gynecology and Obstetrics, where a protest campaign began to rescue the drug.[4] As pressure built from physicians, scientists, feminists, and family planning organizations, the French government decided to intervene. Minister of Health Claude

Evin ordered Roussel to resume distribution of what he declared the "moral property of women, not just the property of the drug company."[5] By 1990, MA accounted for some 25-30% of all abortions performed in France,[6] results from over 500 published research reports supported its use as a safe and effective alternative to surgical abortion, and public health experts recognized its potential to drastically reduce abortion-related morbidity and mortality in the developing world.[7]

Meanwhile, the US National Institutes of Health (NIH) continued to deny funding to any research project involving mifepristone; in 1986, the Secretary of Health and Human Services explained this was due to "congressional directives" and "administration policy.[8] The only privately funded, large-scale clinical trial was cut short due to difficulties obtaining the drug for research[9]. As Gary Hodgen, a scientist in the field, explained in 1990:

> "The problem is not due to any lack of effort by researchers or their professional associations. What we are facing is a political agenda of the anti-abortion side that acts to directly prevent federal funding and regulatory review of the potentially therapeutic effects of RU 486 and similar medications… these political forces are the same ones that have blocked federal research funds since the mid-1970s for study of human fertilization, embryogenesis, and fetal development. Has this limiting of federal leadership and cooperation in reproductive research compromised our nation's scientific integrity? Unquestionably, yes!"[10]

The federal government's alignment with the anti-abortion movement has compromised not only the country's scientific integrity but also the medical legitimacy of regulations governing access to abortion. Despite mounting evidence in support of MA, it would not be offered through the formal health care system for another ten years. The tide turned in 1993, when President Clinton directed the Food and Drug Administration (FDA) to revoke its import ban on mifepristone and initiate its testing, licensing and manufacturing. Soon after, Roussel Uclauf transferred patent rights to The Population Council, and data from the clinical trials that followed was submitted to the FDA in 1996.[11] When the FDA finally did approve the regimen in 2000, the agency attached

a set of heavy regulations that make the medication difficult to access and inconvenient to prescribe. These regulations are supposedly in place to protect the health and safety of women[a] but are widely recognized as medically unnecessary, and the movement demanding their removal is supported by professional organizations such as the American College of Obstetricians and Gynecologists (ACOG).[12] As a result of the restrictions, MA is sorely underutilized as a way to better serve populations in areas with critical abortion provider shortages.

This incongruity between the stated purpose of abortion regulations and their actual effects is nothing new, and it is not unique to the specific method of MA. Federal and state laws have unjustifiably limited access to abortion care since the medical profession was established in the US. Rather than driving the decline in abortion rates over time, as their anti-abortion proponents would like to believe, these laws merely impose hardships on those seeking and providing abortion.[13] Consequently, women have had to find alternative sources of abortion care.

Many have heard of the "coat-hanger" or other "back-alley" methods practiced in the era before *Roe v. Wade* legalized abortion in 1973. Some of these services were offered by medical professionals who risked the loss of their licenses, while others were done by women themselves, such as members of the Jane collective who arranged and performed over 11,000 abortions between 1969-1973.[14] Yet other women worked alone, trying various home remedies in complete secrecy. The risks of illegal abortion varied with the exact technique and skill level of the provider, but the overall morbidity and mortality rates associated with the pre-*Roe* illegal underground are harrowing. However, the tragic toll of unsafe abortion cannot be isolated to any

[a] I do not mean to imply that all pregnant people and all who seek abortion care are cisgender women. Trans men and non-binary folk are part of this conversation as well, and gender-neutral language about pregnancy would instead reference "pregnant people." Throughout this thesis, my use of the word "woman" reflects the literature and science research that centers the term. More research is needed on the experiences of trans and non-binary folk in medicine, particularly pertaining to abortion.

particular geographic setting nor period of time—still today, it is one of the leading causes of maternal mortality worldwide (13%).[15] The reality is, there have always been and will always be people who would rather face extreme danger—including the threat of death—than continue life with an unwanted pregnancy. As access in the US dwindles by day and the possibility of *Roe v. Wade* being overturned looms ahead, Americans are anxiously wondering if past will be prologue. In a post-*Roe* world, how many more lives will be lost to illegal abortion?

Owing to the advent of MA, the answer could be next to none. Though the only legal route to access is over the barriers and through the formal health care system, the pills can be found on numerous online pharmacies that circumvent FDA regulations. A woman who places an order today could expect to receive the package within three weeks and have successfully terminated her pregnancy two days after its arrival.[16] Unlike dilation and evacuation (D&E) and vacuum aspiration abortion, the other two methods recommended by the World Health Organization (WHO), MA is remarkably simple to administer. It has a consistently proven success rate of over 95% through the 12th week of pregnancy,[17] and evidence shows that women who can obtain the medications and follow instructions for proper administration can safely and effectively provide their own abortions.[18] It is worth mentioning that all MA is to a degree "self-managed," as women must always manage the symptoms at home (after a doctor hands over the medications), but the term only truly applies when the pills have been sourced outside the formal health care system. Women who choose to do this shoulder some risk of criminal prosecution, but their health and well-being are not otherwise on the line. Although it is impossible to know just how populated the route is, research indicates that many are already practicing self-managed MA, and interest is growing quickly.

Importantly, diminished access to abortion is not the sole force driving demand; a variety of factors unique to self-managed MA make it the first choice for some. Not only is it much less expensive than clinic-based care on average,[19] but the ability to complete the procedure from home increases the potential for privacy, comfort and convenience, and some cite autonomy during the process and the feeling of empowerment as motivations for seeking abortion pills online.[20] Women throughout history have elected to self-manage their abortions for many of the same reasons, but before MA existed, the most effective methods were also the most dangerous.

The development of MA has forced us to reevaluate long-established relationships between the words "self-managed," "safe" and "legal." No longer does safe equal legal, and no longer must illegal mean unsafe. For the first time in history, illegal avenues are sometimes the most accessible routes to safe abortion, the primary risks of self-managed abortion are legal rather than health-related, and some people may choose to self-manage out of preference rather than necessity.

This thesis is by no means a comprehensive account of self-managed MA. When I refer to "MA," I am specifically speaking of the combined use of mifepristone and misoprostol. By focusing on this dual-drug regimen, I am abbreviating an equally worthwhile discussion of the "miso-only" method. Misoprostol can be used alone, in three separate rounds administered 3-12 hours apart, at an 85% success rate. Though this protocol is less effective than the combined regimen, it can also be used safely through the 12th week of pregnancy and is recommended by the WHO when mifepristone cannot be obtained.[21] Misoprostol is much less expensive and far more accessible than mifepristone, as it is commonly used to treat ulcers and arthritis and can be found over-the-counter (OTC) in many countries, including Mexico. I follow the lead of most research conducted in the US in choosing to focus on the dual-drug regimen; the fact that it is an

FDA-approved, standard treatment has enabled the collection of far more data. For similar reasons, when I mention "self-managed MA," I am generally referring to the practice of self-sourcing the pills through online, unregulated pharmacies. Although this is far from the only channel used to obtain them, we know much less about the alternatives, and hardly any data on them exists.

In this thesis, I explore how the politicized history of abortion in the US has influenced the emergence of MA and manipulated the ways in which it is used and understood, considering its potential as a tool for harm reduction, health equity and social change. Even when not explicit, this inquiry constantly draws on the theories of Actor-Network Theory (ANT) and reproductive justice. The former is an approach to social theory that hinges on networks of human and non-human actors surrounding all technological achievements, each entity acting according to particular interests.[22] It is a useful tool for conceptualizing the power and motivations of entities such as state legislatures, regulatory bodies, abortion providers and those seeking care, as well as for characterizing the relationships among them. "Reproductive justice," is a framework that centers material access to abortion rather than the theoretical ability to "choose." It is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[23] The framework aims to deconstruct power systems and center those most marginalized, making it an ideal lens through which to consider the benefits of MA. Ultimately, I argue that MA has been underutilized as an instrument of reproductive justice due to longstanding and unbalanced power dynamics in the struggle for reproductive control—power dynamics that are threatened and destabilized by the practice of self-managed MA.

My first chapter provides a brief history of self-managed abortion with the goal of highlighting how MA revolutionized the practice. Whereas we typically think of abortion as a medical procedure, it was, until relatively recently, a skill learned from hands-on experience. Early knowledge about abortion came from observing miscarriage, and boundaries between the two were blurry. Rather than seek care from a doctor, women were more likely to turn to friends or midwives for counsel, and traditional remedies were typically applied at home. Notably, we see that preferences such as privacy have long contributed to women's decisions about abortion, and that for millennia, the practice was largely self-managed. Before mifepristone and misoprostol were available, self-managed abortion necessarily carried a low chance of success and high risk of complications. This is still true in some parts of the world, though abortion medications are gradually succeeding traditional methods. They are overwhelmingly safe when used as recommended by the WHO but can still be dangerous when taken in improper doses or too far along in pregnancy.

In Chapter Two, I chronicle the development of MA and review the science at play. We see how the push to put mifepristone on the market in France exacerbated tension between anti-abortion groups and feminist activists as well as invited controversy over potential adverse health effects. As the science became more clear, public perception did not; the debate remained highly polarized despite an increasing number of studies validating the safety and efficacy of MA. In this chapter, I draw special attention to the similarities between MA and miscarriage, the natural result of 15-20% of all pregnancies.[24] Not only are their mechanisms nearly indistinguishable, but so too are their symptoms, complication rates and follow-up treatment. A brief overview of the legitimate health risks associated with MA is included to emphasize the contrast between current regulations and what is medically justifiable.

This prompts Chapter Three's inquiry of how and why such scientifically unsound regulations came to be. By tracing back their roots in the struggle for reproductive control, persistent patterns of race- and class-based inequality materialize. That is, low-income women and women of color have borne the brunt of hardships imposed by abortion restrictions and experienced adverse health effects at higher rates than their white, middle-class and wealthy counterparts. Their reproductive autonomy, along with that of people with mental and intellectual disabilities, has also been disproportionately suppressed by abuses such as sterilizations forced by racist, eugenic actors. As explained by Loretta Ross, a cocreator of the reproductive justice framework, "past abuses of women's reproductive bodies live on in contemporary harms and coercion."[25] Various entities throughout history have repressed and exploited the reproductive capacity of the most vulnerable populations. As the analysis will show, the mechanisms have changed over time, but the reasons are rooted in the same unbalanced power dynamics.

In Chapter Four, I illustrate how these dynamics would likely materialize in a new phase of the struggle for reproductive control, one in which *Roe* has been overturned or rendered ineffective. We see that once again, marginalized communities would feel the consequences disproportionately, while abortion would remain accessible to those who can afford to travel for services. In fact, this picture isn't that different from our current reality. Self-managed MA is often billed as the starring role in a post-*Roe* world, but it's already the most accessible path to safe abortion for many who live in abortion deserts today. Demand for unofficial sources of abortion pills is certainly increasing, but among a much wider population than would be expected if barriers to access alone were driving demand. In this chapter, I argue that we must

look beyond the context of a post-*Roe* world in order to fully understand the potential uses and subversive power of self-managed MA.

Whether this subversive power is any match for the institutionalized power of state and medical control is the subject of Chapter Five's investigation. Drawing on the ANT approach, I inspect the functions and motivations of various actors with a stake in how abortion pills are used and distributed. These relationships call into question the legitimacy of authoritative power claimed by the government and its regulatory bodies. I make the case that MA regulations, which serve no medical purpose, are manifestations of the politicization of abortion that rely on increasingly unsteady power dynamics among women, physicians, activist networks, lawmakers, online unregulated pharmacies and the FDA. Furthermore, I argue that the American federal government's authority is seriously threatened by international actors that ship abortion pills to US residents and provide all the information needed to successfully manage their own abortion. Though it is unclear how this power struggle will resolve, it certainly has the potential to shift deep-rooted dynamics.

In my concluding chapter, I connect the power-shifting abilities of MA to its expansive potential as a tool for achieving reproductive justice. In the words of Marlene G. Fried and Susan Yanow, the two women who introduced "self-managed abortion" into my vocabulary at the 2019 Civil Liberties and Public Policy Conference (CLPP): "Looking at self-managed abortion through a reproductive justice lens highlights the ways in which the practice lies at the intersection of human rights, public health, empowerment and access."[26]

I must acknowledge that I cannot and do not present a narrative of self-managed MA that is representative of the diverse range of experiences it generates. In an attempt to balance the narrative as best I can, I draw from a wide variety of sources and incorporate first-hand accounts

where possible. Nonetheless, my positionality as a white, cisgender and middle-class woman means I am particularly ill-equipped to imagine, interpret and analyze perspectives from the marginalized communities centered in a reproductive justice framework. As a result, there will be important pieces left unsaid and unanalyzed; I apologize in advance for these omissions and welcome both critique and continued conversation.

I would be remiss not to also recognize the rapidly-evolving nature of this subject and its impact on my work. I began my research in the midst of an unprecedented wave of extreme anti-abortion legislation[b] that succeeded in bringing the first major abortion case to the US Supreme Court since Brett Kavanaugh's confirmation in 2018. That case, *June Medical Services v. Russo,* was argued on March 4th, and the decision is expected later this year,[27] as the onslaught of radical legislation continues and we gear up for a fateful election season. Much is at stake in 2020, and those aware of self-managed MA's key role in a post-*Roe* America have been working overtime to spread information and build grassroots support. I knew my research would be complicated by a surge of stories with titles along the lines of: "More People Are Starting to Prefer Doing Their Abortions on Their Own,"[28] One thing I did not anticipate, however, was a global pandemic that would further obstruct access, disrupt the international supply chain of abortion pills and bring MA regulation into the national spotlight.

The Coronavirus Disease 2019 (COVID-19) emergency has necessitated the suspension of "nonessential" medical procedures and compelled the broad shift to telemedicine.[29] To prevent unnecessary travel, interaction and use of limited medical

[b] According to the Guttmacher Institute's "State Policy Trends 2019," of the 58 restrictions passed in 2019, 25 would ban all, some or most abortions at the state level. In violating Roe v. Wade, these laws are designed create opportunities for the US Supreme Court to undermine its constitutional protections.

resources, the UK government temporarily changed abortion policy to allow delivery and at-home use of abortion pills.[30] In the US, several senators and a coalition of 21 attorneys general have urged the federal government to do the same:

> "People who need an abortion cannot delay care and should not needlessly risk coronavirus exposure. Given the years of scientific evidence indicating that medication abortion is a safe and effective treatment, we ask that FDA take immediate steps to temporarily exercise enforcement discretion on in-person dispensing requirements, so that people can more easily access abortion care without putting themselves or their health care providers at risk of infection from COVID-19,"[31] - Senators Elizabeth Warren (MA), Patty Murray (WA) and Tammy Baldwin (WI)

> "The FDA should not mandate this medically unnecessary travel, particularly during the COVID-19 crisis where not only are women being advised to stay home, but families are faced with additional childcare and financial constraints,"[32]—attorneys general from 21 states

Meanwhile, the US is seeing a wave of anti-abortion opportunism. As of April 14th, 2020, politicians in thirteen states had attempted to use the pandemic as an excuse to ban abortion altogether by falsely labeling the procedure as "nonessential."[33] This is merely the latest example of such actors prioritizing political interest over the goal of public health. In another thesis, one I embarked on today, my core chapters would explore the effects of COVID-19 on patterns of perception and utilization of MA. Though the past year has brought much more change than I will be able to address, this thesis reflects my understanding of the situation as of April 15, 2020. Going forward, I suspect this will be an interesting moment in the history of self-managed MA upon which to reflect as its evolution continues.

Chapter One

A History of Self-Managed Abortion

"Over the centuries there developed a varied technology of abortion—magical and mechanical, external and internal. When abortions became illegal, these techniques merely went underground. In fact, there is striking continuity between abortion techniques used in ancient societies and those used in modern 'home-remedy' abortions,"[34]

—Linda Gordon, *The Moral Property of Women*

Self-managed abortion, also called self-induced, self-sourced, self-administered, or "DIY" abortion, describes any action taken by a person to intentionally end their own pregnancy without the supervision of a clinician. Although this thesis focuses on one method in particular (the combined use of mifepristone and misoprostol in the MA regimen) it is important to frame its development as the latest chapter in a long history—one which is often misconstrued in debates of high morals and principles. In reality, abortion is and has always been a matter of compelling circumstances; in almost every society to date, there have been women who feared continuing an unwanted pregnancy more than the risks associated with ending it. Today, the most likely consequence of inducing an abortion with modern medication is legal punishment, but for centuries self-managed abortion was often fatal. Until misoprostol and mifepristone came into use as abortifacients, the most effective DIY methods were those that posed the greatest threat of death. To understand how the advent of MA revolutionized the practice of self-managed abortion, we must place it in the appropriate historical context.

In the Ancient World

Home remedies for early-term abortions are described in many ancient texts. The earliest known Egyptian medical document describes using plant substances, and a 4600-year-old document from China advocates the use of the highly toxic chemical mercury.[35] Texts from

classical antiquity also confirm that abortion, though frowned upon by some, was generally considered a standard practice. Most Greek doctors were willing to perform abortions for medical reasons, and few would refuse to treat a woman seeking help after attempting to self-induce and harming herself.[36] Still, women were more likely to seek the counsel of a midwife, medical woman, or friend who was knowledgeable about pregnancy, as all knowledge of induced abortions came from experience with miscarriage. That is, the same situations and substances used to safeguard pregnancy could also be used as abortifacients:

> "After the conception one must refrain from any exaggeration and agitation, physical and mental, for the sperm is expelled as a result of sudden fear and sorrow and joy, and on the whole as a result of a powerful shock of the mind, and strenuous exercise and violent intermissions of breath, coughs, sneezes, beatings, falls—and in particular on one's back—lifting weights, jumps, hard seats, use of drugs, administration of pungent drugs and sternutatories, malnutrition, indigestion, drunkenness, vomiting, looseness of the bowels, loss of blood through the nose, the hemorrhoids or another outlet, relaxation through an agent which can increase the temperature, and because of high fever, and shiver and spasm, and in general anything which can cause a violent motion, that is, the means to cause an abortion,"—Soranus, 2nd century AD.[37]

Because perceptions were influenced by religion and superstition, and abortion was linked to irrelevant factors such as shock, sorrow and sneezing, available knowledge on the matter was not very accurate. Even so, this did not bear much impact on the actual practices and procedures, as induced abortion was a skill people learned from hands-on experience.

Information from medical and non-medical texts suggest that by the classical period, a huge variety of methods were already known and practiced. Oral drugs were both the most accessible and the least troublesome, ranging from simple substances such as cyclamen plants to complex potions made of several ingredients in precise measurements. Modern science has shown that some herbs, such as cyclamen, mountain rue, birthwort, bryony and squirting cucumber actually do possess the abortifacient properties attributed to them, but the toxicity that

served to terminate a pregnancy could also be detrimental to the mother.[38] As Galen summarizes: "Most of the drugs… are too weak to be efficient from such an undertaking, but some, even though potent, are dangerous for human life."[39]

Similar substances were sometimes applied as vaginal suppositories, which carried greater risks overall. These suppositories were explicitly prohibited in the Hippocratic Oath (which did not ban abortion altogether), likely because their irritant properties often caused ulcerations, inflammation and septic abortions.[40] A woman weary of medical risk might first try oral drugs, or, for an even lower chance of harm (and success), she might externally apply an abortifacient cream to her abdomen. If these methods failed, or if access to abortifacients was an issue, she could attempt to induce an abortion by means of physical violence or over-exertion. Although mechanical means offered the advantage of being able to present the abortion as an accident, its already limited efficacy was completely dependent on the woman's courage and ability to exert substantial violence onto her own body.[41]

The lack of relevant writing by women makes it difficult to determine just how much they knew about these methods and their associated risks. It is nevertheless clear that abortion was understood to be a dangerous endeavor, as confirmed by references in non-medical literature. The Roman poet Ovid provides an example in the 13th piece of his second book:

> Aiming to end her pregnancy—so rashly—
> Corrina lies exhausted, life in doubt.
> To run such fearful risks without my knowledge
> Should make me rage, but fear's put rage to rout…
> O Isis, patroness of Paratonium…
> Turn your eyes here; on her—and me—have mercy;
> You will give life to her and she to me..
> You too, kind Ilithyia, who take pity
> When girls are locked in labour, and relieve
> Their hidden load, be present, hear my prayer…

Because women who wanted to terminate usually wanted to hide the existence of the pregnancy in the first place, they were unlikely to seek help from well-known and experienced practitioners. Some turned to friends, midwives, religious figures, magicians and others with obscure credentials for advice or assistance, while others self-managed completely.[42] Thus, methods that could be used in the privacy of one's own home, such as drugs administered orally or externally, pessaries and mechanical means, were highly attractive for their guaranteed secrecy. Women often combined techniques, starting with safer and less painful options and moving on to more drastic measures. Just how far she went would depend on the availability of abortifacients, the urgency of her circumstances and her state of mind. As an absolute last resort or in an emergency, she might go to a practitioner for surgical abortion, but poor sterilization techniques and the lack of anesthesia and antibiotics made each procedure an excruciating, life-threatening ordeal.[43]

Abortion in the ancient world was largely self-managed. Women typically induced their abortions alone or with the guidance of non-doctors, and from the wide variety of documented methods, it is clear that they were willing to go to great lengths and experiment with highly toxic substances in order to end unwanted pregnancies. Not even the threat of death could deter a woman if she believed that continuing the pregnancy under existing circumstances would make life unbearable. Evidence suggests that the phenomenon has existed in almost every society to date, making self-managed abortion an extremely old practice that is unlikely to ever disappear.

In the Modern World

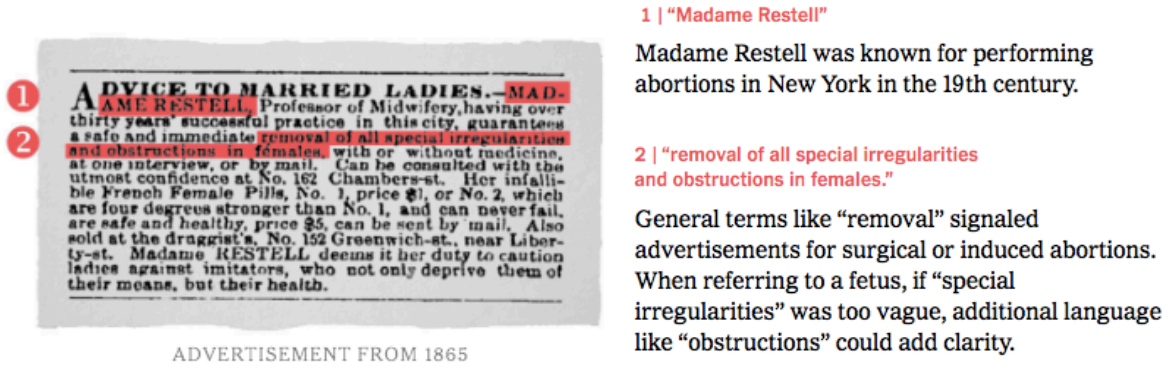

Figure 1. Coded advertisement for abortion services in an 1865 newspaper, annotated by Thompson.

Source: Lauren MacIvor Thompson, The New York Times, 2019

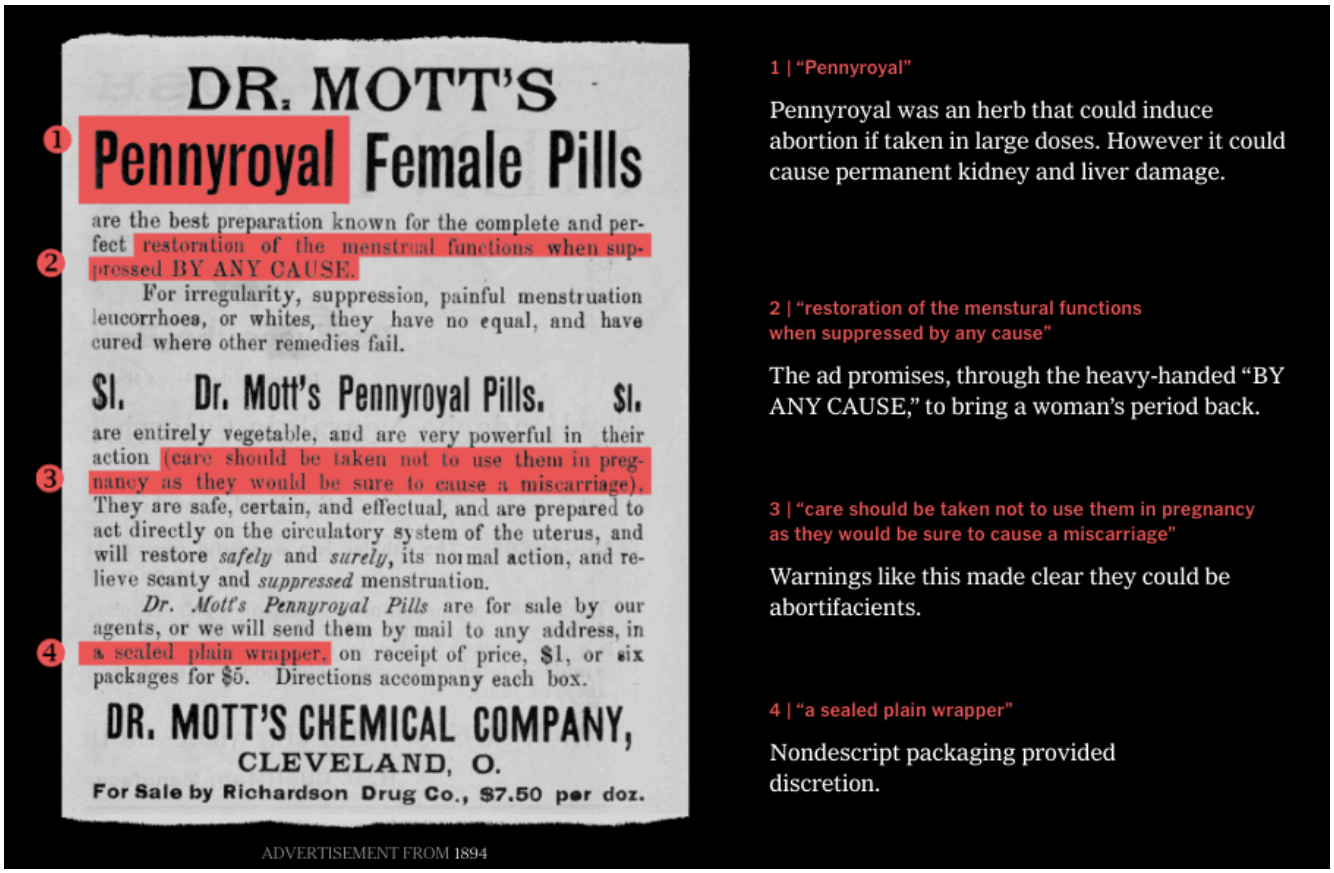

Figure 2. Coded advertisement for abortifacients in an 1894 newspaper, annotated by Thompson.

Source: Lauren MacIvor Thompson, The New York Times, 2019

In 19th century America, what was considered "birth control" included breastfeeding, abstinence, the rhythm method, vaginal douching and the use of herbs thought to stimulate menstruation. Though these practices were often dangerous and largely irregulated, women considered them essential, as evidenced by the prevalence of newspaper advertisements that promoted abortifacients in coded language by the 1820s (*Figures 1-2*).[44] Some of these substances, such as pennyroyal, were among the herbs recorded in early history, which have been used in many societies since. Around the world, however, self-managed abortion methods developed with as much variation as any other cultural practice. In several African countries, traditional herbs were supplanted by laundry bleach; in Britain, they were replaced by gin, iron filings and quinine. Women in late 20th century Morocco reported using herbal potions, contraceptive pill cocktails and squatting over a dish of smoking herbs to induce bleeding, while women in Thailand regularly practiced traditional abdominal massage. Despite the high risk of hemorrhage and pelvic inflammation, these procedures outnumbered abortions by Thai physicians 2500 to one at the turn of the 21st century.[45] Meanwhile, women in Brazil had discovered that the over-the-counter drug Cytotec (misoprostol), introduced there in 1986 for the treatment of gastric ulcers, could be adapted as an abortifacient.

Misoprostol has since been approved in many countries for medical termination of pregnancy, and in those where it is only available for gastric-related indications, "off-label" use is growing for self-managed abortion.[46] Used alone, it has a success rate of 75-80% through the 12th week of pregnancy and offers a safe alternative to the combined misoprostol-mifepristone regimen, which is 95-98% effective in completing early abortion.[47] WHO recommends both methods but prefers the dual-drug regimen when mifepristone is available.[48] According to The Medical Abortion Commodities Database, mifepristone is licensed for use as an abortifacient in

46 countries, and misoprostol is available for one or more indications[c] in 99 countries.[49] When MA care is provided by a practitioner, the abortion is not "self-managed," even though much of the process, including the actual passing of the pregnancy, happens outside of the clinic. The procedure *is* considered self-managed when carried out without the supervision of a clinician, which entails obtaining the medications through unofficial channels. Though online pharmacies are the focus of most research and media coverage, there are other ways to self-source the pills, such as buying from individual sellers.

The risks of self-managed abortion vary alongside the methods. Of those that have been discussed, modern abortion medications are the only safe options. Although the quality of evidence is greatest for pregnancies in the first trimester, a growing body of literature suggests that both the combined MA regimen and misoprostol alone can be used safely and effectively far past that window.[50] For each method, WHO has different guidelines for dosage, timing and route of administration depending on the gestational age, while the FDA only approves a specific dual-drug regimen up to 10 weeks' gestation.[51]

The demonstrated safety of self-managed MA prompted the WHO to reconceptualize its longstanding dichotomy between "safe" and "unsafe" abortion. The organization defines unsafe abortion as "a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both," and for an abortion to be "safe," it must be provided by a health-care worker.[52] In this framework, a self-managed abortion cannot truly be classified as safe even when WHO guidelines are followed. Yet, WHO also recognizes that broader use of abortion pills has been linked to decreased

[c] In addition to prevention and treatment of gastric ulcers and medical termination of pregnancy, misoprostol can be used for various obstetric indications including ripening of the cervix, induction of labor, prevention and treatment of post-partum hemorrhage and treatment of incomplete abortion.

complications from unsafe abortion.[53] This contradiction compelled WHO to redefine safety as existing on a continuum of risk, one that considers social and legal context in addition to technique and physical setting.[54] Similarly, experts at the Guttmacher Institute describe moving toward a "spectrum of safety" that recognizes three main categories: safe, less safe, and least safe.[55] In order for an abortion to be less safe, it must meet one of WHO's two criteria for a safe abortion—(1) the provider must either use a WHO-recommended method or (2) have the appropriate training. Safe abortions meet both criteria, and least safe abortions meet neither. In this system, properly administered MAs are considered less safe, and all other "DIY" methods are least safe.

There are some cases in which MA, too, would be considered "least safe," such as when a woman takes the incorrect dosage or obtains counterfeit drugs. This usually happens when the pills are bought from individual sellers found through personal networks. A recent study conducted in Chile revealed this to be common experience there.[56] As a woman named Karina told the researchers:

> "*My best friend had an abortion, and she was the first person I went to. I knew she would help; she had the information, which she had from a feminist group in my Faculty. She gave me the telephone number and put me in contact with a person who I phoned and bought the pills from.*"[57]

There is no standard among these pill sellers, and they offered different types and numbers of pills with various price tags. Another woman, Wilma, described her interaction with the seller:

> "*He said: 'I have 2 types of pills. One that costs $70,000 for 4 misotrol, and one that costs $90,000 which includes 6 mifepristone, which I think is the best dose to use. It's up to you.'*"[58]

Even though half of the participants consulted online activist networks for instructions, and a third asked medical professionals for advice, many did not get accurate information on dosage and administration. Of the 30 women, 27 sought medical attention at some point during the

abortion process and nine required further treatment—a 70% success rate.[59] It is clearly in the interest of public health to spread accurate information about how to properly take abortion medications.

The use of mifepristone and misoprostol is increasing globally, but at greater rates in industrialized countries where barriers to access are lower and fewer. In developing countries, pill sources are generally less reliable, and barriers push many down more dangerous routes. As a result, almost all abortion-related deaths occur in those countries, accounting for 4.7-13.2% of all maternal deaths and making unsafe abortion one of the leading causes of maternal mortality worldwide.[60] Other barriers to safe abortion include restrictive laws, poor availability of services, high cost, stigma, conscientious objection of health-care providers and unnecessary requirements.[61]

Though some difficulties persist when seeking self-managed MA, it has never been easier or safer to terminate one's own pregnancy. So long as one is able to access the internet, understand the instructions of unregulated pharmacies and activist networks and receive mail, safe abortion is within reach. Cost remains an issue for some—a 2018 study, "Exploring the feasibility of obtaining mifepristone and misoprostol from the internet," found that prices ranged from $110 to $360[62]—but a universally affordable option has existed since March of 2018, when Dr. Rebecca Gomperts launched a website called Aid Access. The site connects pregnant people with a physician who can remotely determine their eligibility for MA and refer them to a pharmacy in India that fulfills the prescription. A $90 donation is suggested, but the service is provided on a sliding scale fee. Should the proportion of people seeking care who cannot pay increase, Aid Access's ability to continue shipping pills for free will be put to the test. Additional hardships exist for people who don't have internet access, who face language barriers, who lack

mailing addresses or who need to hide their actions from the people they live with, and many who need self-managed care may not even know a safe option exists. Though self-managed MA by no means eliminates all barriers, for many, it is the most accessible route to safe abortion.

Before the development of MA, no road to safe abortion could bypass the doctor's office; it takes extensive training and experience to become a competent provider of vacuum aspiration and D&E abortion. In contrast, MA workshops train clinicians in a matter of hours,[63] and the necessity of formal training is debatable. Studies reporting high success rates from at-home administration suggest that the ability to follow a simple set of instructions is all one needs to safely operate as their own provider. This can of course be complicated by language barriers, and it assumes that authentic medications in the proper dosage can be acquired. Still, owing to modern medication, the perils of self-managed abortion are no longer necessarily health-related.

The true magnitude of this achievement can be appreciated only after looking back in time and around the world. As Linda Gordon writes in *The Moral Property of Women*, a book lauded as the most complete history of birth control ever written: "Women accepted the pain and danger of abortion in the same manner that they accepted the pain and danger of childbirth, with the assumption that both were necessary for their own and their communities' health and welfare."[64] Our knowledge of traditional practices, though limited, is evidence that women have long sought to control reproduction and viewed birth control as their responsibility. Some went to greater lengths than others, and those who needed to disguise their actions often accepted additional risks. While safe abortion eventually became standard medical practice, communities deprived of professional medical care, whether due to economic or legal constraints, continued to depend on "home remedies." Modern DIY techniques bear many similarities to those used in

ancient societies, which explains the costly contribution of unsafe abortion to global maternal mortality rates. The difference is, these deaths are now avoidable.

Unsafe self-managed abortion continues not because safe technology doesn't exist, but because it has been suppressed. The advent of MA created a safe, effective method easily carried out in the privacy of one's own home, and it came with the potential to revolutionize the long, varied practice of self-managed abortion. In the following chapter, I will explore the discovery of this potential, fraught as it was with controversy, as well as the actual science at play. In doing so, I hope to highlight how politics have worked against fact from the very beginning.

Chapter Two

The Development of Medication Abortion

"One persistent theme in this story is that members of the women's health and family planning communities, the pharmaceutical industry, or the antiabortion movement have publicly questioned the sincerity of the public statements made by each other…As a result, there is no single authoritative source of information on the motivations of those who have worked to promote or to discourage the development of the so-called abortion pill,"[65]

—R. Alta Charo, "A Political History of RU-486"

The dual-drug MA regimen was not possible until mifepristone came onto the scene in the early 1980s. It was first synthesized by Georges Teutsch, Daniel Philibert and Etienne-Emile Baulieu, scientists affiliated with the pharmaceutical company Roussel Uclauf (hence the original trade name RU 486). Since its arrival, some entities have fought to keep MA far out of reach while others have urged its broad distribution. This chapter attempts to contextualize the development of MA in its fractured reception, which endured despite increasing clarity of the associated risks. Both sides claimed to have women's health and safety at heart, but neither were inclined to let the facts speak for themselves. Where did the disconnect between evidence and discourse begin, and how has it manifested in current understandings and applications of the technology?

A Polarized Reaction

The introduction of MA in France coincided with a global wave of anti-abortion fundamentalism incited by the US Supreme Court's landmark ruling in *Roe v. Wade*. Just one month after the Health Ministry of France gave Roussel Uclauf marketing approval in 1988, threats from anti-abortion groups pressured the company to withdraw distribution. Their success lasted all of two days, until the French government ordered Roussel Uclauf to resume distribution. Since then, all national introductions of mifepristone have been met with resistance

from anti-abortion groups. When these efforts came to the US, feminist groups responded with literature imploring allies to fight back. This had the effect of polarizing public dialogue on the issue from the start. It left little room for feminists to question the safety and efficacy of mifepristone, as that would have been perceived as playing into the hands of the "bad guys," enemies who were merely interested in advancing their campaign against a woman's right to abortion.[66]

Perhaps hoping to distance themselves from the controversy, Teutsch, Philibert and Baulieu denied that their intention was to discover an abortifacient. Instead, they claimed to have been searching for a molecule that would bind to the glucocorticoid receptor[d] when they accidentally synthesized a steroid that also served as a progesterone antagonist. Because Baulieu had an established interest in hormonal contraception, the team carried out further investigation that confirmed the drug's ability to prevent ovulation and interrupt pregnancy. After 17 months of trials on animals, mifepristone was deemed safe enough to warrant clinical trials on women—an unusually fast application of basic research findings that was attributed to competition from American and German pharmaceutical companies.[67] Early success rates for termination using mifepristone alone varied from 54%-90%, demonstrating the need for protocol enhancement. The solution came in the form of prostaglandins.[68]

Misoprostol, which had been used to induce uterine contractions and terminate pregnancies since 1970, became the prostaglandin of choice for its low cost, long shelf life without refrigeration and worldwide availability.[69] Abortion success rates were expected to increase when a dose was administered following mifepristone. Though initial results were disappointing, later studies that varied the administration route of prostaglandin and dosage of

[d] Which is indeed another function of the steroid—discussed on page 18.

mifepristone proved the combined approach to be more effective than mifepristone alone, reducing failure from 20% to 2-4%.[70] It is worth noting that these clinical trials were carried out before basic research had been done to rule out potential adverse effects from the interaction of the two drugs, although later studies found no such effects with the dosages used .[71] Notwithstanding potential shortcuts taken to get mifepristone on the market, its administration in conjunction with a prostaglandin analogue has been consistently verified as a safe and effective method of interrupting pregnancy.

The response from American feminists was very enthusiastic, generating a campaign that called on Roussel Uclauf to distribute mifepristone in other countries, including the US. The Reproductive Health Technologies Project initiated the campaign, gaining support from the Feminist Majority as well as American Medical Association (AMA) and Planned Parenthood.[72] Criticisms have been leveled at the feminist press for being exceedingly optimistic during this time—specifically, for promoting mifepristone as a "miracle drug" without noting the possible side effects and slight chance of failure. Perhaps they did present an oversimplified version of the debate in which the struggle is entirely between "bad" antiabortionists and "good" scientists who made the drug to help women reclaim their "moral property."[73] Since then, however, the messaging of activists has evolved to conscientiously promote safe and effective use of MA while fighting for increased access.

A major shift occurred in 2000, when the FDA approved mifepristone under the brand-name Mifeprex for early abortion with misoprostol. The regimen consists of one 200mg tablet of mifepristone taken orally, followed 24-48 hours later by 800mcg of misoprostol taken buccally or sublingually. Even with its legal status, significant barriers to MA access remain, in large part due to the FDA's institution of a Risk Evaluation and Mitigation Strategy (REMS).

According to their website, the FDA can require a REMS "for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks."[74] In the case of Mifeprex, distribution is restricted to registered providers in clinics, hospitals and medical offices. Each provider is required to enroll in a national registry, which effectively deters those who would be willing to provide MA care if it didn't make them public identifiable as an abortion provider.[75] As we will return to later, increasing the distribution of accurate information and lifting the REMS have become priorities of activists, who characterize the classification as the misuse of a tool meant for drugs with high-risk profiles. In 2016, the FDA's label was changed to better convey the drug's safety and efficacy and establish modifications to the REMS, but these did not affect any material change.[76] Activist efforts thus continue to focus on abolishing REMS in addition to expanding access, decreasing the cost barrier, reducing social stigma and increasing public awareness of proper administration techniques, side effects and risks.

Increasing access to abortion pills has been an uphill battle, and stigma and fear continue to pollute the narrative. A 21st century self-managed abortion is nothing like the "back-alley" methods that haunt our conceptions of a "post-*Roe*" world, yet the coat hanger lives on a symbol of illegal abortion. When self-managed MA does come into the conversation, it is frequently discussed using the rhetoric of harm reduction, a common-sense approach that aims to minimize the adverse consequences of risky behavior (for example, using a nicotine patch would be a harm-reduction approach to smoking cigarettes). When applied to self-managed MA, it typically frames the practice as a "less unsafe" option to turn to when clinician-supervised abortions are inaccessible. This is far from the full picture; beyond creating a universal opportunity for safe abortion regardless of the law, the method is preferred by many who value the enhanced privacy,

autonomy and convenience that sets it apart from other options. Thus, the rhetoric of harm reduction is reduct*ive* and should not be the only language used to discuss self-managed MA. It is especially imperative to promote a more nuanced narrative of the technology because those who favor it have historically rushed development and downplayed disadvantages, while anti-abortion activists have intentionally contorted the science to serve their goals. One popular and intentional tactic of the far right is to conflate abortion pills with emergency contraception (EC), as Kanye West did on video in a recent interview.[77] However, they're far from the only people who make this mistake, and the public confusion between MA and EC highlights a concerning lack of understanding of the science behind these technologies. To understand MA's mechanism of action and how it compares to that of EC, it is necessary to contextualize both in the basic science of pregnancy.

The Science

Unlike morning-after pills, which help to prevent a pregnancy from occurring, abortion pills help end a pregnancy that has already begun. An individual typically learns they are pregnant through an at-home pregnancy test that detects the presence of a hormone, human chorionic gonadotrophin (hCG), which is released when the embryo attaches to the uterus. The moment such a test can detect a pregnancy is the same moment that medical, legal and governmental authorities all consider to be its beginning—implantation.[78] An embryo may complete this process of burrowing deep into the uterine lining anywhere between 6-12 days after "conception" (fertilization) which could happen up to 18 days after unprotected intercourse or artificial insemination.[79]

For pregnancy to occur, fertilization must happen within 12-24 hours of ovulation, when an oocyte is released from an ovary into a fallopian tube. After this time, the egg begins to

rapidly deteriorate, and fertilization will either fail or lead to a defective embryo. However, because spermatozoa can survive in the female reproductive tract for 5-6 days, the "fertile window" of the menstrual cycle extends from 5 days before ovulation to the day of ovulation.[80] During this period, unprotected intercourse may result in fertilization, but emergency contraception can be used to reduce this risk. Though there is some disagreement among scientists, the overwhelming majority of research suggests that EC works by inhibiting ovulation, thereby eliminating any chance of fertilization. Both types of EC pills available in the US, levonorgestrel-containing (LNG) and ulipristal acetate-containing (UPA), have been proven safe and 75-95% effective depending on how soon after intercourse it is initiated.[81] This must happen within 5 days, during the "fertile window," as blocking ovulation would have no effect on an already-fertilized embryo nor an established pregnancy.

Even if EC fails, it is far from guaranteed that pregnancy will occur. Exact estimates vary, but somewhere between 40-70% of embryos are lost between fertilization and birth, with 10-40% of losses occurring before implantation.[82] About half are due to chromosomal errors from mitotic division, and many others result from poor timing. The embryo must begin the process of implantation within a specific window when the endometrium lining is receptive to adherence, called the window of implantation (WOI), which begins 6 days after the post-ovulatory progesterone surge and lasts about 2-4 days.[83] Embryos that arrive outside this period often fail to implant, and those that succeed are at high-risk of spontaneous abortion later on.[84] Spontaneous abortion, also referred to as early pregnancy loss or miscarriage, is an extremely common phenomenon, and it is physically nearly indistinguishable from MA. To see this, it's important that we have a basic understanding of the role of hormones in pregnancy.

Before a successful pregnancy can be established, the reproductive system must prepare itself for the possibility. Right after ovulation, progesterone begins the work of thickening the uterine lining to make it possible for a fertilized egg to attach. After implantation, the hormone has the additional duties of keeping the uterus malleable enough to accommodate growth of the embryo, blocking muscle contraction to prevent menstruation and allowing uterine blood vessels to surround the embryo. It also stimulates the production of new vessels and starts to form a region called the decidua, which eventually becomes the maternal portion of the placenta. In turn, the decidua instructs external trophoblast cells of the embryo to form the embryonic portion of the placenta. These trophoblast cells are key players in establishing pregnancy, as they lead the way in "invading" the uterine tissue after adhering to its lining, after which they begin to secrete hCG. Throughout early pregnancy, measurements of hCG are used to assess how the pregnancy is progressing, as its primary role is to nourish the embryo by maintaining production of progesterone. Unusually low levels may indicate a potential miscarriage, whereas very high levels could indicate twins or, in rare cases, trophoblastic disease.[85] The concentration of hCG peaks between weeks 8-10 and plateaus at a lower level for the rest of pregnancy, at which point the placenta takes over the vital role of progesterone production and substantially increases output.[86] If there's one thing to remember, it's that progesterone runs the show.

When progesterone levels are unusually low, the conceptus may not be receiving enough nourishment to continue growth. Miscarriage, or spontaneous abortion, ensues if the hormone is unable to carry out the various tasks necessary to maintain pregnancy. This happens in 10-30% of pregnancies before the end of the first trimester (week 13)—often before the carrier even knows they are pregnant. Spontaneous abortion can occur due to a variety of factors, including chromosomal abnormalities, maternal age, thrombophilic disorders, immune dysfunction and

various endocrine disturbances.[87] In each case, the body notices something is wrong and stops maintaining hormone levels, so the embryo stops growing. Knowing the crucial role of progesterone, many researchers have investigated whether supplements can prevent or reverse miscarriage. Overall, the results suggest that they do not improve outcomes, save for some evidence that supplements reduce risk of spontaneous abortion in people with a history of three or more miscarriages. Recurrent miscarriage is but one type of miscarriage among many. The rest are worth elaborating, as the differences will help us understand how MA fits into the picture.

i. *Threatened miscarriage*: the body shows signs of potential miscarriage, such as low hCG levels, some vaginal bleeding or abdominal pain. The cervix remains closed, and symptoms may last weeks. This may progress into an inevitable miscarriage, or it may resolve into a healthy pregnancy.

ii. *Inevitable miscarriage*: may either happen after a threatened miscarriage or come out of the blue. Bleeding and abdominal cramping is much greater, and the cervix opens for the conceptus to be expelled with the blood.

iii. *Complete miscarriage*: has occurred when the conceptus and all of the uterine lining has completely left the uterus. Bleeding may persist for days, and extremely intense cramping pain is common.

iv. *Incomplete miscarriage*: some of the pregnancy tissue remains in the uterus. Continues bleeding and cramping is likely as the uterus tries to expel the remnants.

v. *Missed miscarriage*: in this case, the conceptus has stopped growing but the uterus has not begun to expel the pregnancy. Ceased symptoms of pregnancy and a brownish discharge are common signs.

If an incomplete or missed miscarriage occurs, follow-up treatment is necessary to help the body pass the pregnancy tissue. Physicians can either perform a D&E or provide medication to take at home—the same medication used to induce abortion. The medical standard is to treat incomplete and missed abortion at 12 weeks or less gestation with 800ug misoprostol, though a recent study found better outcomes when mifepristone was taken as pretreatment.[88] These pills are prescribed because they mimic the mechanism of complete miscarriage in a safe and effective manner. It is for this very reason that they work so well as abortifacients.

When mifepristone and misoprostol are used in a combined regimen, there is a 98% chance that the abortion will reach completion. Mifepristone is a synthetic hormone antagonist with both antiprogesterone and antiglucocorticosteroid properties, working at the receptor level.[89] It acts on uterine progesterone receptors, which normally bind to progesterone to activate the transcription of various protein-coding genes. When mifepristone binds to a receptor, it induces a conformational change that prohibits progesterone binding, rendering the receptor inactive.[90] This interrupts the signaling pathway and impedes the synthesis of proteins with vital functions in pregnancy maintenance. As a result, the uterine lining begins to break down, the embryo receives inadequate nourishment and hCG levels decrease. Much like in miscarriage, progesterone can no longer keep the cervix firm and prevent uterine contractions, making it easier for the embryo to be expelled. Mifepristone also functions as an antiglucocorticosteroid, blocking glucocorticoid receptors. Negative feedback induces the anterior pituitary to secrete corticotropin (ACTH), which in turn stimulates the adrenal gland to secrete cortisol.[e]

[e] Mifepristone's antiglucocorticosteroid effect makes it useful for the treatment of Cushing's Disease, which is characterized by overproduction of ACTH by the pituitary gland. By antagonizing cortisol receptors, mifepristone blocks the effect of excessive cortisol.
Source: Raymond, Klein and Dumble, 1991.

To optimize its efficacy for terminating pregnancy, scientists sought to minimize the antiglucocorticosteroid effect and maximize the antiprogesterone effect. Misoprostol, the prostaglandin of choice, works by softening and dilating the cervix while inducing uterine contractions, thereby complementing the mechanism of mifepristone, which is more effective at stopping further development than expelling the pregnancy tissue. Misoprostol's evacuative effect makes it optimal for treatment of incomplete and missed miscarriage as well as for cervical ripening prior to surgical abortion or gynecological procedures. In smaller doses, it can also be used to induce labor.[91] Misoprostol is frequently used alone, as it is OTC in much of the world and is less expensive than mifepristone. Side effects for the misoprostol-only and combined approach are similar, but they are more intense when misoprostol is used alone.

Risk v. Regulation

Overall, the side effects of MA are minor and similar to those of a miscarriage, including bleeding, uterine cramping and pain. About 85% of patients additionally report at least one of the following side effects: nausea, vomiting, weakness, diarrhea, headache dizziness, fever and chills.[92] With the combined approach, the continuing pregnancy rate is less than 0.5%, and abortion usually occurs within 3.5 hours of administering misoprostol.[93] Because it is a non-invasive procedure, MA does not come with risks of surgical abortion such as cervical injury and uterine perforation. Research also suggests that MA carries a lower rate of endometritis (from infection); large trials have shown rates varying from 0.1%-0.9% for MA and 0.1-4.7% for surgical abortion.[94] Though deaths from abortion are hard to estimate, the best numbers suggest a rate of one death per 100,000 MAs through the ninth week of pregnancy.[95] In comparison, five men die from Viagra-related drug reactions out every 100,000 prescriptions written,[96] and there are 17.2 pregnancy-related deaths in the U.S. per 100,000 live births.[97] Abortion pills are, in fact,

some of the safest modern medications on the market, with complication rates lower than those of many widely used drugs such as Tylenol, Ritalin, Flonase Nasal Spray and Xanax.[98]

The long, proven track record of MA leaves little room for questioning whether it is a safe and effective way to terminate pregnancy. As we will discuss in greater detail later on, there are many other reasons a woman might choose MA over another type of abortion (it can be used very early on, there is no need for anesthesia, it is noninvasive, etc.). These advantages have not gone unnoticed in the US. Since FDA approval in 2000, MA went from accounting for 0% of legal abortions to 39% in 2017.[99] This is despite the REMS that limit distribution to specific providers and settings, thus creating insurmountable barriers within the formal health care system for many who would otherwise formally seek or provide MA. Abortion activists are not the only actors who see inconsistencies between the REMS and MA's safety record. In 2017, an expert panel of researchers in the Mifeprex REMS Study Group made the same conclusion, arguing that the REMS place an unfair burden on those seeking access and on the health care system. Physicians, too, largely agree: "This shouldn't be a political decision. It should be based on science, which has very clearly shown this is a very safe drug, safer than ones that don't have this restriction," explains Dr. Daniel Grossman, director of Advancing New Standards in Reproductive Health at the University of California San Francisco (UCSF).[100] Several leading medical organizations also support lifting them, including the AMA, ACOG, and the American Academy of Family Physicians (AAFP).

> "15 years of use of mifepristone for induced abortion has not just proven it to be safe and effective, but have also supported an evidence-based regimen that improves care and the personal experience for women who find that it is the right choice for them… The REMS requirement is inconsistent with requirements for other drugs with similar or greater risks, especially in light of the significant benefit that mifepristone provides to patients,"—Mark S.DeFrancesco, MD, MBA, President of ACOG.[101]

> "RESOLVED, That our American Medical Association support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone."[102]
>
> "RESOLVED, That the American Academy of Family Physicians engage in efforts to overturn the Risk Evaluation and Mitigation Strategies (REMS) classification on mifepristone."[103]

If the FDA were to alter regulations to be consistent with research findings and recommendations from evidence-based practice, they would immediately allow its distribution through telemedicine and lift the provider certification requirement.[104] The comparison between MA's safety profile and those of drugs such as Tylenol and Viagra begs the next question: should Mifeprex be available OTC? A 2017 study co-authored by Dr. Grossman answered with a qualified yes, explaining that while research gaps must be filled to definitively determine whether the regimen meets FDA criteria for OTC sale, preliminary evidence is very encouraging.[105] On the topic of self-managed abortion, he asserts:

> The limited data so far suggests women are doing this safely—and there is no question that use of these medications has contributed to a reduction in abortion-related mortality worldwide… From a purely medical perspective, it no longer makes sense to demonize women's safe use of abortion medications at home."[106]

The discrepancy between risk and regulation is impossible to justify with legitimate science. Instead, MA opponents propagate misinformation. In a recent blog post, the anti-abortion organization Family Research Council wrote: "Few legal drugs wreak havoc on the human body like the chemical abortion pill… the patient is at an incredible risk of the extreme bleeding that has become the pill's life-threatening signature."[107] Such organizations often claim researchers and activists propagate "misleading information about the real risks of the abortion pill regimen"[108] and "downplay the excruciating process that awaits unsuspecting women."[109] In reading these allegations, I am reminded of those directed at feminists in the early days of

mifepristone's development for "overenthusiastically" hailing mifepristone as a "miracle drug." How has the rhetoric remained so stagnant despite leaps in scientific understanding of MA?

The debate has never been centered on factual evidence. Those invested in expanding reproductive autonomy saw mifepristone's development as the "biggest breakthrough in the battle for reproductive choices since the development of birth control," whereas those seeking to end abortion altogether declared it "chemical warfare against the child in the womb."[110] One side proclaimed its safety before scientists had decisively ruled out the possibility of serious adverse effects, while the other exaggerated MA's potential to cause serious harm. Before its safety had been consistently demonstrated, the dialogue became polarized along political lines. Thus, American politicians could not approach the matter of regulation objectively. The inconsistency between risk and regulation today, I argue, can be traced back to the early disjunction between rhetoric and reality.

But the stage had long been set for MA's polarized reception. To fully understand how such medically unnecessary regulations materialized, we'll need to explore the larger landscape of abortion access, whose borders can be traced through the dark history of reproductive control in the US.

Chapter Three

An Ongoing Fight for Reproductive Control

"Reproductive justice uses a human rights framework to draw attention to—and resist—laws and public and corporate policies based on racial, gender, and class prejudices. These laws and policies deny people the right to control their bodies, interfere with their reproductive decision making, and, ultimately, prevent many people from being able to live with dignity in safe and healthy communities,"[111]

—Loretta Ross, *Reproductive Justice: An Introduction*

Previously, we established that current FDA restrictions governing access to MA are medically unnecessary, existing only to serve political interests. This is far from an isolated case, as abortion regulations have never come from an interest in women's health. Rather, they are outputs of longstanding, unbalanced power dynamics between women who know what's best for their bodies and actors who think they have a claim to making reproductive decisions for them. The "reproductive justice" framework, established by a group of black women in 1994, recognizes that not all women have suffered equally; populations furthest removed from institutionalized power have been the most vulnerable to abuses such as rape, forced sterilization and discrimination in health care.[112] Furthermore, their needs were widely neglected by the mainstream women's rights movement led by their white, middle class and wealthy counterparts, who had a different set of priorities. In this chapter, I make the case that while *Roe v. Wade* granted the constitutional right to abortion, the premises on which it was decided ensured that nothing would be done to substantially shift the balance of reproductive power. As a result, the same populations targeted for reproductive injustices before *Roe* are disproportionately affected by barriers to access today. A familiarity with this history is crucial to understanding the subversive power of self-managed MA.

A Longstanding Struggle

Current debates over the where MA belongs in the landscape of reproductive health care in the US arose from a complex history of reproductive control that began in the mid-nineteenth century. Before then, reproductive choices had generally been seen as private matters. There were no legal restrictions on contraception, and abortion was not considered wrong if it happened before the "quickening," when, about halfway through pregnancy, a woman could first detect fetal movement.[113] By the end of the century, however, every state had passed a restrictive policy, and the Catholic Church had equated abortion to murder.[114]

This dramatic shift was influenced by a variety of factors. Between 1830-1870, the fertility rate of white American women plummeted, and the immigrant population escalated. Racist anti-abortion crusaders argued that banning abortion was the only way to ensure the "proper" balance of fertility rates between the "best" and "inferior" stock.[115] Meanwhile, male doctors began organizing to seize the medical profession from midwives, forming the AMA in 1847. In order to legitimize their claim to superior scientific knowledge,[f] the AMA argued that abortion was dangerous and morally repugnant in an attempt to cast the midwives who provided them as morally questionable and professionally inferior. In 1859, they passed a resolution that condemned the practice altogether, save for life-threatening situations.[116] This hugely influential resolution, which catalyzed the change in state legislatures, was not about the health and safety of women, and it was not even aimed at eliminating abortions. Rather, it was part of the AMA's effort to eliminate the competition of midwives—it was about power:

> "It will not get us anywhere to say that midwives do just as good work as the average doctor, which may be true. It should not be a question of the lesser of two

[f] This claim was, in fact, wholly illegitimate. Physicians were guided by superstition, religious belief and ancient tradition rather than actual scientific knowledge. They went so far as to resist new scientific practices that challenged traditional methods
Source: Martinelli-Fernandez, Baker Sperry and McIlvaine-Newsad, 2009

> evils. Neither is fit. We want something better, we want well trained doctors to attend to women in confinement."[117]

This excerpt comes from an article in the American Journal of Public Health, which targets death as singular example of midwifery's inferiority and establishes the state's interest in preventing the "awful loss of life and economic wastage."[118] Yet, once the AMA established the medical profession's control over the procedure, the anti-abortion rhetoric subsided, and services remained available through the first half of the 20th century despite widespread criminalization.[119]

In the 1930s, six states had no abortion bans, and illegal abortions were rarely prosecuted. Even with growing concern over the mortality rates associated with illegal abortion—an estimated 10,000 women died annually over the decade—little was done to intervene with the underground scene. Legal abortion was also possible to obtain from physicians if the procedure was deemed "medically necessary," a characterization loosely justified until the 1950s, when the site of medical care moved from home to hospital. In addition to the establishment of oversight and review boards, more vocal articulation of Catholic opposition contributed to a sharp decline in the number of legal abortions by the early 1960s.[120] Simultaneously, state officials and physicians began using sterilization to control the reproduction of poor women and women of color without their consent. These forced sterilizations became increasingly popular in the 1960s to prevent the reproduction of the "unfit," a eugenic classification which extended to drug addicts, prostitutes, criminals and people with cognitive impairments or mental illnesses.[121]

On the other side of the struggle for reproductive control were activists fighting to reclaim it. Feminists, doctors and allies joined forces to maintain abortion access through the underground movement, and estimates of the number of illegal abortions in the 1950s and 1960s reach 1.2 million per year. This period, just prior to the 1973 ruling in *Roe v. Wade*, was the era of "coat-hanger" and other "back alley" abortions frequently referenced in discussions of self-

managed abortion. But some were actually provided by well-trained medical practitioners who risked fines, imprisonment, and loss of their licenses. Information about these services traveled by word of mouth, and various referral groups were established to connect women with competent, reliable providers. The Chicago-based collective called Jane was the most sophisticated of these counseling services. Eventually, they took their services to the next level, hiring their own doctor so that each component of the process could be carefully controlled to secure safety and secrecy. A woman seeking abortion services would call "Jane" and leave a voicemail, after which a "Callback Jane" would phone back to collect information that was passed on to "Big Jane." The patient would receive counseling at one location, "the front," before they were taken (sometimes blindfolded) to a second address where a doctor did the abortion. That is, until the Janes discovered that the "doctor" they hired wasn't a physician at all, and said, "Well, the hell with it. If he can do them, we can do them."[122] Soon, they learned from him all the technical skills necessary to safely perform abortion and went on to provide over 11,000 abortions in their four years of operation.[123]

By taking it upon themselves to learn safe abortion techniques, the Jane collective acted both to demystify the medical construction of abortion and to subvert imbalanced power dynamics between women and the medical establishment. They realized the barriers set up between patient and practitioner served neither woman's needs or the needs of the situation but were instead "a function of disciplinary power and a means of hoarding both institutional authority and useful knowledge."[124] In *The Story of Jane*, former Jane member Laura Kaplan writes:

> "We were ordinary women who, working together, accomplished something extraordinary. Our actions, which we saw as potentially transforming for other women, changed us, too. By taking responsibility, we became responsible. Most of us grew stronger, more self-assured, confident in our own abilities. In picking up the tools of our own liberation, in our

> case medical instruments, we broke a powerful taboo. That act was terrifying, but it was also exhilarating. We ourselves felt exactly the same powerfulness that we wanted other women to feel."[125]

Jane enabled women to actively participate in their own care in such a way that denaturalized the condescending treatment many had come to expect from male physicians. By assuming complete control over the procedures, they empowered women who otherwise would have been dependent on illegal practitioners that charged, on average, four times the fee for much riskier services.[126] Jane's exemplary safety record, unfortunately, was nowhere near representative of the larger underground.

There were entire hospital wards dedicated to complications from unsafe abortion during the pre-*Roe* era. Death was a "common occurrence," as explained by a physician who worked in one: "I saw chemical burns, as well as perforations of the bladder, vagina, uterus, and rectum. Some women came in with overwhelming infections or in septic shock."[127] The associated death toll and other complications disproportionately affected poor women and women of color; from 1972-1974, the mortality rate for nonwhite women was 12 times higher than that for white women.[128] Wealth also played a role—women with economic means could afford the services of skilled practitioners, while poor women were more likely to self-induce. A study in the 1960s of low-income women in New York City found that of the 8% who had attempted to illegally terminate a pregnancy, 77% attempted to self-induce and just 2% said a physician had been at all involved. Even if a woman could produce hundreds of dollars for the procedure, the costs of travel and lodging often made the economic barrier insurmountable—the year before *Roe* passed, over 100,000 women journeyed to NYC from their own state, half of whom traveled over 500 miles.[129]

When *Roe* finally did pass, it was not on feminist terms. Second wave American feminism—which was, itself, ambivalent about abortion being a movement issue at first—was but one of three streams of social movement organization that led to the 1973 decision. The medical profession was primarily seeking the freedom to practice medicine without government interference, and public health advocates aimed to end the public health crisis of unsafe and dangerous abortions that disproportionately affected poor women and minorities. Activism was an important driving force, but feminists had only recently united to press for repeal of abortion laws instead of reform. As Lucinda (Cindy) Cisler, a leading women's liberation strategist at the time explained:

> "Proposals for "reform" are based on the notion that abortions must be regulated, meted out to deserving women under an elaborate set of rules designed to provide 'safeguards against abuse'… Repeal is based in the quaint idea of justice: that abortion is a women's right and that no-one can veto her decision and compel her to bear a child against her will."[130]

Feminists made it impossible for the Supreme Court to ignore the issue by speaking out across the country about their scars from the illegal underground and by bringing mass lawsuits to state courts in the late 1960s and early 1970s. Even so, when *Roe* finally made it to the Supreme Court, physicians' needs were prioritized over those of women seeking abortions. In her study of abortion cases, Susan Behuniak describes finding an absence of patients' concerns and experiences in the amicus briefs: "There are no first-person accounts of what abortion means (for better or for worse) for the women who have experienced it, no stories, no telling of the horror of what it was like to undergo an illegal abortion or how it felt to lack reliable information about the procedure."[131] She explains that the same result-oriented legal norms that muted the emotional, experiential knowledge of these women acted to amplify the voice of medical knowledge: "By defining abortion as a medical issue, physicians moved to the center of the case whether they had

official standing or not."[132] The feminist movement played a crucial role in advancing *Roe* to the Supreme Court, but it was ultimately overshadowed by the priorities of other actors. Essentially, "*Roe* holds that while the state may not interfere with the woman's decision during the first trimester, the physician, a lack of physicians, or a lack of money may."[133] The ruling established physicians as required participants in the decision to abort and privileged physicians' discretion over women's rights.

Roe v. Wade may have established the constitutional right to abortion, but it opened the door for various state-level restrictions. After the first trimester, it allows a state to restrict abortion for the sake of the mother's health, and after the point of viability, the state may prohibit abortions in non-life-threatening situations. Justice Harry A. Blackmun, who wrote the majority opinion, offered this framework in response to arguments from The State of Texas. Counsel for Texas argued that human life begins at conception, and that even if a fetus is not a person—which they argued it was—the state had a compelling interest in protecting the life of a fetus that requires prohibiting abortion. Though Blackmun declared the Supreme Court was not in a position to determine the point at which life begins, he acknowledged that at some point in pregnancy, the state's interest became a sufficiently compelling reason to set restrictions on abortion.[134] The trimester system has been criticized as "arbitrary," as has the decision to set the cutoff for non-life-threatening situations at the point of viability, which is itself variable and continues to reach a lower gestational age with the development of medical technology. Thus, a woman's right to abortion could be eclipsed by a doctor's discretion and by the state's "justifiable" interest in the health of the pregnant woman and in protecting a potential human life. Not only were feminists outraged, but so too were those who felt the Court hadn't done enough to protect the "human life" that begins at conception.

In fact, the response to *Roe v. Wade* transformed American politics, generating the polarized debate that currently surrounds abortion. At the time of the 7-2 decision, neither major political party was strongly associated with either abortion rights or the anti-abortion movement. Of the seven Justices who ruled in favor of *Roe*, five had been appointed by Republican presidents (though one was a Democrat himself), and two had been appointed by Democratic presidents. Meanwhile, a Republican and Democratic president each appointed one of the two dissenters.[135] In the following years, however, the fervent opposition among social and religious conservatives grew into movements that soon found a home in the Republican Party and helped get "pro-life" candidates into office.[136] This alliance solidified quickly, and by 1980 the Republican Party platform included a call for "a constitutional amendment to restore protection of the right to life for unborn children."[137] As the Republican Party increasingly identified with anti-abortion movement, the more liberal Democratic party became firmly pro-choice. Ever since, presidents have sought to nominate Justices who would promote constitutional values in line with their own positions on abortion, putting the Supreme Court's authority and independence from partisan politics into question. When the Court heard another landmark case, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, in 1992, three Republican-appointed Justices had joined since *Roe*, and they were expected to tip the scales toward overturning it. Instead, they reaffirmed it, explaining:

> "Only the most convincing justification under accepted standards of precedent could suffice to demonstrate that a later decision overruling the first was anything but a surrender to political pressure and an unjustified repudiation of the principle on which the Court staked its authority in the first instance."[138]

Casey didn't overturn *Roe*, but it did severely weaken it. The 1992 decision did away with the trimester framework to assert that the state has an interest in protecting fetal life throughout *all* of pregnancy, not just after the point of viability. From then on, states have been

able to pass laws regulating abortion for two purposes—protecting potential fetal life or protecting a women's health and safety—so long as it did not present an "undue burden" for a woman seeking pregnancy. As constitutional law expert Jessica Mason Pieklo said in an interview with Vox, "*Casey* opened the door for a whole host of restrictions that would have probably been unconstitutional under a straight Roe analysis."[139] States could now use the guise of protecting women's health to pass regulations that made it harder for providers to stay open. With an expanded toolbelt, lawmakers have continued what they began in 1973, passing a total of 1,272 abortion restrictions as of July, 2019.[140] These bills have shaped the severely limited landscape of abortion access today.

The Landscape of Restrictions

A recent policy analysis by the Guttmacher Institute organizes laws that restrict and protect access into six categories:

Six abortion restrictions	Six protective policies
• Ban pre- or postviability abortions in violation of constitutional protections • Require in-person abortion counseling followed by a waiting period before the procedure (thereby requiring at least two trips to the facility) • Restrict Medicaid coverage for abortion • Prohibit the use of telemedicine to provide medication abortion • Limit access to abortion for those younger than 18 without parental involvement • Impose unnecessary and onerous abortion clinic regulations	• Affirm a right to abortion in the state constitution • Establish a legal standard that protects access to abortion • Guarantee abortion coverage through Medicaid • Allow advanced practice clinicians to provide abortion by law or Attorney General Opinion • Mandate private health insurance plans cover abortion • Protect access to abortion clinics

Each state is then classified on a scale of hostility (ranging from "very hostile" to "very supportive") based on the number of policies in each of the two groups.[141]

Figure 3 shows that six states are very hostile, 16 states are hostile, seven states lean hostile, seven states are middle-ground, nine states lean supportive, four states are supportive and one state is very supportive. These numbers reflect policies in effect as of April 1st, 2020, but Guttmacher ran the same analysis on the policy landscapes as of 2010 and 2000 to illustrate change over time.

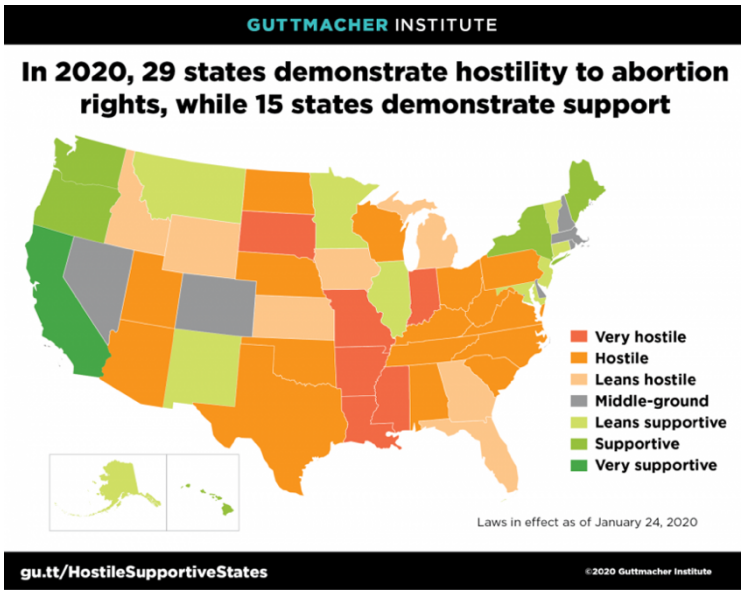

Figure 3. US abortion policy landscape, 2020.

Source: Guttmacher Institute, 2010

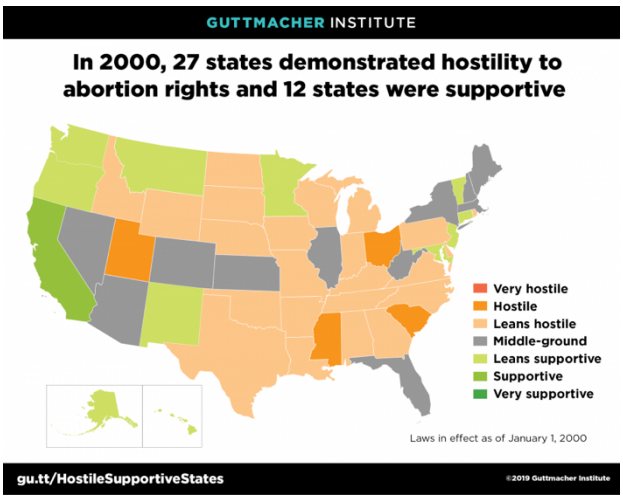

Figure 4. US abortion policy landscape, 2000.

Source: Guttmacher Institute, 2020

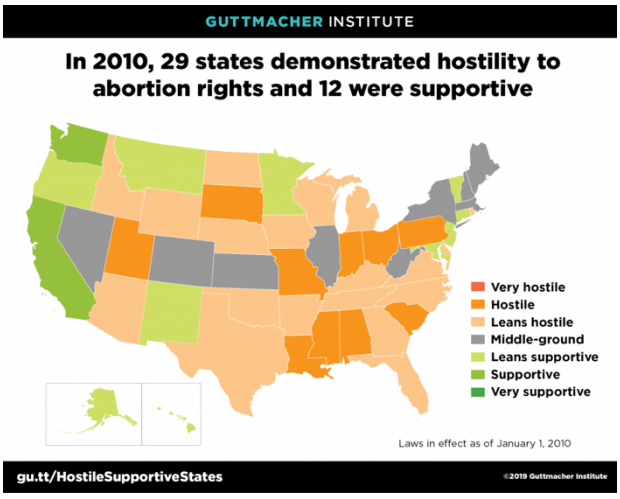

Figure 5. US abortion policy landscape, 2010.

Source: Guttmacher Institute, 2020

The number of orange (very hostile) states quadrupled between 2000 and 2020, and complete lack of red in both maps signifies that *no* states were very hostile to abortion before 2010 (*Figures 4-5*). The uptick in enacted legislation speaks to the impact of the 2010 midterm

elections—of those 1,272 abortion restrictions passed in the 46 years between 1973 and mid-2019, 38%[g] were enacted after 2010.[142]

But what exactly do these restrictions do? In all 40 states with physician and hospital requirements, the abortion provider *must* be a licensed physician, despite overwhelming evidence that with training, nurses, midwives and physician assistants are capable of competently providing the full range of abortion care.[143] After specified points in pregnancy, 17 of those states require the involvement of a second physician, and 19 require the abortion take place in a hospital. In the 43 states with gestational limits, abortions in non-life-threatening situations are prohibited after a certain point in pregnancy—in just the first half of 2019, nine states passed laws to outlaw abortion after 6-8, before many women even know they are pregnant.[144] 21 states outlaw dilation and extraction (D&X), or "partial-birth" abortions, 45 states allow individual health care providers to refuse to perform an abortion, 37 states require that minors involve their parents in the decision, and 18 states mandate counseling prior to obtaining an abortion. While 16 states pay for at least most medically necessary abortions for Medicaid enrollees, 33 states prohibit the use of state funds, and 12 states restrict coverage by private insurance. Finally, 27 states require women to wait at least 24 hours between receiving counseling and the procedure, and half of these states effectively require the woman make two separate trips to the clinic.[145] The ever-increasing volume of such laws has forced dozens of abortion clinics to shut down in recent years, and six states are left with just one clinic.[146] As a result, distance to an abortion provider

[g] This number comes from combination of publications by the Guttmacher Institute. In "Last Five Years Account for More Than One-quarter of All Abortion Restrictions Enacted Since Roe," they call attention to the 288 restrictions enacted between 2011-2015, 27% of the 1,074 since *Roe v. Wade*. "Policy Trends in the States, 2017," "State Policy Trends 2018," and "State Policy Trends at Mid-Year 2019" provide the numbers for 2016, 2017, 2018 and mid-year 2019: 50, 63, 27 and 58, respectively.

has become an increasingly significant barrier to access, as illustrated in a series of maps published in the New York Times (*Figure 6*).

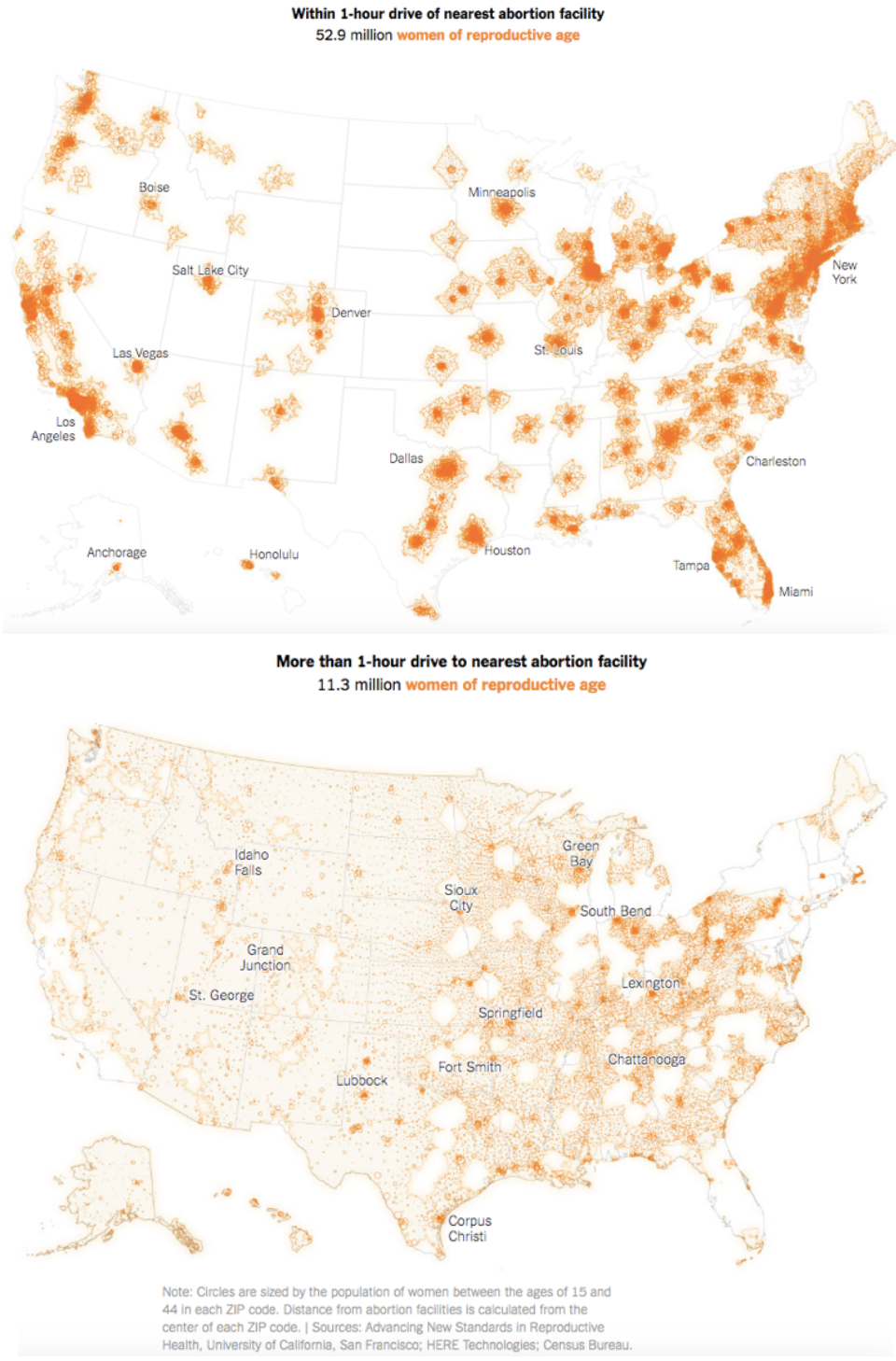

Figure 6. For 11 million American women, the nearest abortion facility is over an hour's drive away

Source: The New York Times, 2019

Since 2013, at least 275 abortion facilities have closed across the country (*Figure 7*).

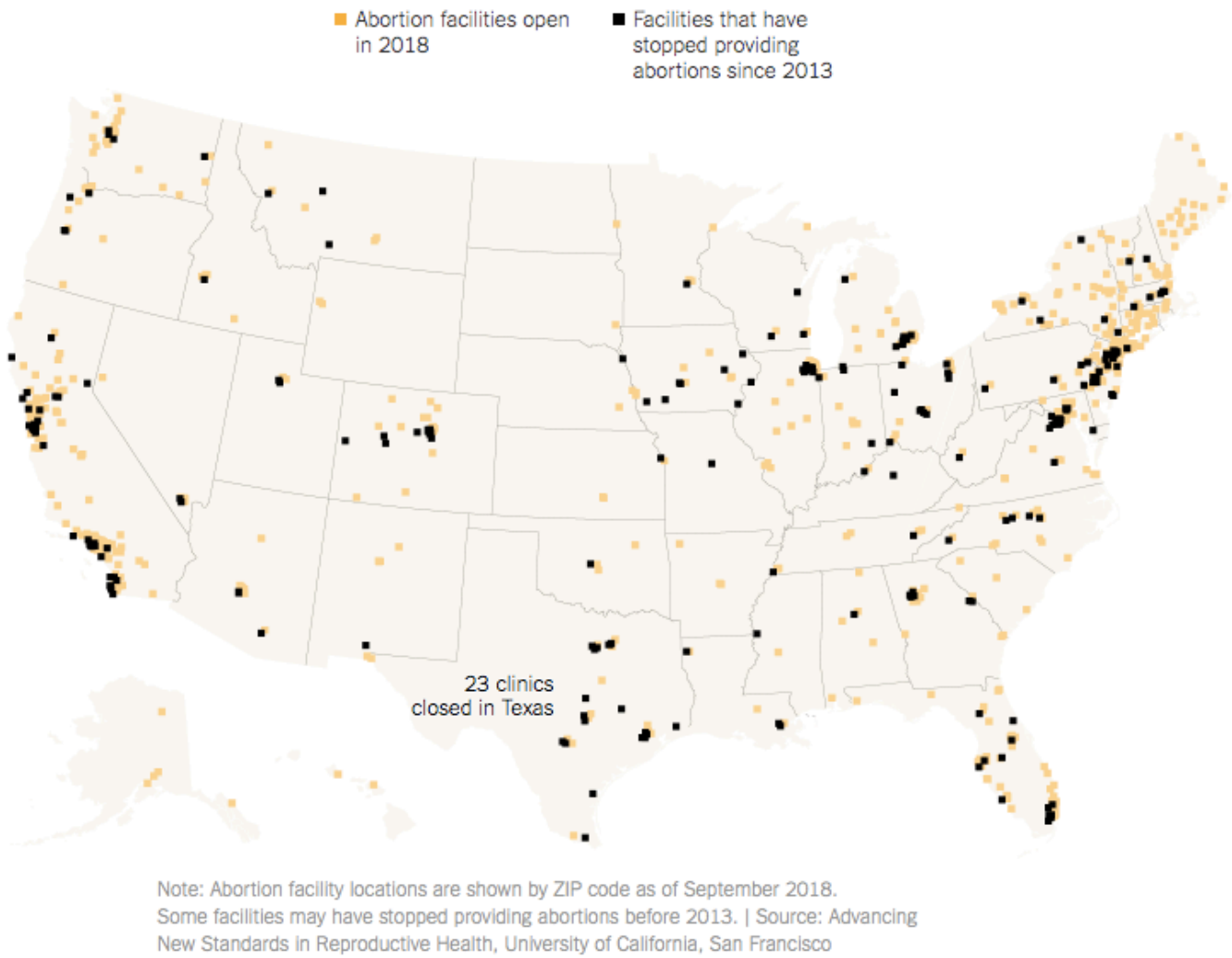

Figure 7. Nationwide, 275 abortion facilities closed between 2013-2018
Source: The New York Times, 2019

According to abortion providers, the onslaught of recent regulations has not decreased demand for abortion, but has instead increased distance patients need to travel as well as strain on remaining facilities. Deputy director of Hope Clinic for Women in Granite City, Illinois explains: "We've already had to shoulder a 30 percent increase… [w]e are kind of in crisis mode. I think there's just a lot of anxiety and confusion, as the news changes every day, from our

staff and our patients."[147] Furthermore, roughly 40% of the nation's 750 abortion facilities do not provide after 13 weeks.[148] As of 2017, 89% of counties had zero abortion clinics, 38% of women were living in these counties, and people in 27 cities had to travel at least 100 miles to reach the nearest provider.[149]

Uneven Burdens

It should come as no surprise that distance is a greater barrier to access for low-income women, who are already more likely to live far from abortion facilities. An analysis by the Washington Post shows that nationwide, 22% of women living below the poverty would have to drive over an hour, compared to 18% of non-poor women.[150] Though drive times vary considerably among regions in the US, this disparity is consistent. But even if the drive times were equal, distance would continue to disproportionately affect women who don't have access to a car, women who lack money for gas or public transportation, and women who may not be able to afford taking time off of work or hire childcare for the time they're away. These obstacles double in states that require multiple visits over multiple days, the states in which the majority of poor women who must travel over an hour live.[151] Many are unable to afford abortion care once the expenses associated with travel are tacked on. For many others, cost is already an insurmountable barrier.

Abortion is an expensive procedure in it of itself, ranging from $75-$1,633 (mean of $535) for MA, $435-955 (mean of $508) for vacuum aspiration abortions, $500-$3,000 or more for D&E, and $8,000-$15,000 for late abortions.[152] Since the Hyde Amendment was passed in 1976 to prohibit federal dollars from going to abortion in non-extreme cases, most people who rely on Medicaid must pay out-of-pocket—with the exception of those who live in the 16 states that cover abortion care with their own funds. Meanwhile, 47% of Americans would not be able

to afford a $400 emergency without borrowing or selling something, and 75% of abortion patients in 2014 were low-income.[153] Studies assessing the impact of Hyde show that many poor women seeking abortion delay or forgo paying rent or utility bills or buying food, while others rely on financial assistance from clinics and family members or sell their personal belongings.[154] Too often, the delays that come with raising funds cause additional costs (abortion becomes more expensive as gestational age increases) which then leads to additional delays as women postpone the procedure to gather the extra money. What's more, the (still low) risk of complication increases with gestational age.[155] Because women of color are more likely to receive Medicaid than white women due to the link between socioeconomic inequality and racism and discrimination, they are much more likely to get caught in this relentless cycle of costs and delays (*Figure 8*). The Hyde Amendment ensures that abortion restrictions disproportionately affect the most vulnerable populations.

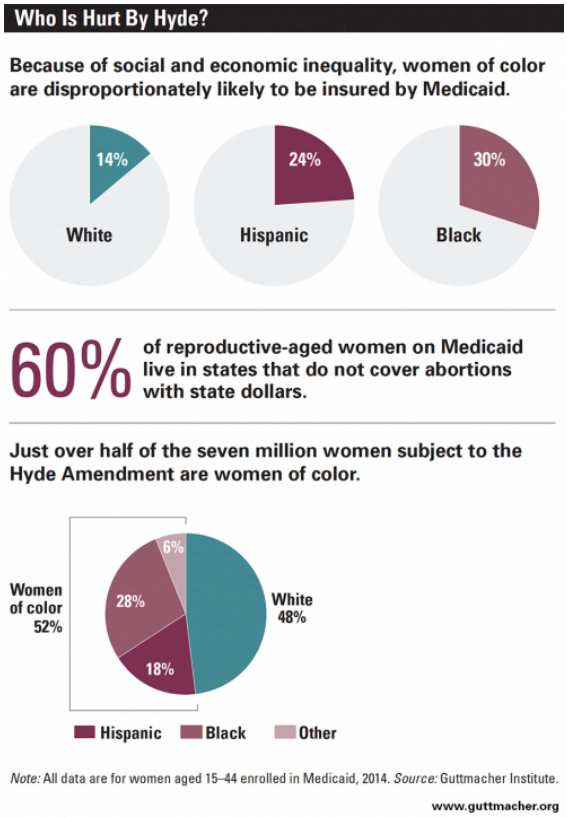

Figure 8. The Hyde Amendment falls particularly hard on women of color

Source: Guttmacher Institute, 2016

Abortion-Rights Activists Respond

There's more to the landscape of abortion access than the accomplishments of those working to diminish it. With the surge of anti-abortion legislation has come a surge in abortion activism. On the latter side, a grassroots network of abortion funds has spread across the country to help women pay for abortion care and the associated costs, and a network of abortion doulas

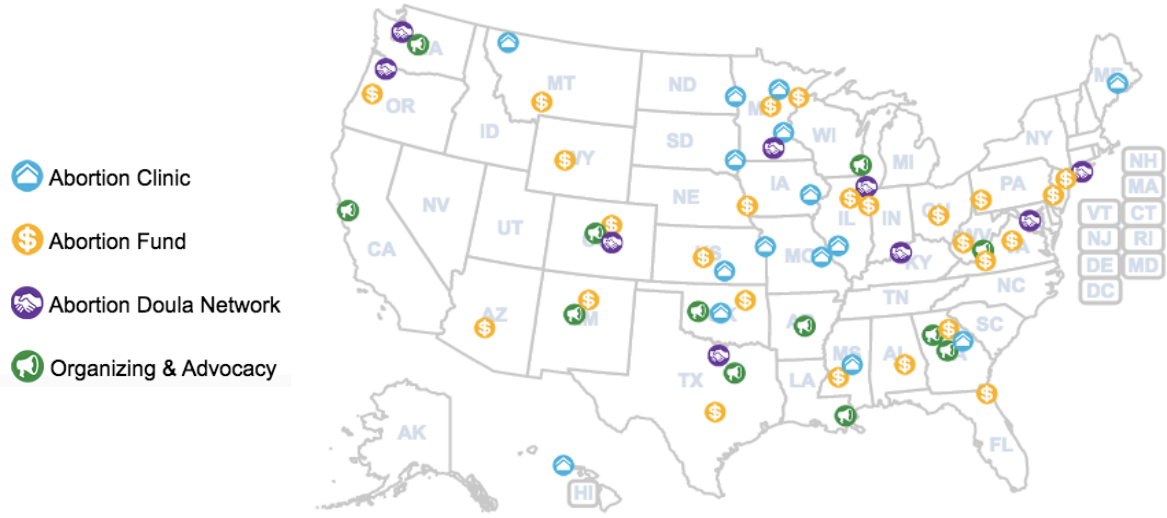

Figure 9. Types of abortion access activism taking place around the country
Source: The Nation, 2019 (map produced by Josh Leeman)

has formed to provide patients with support. Also nationwide, abortion clinics and advocacy groups have been organizing to fight restrictions at every level of government, determined to make abortion and other reproductive health care services more accessible. A map published in *The Nation* illustrates a sampling of these organizations (*Figure 9*).[156] In total, there are 79 abortion funds and 35 abortion doula groups, and hundreds of abortion providers are members of the National Abortion Federation (NAF), which pushes education and advocacy efforts.[157] There are also legal organizations—such as If/When/How, the American Civil Liberties Union (ACLU) and the Center for Reproductive Rights—that seek to fundamentally transform the landscape of reproductive rights. Another, National Advocates for Pregnant Women (NAPW), specifically works with and for pregnant people, with a focus on those most likely to be targeted for state control and punishment. Yet others, such as the Reproductive Health Access Project (RHAP) are working to integrate reproductive health care into primary care facilities. Planned Parenthood, Black Mamas Matter Alliance, RH Reality Check, Sister Song, NARAL Pro-choice America—the list goes on. In addition to the work they do individually, these organizations band together in

networks such as All* Above All, which specifically aims to build support for lifting the Hyde Amendment. In response to Congress's attempts to defund Planned Parenthood in 2015, the hashtag #ShoutYourAbortion went viral and soon evolved into a grassroots movement of storytelling to normalize abortion. There's even a coalition focused on MA, Coalition to Expand Access to Mifepristone in the US (Mife Coalition). These organizations fight for much more than abortion rights. In collectively embracing the reproductive justice framework, they've launched a movement that goes beyond the tired "pro-life"/"pro-choice" debate, defined by the three principles of reproductive justice: "(1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments. "[158] It recognizes that the human right to dignified fertility management, childbirth and parenting cannot be realized without access to certain prerequisites—community-based resources such as housing, education, a living wage and competent, compassionate health care. Truly achieving this world would require substantially shifting power dynamics that have outlived generations of activist efforts.

Roe v. Wade was not a true win for women, and in many ways, it was a setback for reproductive justice. By framing the right to abortion as a negative right (the right to non-governmental interference in the decision to abort) *Roe* did nothing to ensure services would actually be accessible. Yet, situating it within a right to privacy suggested access came with legalization, inspiring the mainstream abortion rights lobby that, by centering "choice" rather than access, effectively trivialized the effects of nonlegal barriers such as poverty.[159] Every woman in the US technically has the "freedom to choose" abortion, but 58% live in states hostile to abortion.[160] Moreover, *Roe* reestablished medical authority—parallel to the AMA's seizure of abortion from midwives, this act was about power rather than health. Just as midwives were

more than capable of providing competent care before the medical takeover, women in the Jane collective had proven that safe abortion didn't have to mean medicalized.

Today, we're facing the possibility of a new phase in the struggle for reproductive control, an era in which *Roe*'s protections cease to exist. Should the constitutional right to abortion be struck down at the federal level, many states hostile to abortion will ban it altogether. How exactly would this change the landscape of abortion access? In the following chapter, I argue that the shift might not be as dramatic as some envision. Yes, entire states will eliminate access to legal services, but as we saw earlier, six states have already shut down all but one abortion facility. Those already living in "post-*Roe*" realities are increasingly looking for alternative sources of abortion care, and health care workers, experts and activists are working around the clock to get the word out about self-managed MA. We'll see that the services are attracting a much wider audience than would be expected if barriers to access were the sole force driving demand. What motivations do people have for seeking self-managed MA, and based on this, what uses could it serve beyond the context of a post-*Roe* world?

Chapter Four

Within, Before and Beyond a Post-*Roe* World

"The graphic was simple but gripping: a black background with a wire coat hanger floating in the middle over one all-caps phrase: THE END OF ROE. HuffPost's editor-in-chief Lydia Polgreen tweeted out the image on Thursday morning, one of a string of left-leaning media nods to the same conclusion: Justice Anthony Kennedy's retirement from the U.S. Supreme Court is the beginning of a certain end to legal abortion access in America,"[161]

—Elizabeth Nolan Brown

Activity on both sides of the abortion debate escalated dramatically following the 2016 presidential election. On the campaign trail, Donald Trump vowed to appoint Justices hostile to abortion rights, who would overturn *Roe*: "I will protect [life] and the biggest way you can protect it is through the Supreme Court and putting people in the court. And actually the biggest way you can protect it, I guess, is by electing me president."[162] Since he took office, Trump has successfully appointed two Justices, Neil Gorsuch and Brett Kavanaugh. Though Gorsuch took the seat of a conservative Justice who called on his colleagues to overrule *Roe* in *Webster v. Reproductive Health Services* (1989), Kavanaugh replaced Anthony Kennedy, one of the three Justices who wrote the controlling opinion in *Casey* that upheld *Roe*. When Kennedy retired, the Court lost its one swing vote, which anti-abortion activists celebrated months before the confirmation of Kavanaugh in October of 2018 officially raised the reversal of *Roe* as a possibility. If this were to happen, the legality of abortion would be up to individual states.

Legal Preparations

Lawmakers have already begun preparing for the post-*Roe* era that may or may not come. In 2019, several states enacted laws that would protect or expand access to abortion, including New York, Illinois, Nevada, Maine, Rhode Island and Vermont. On the other hand, eight states have enacted "trigger bans" that could ban abortion almost completely if *Roe* is rendered

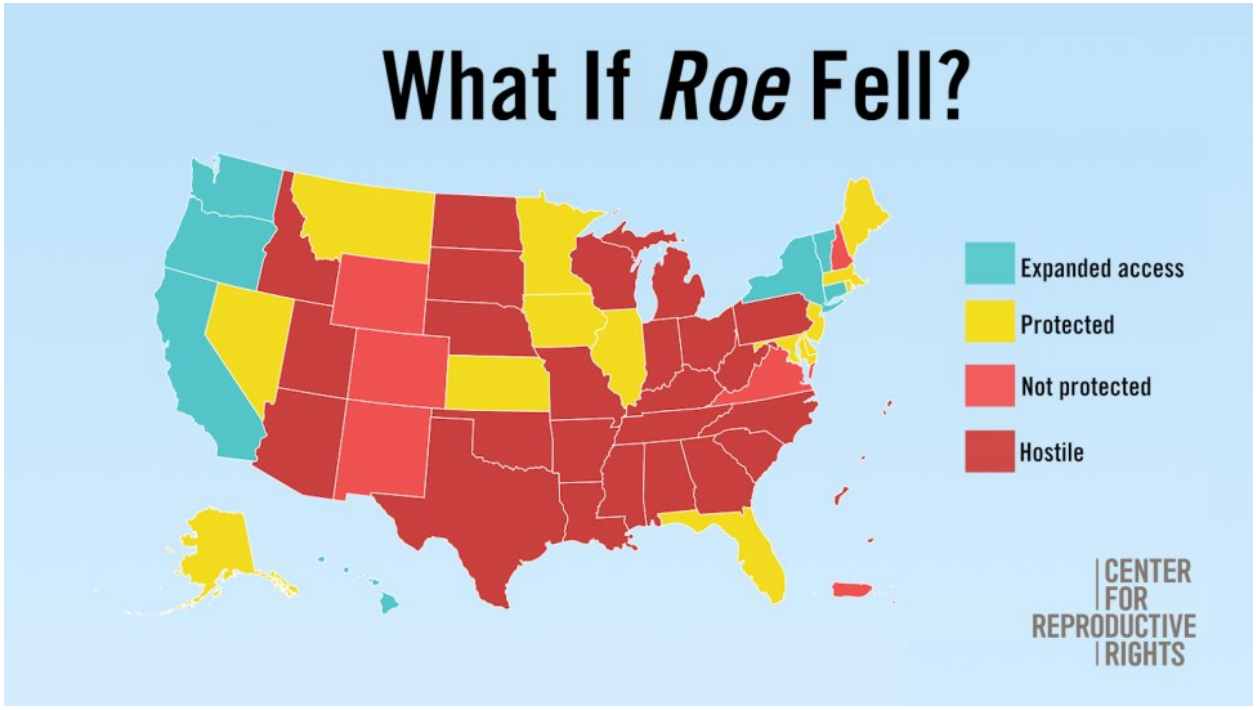

Figure 10. Less than half of US states would protect abortion rights if *Roe* fell
Source: Center for Reproductive Rights, 2020

ineffective.[163] Seven other states have laws that would restrict abortion as far as the Supreme Court would allow. Additionally, nine states have unconstitutional pre-viability bans that are currently blocked in courts, and nine retain total bans from before *Roe* that could be reinstated. Altogether, 20 states have laws that could ban all or nearly all abortions in the absence of *Roe (Figure 10)*.[164]

In response, people have started imagining what this post-*Roe* US might look like. Some invoke images of coat hangers and other back-alley methods from the pre-*Roe* era, but the reality would be much closer to Dr. Willie Parker's assessment: "A post-*Roe* world would look a lot like the world we have now, only more harsh."[165] Dr. Parker provides abortion several states, including two that Guttmacher classifies as "hostile" and one (Mississippi) that is "very hostile," with just one abortion clinic remaining. Abortion deserts already exist, and we already know how they affect women seeking abortion—disproportionately. A Middlebury study funded by

Guttmacher found that if *Roe* were reversed (and all high-risk states banned abortion), travel distance to the nearest abortion provider would increase from 1-791 miles, with an average of 249 miles, for 39% of women aged 15-44.[166] Women who can comfortably afford to travel the distances required of them now will likely *still* be able to in this post-*Roe* scenario, unlike those who would barely be able to scrape the money together today. As we saw in the previous chapter, this is a pattern that has existed at every stage of the struggle for reproductive control. Just as access to illegal abortion before *Roe* was unequal, so too has access to legal services been since its passing, and so too would access be after *Roe*. Inequality has been a devastating constant in the continually shifting landscape of abortion care.

The Middlebury study also found that if women responded to increased distances as women in Texas did after restrictions forced 22 of the state's 41 abortion clinics to close, the national rate of abortion would fall by roughly 32.8% in the year following *Roe* reversal.[167] But other researchers disagree—a paper published in the *Journal of Health Economics* suggests that even if entire states became abortion deserts, the effects on population measures of birth and abortion rates would be small at most.[168] Interestingly, too, the decline in abortion rates following clinic closures in Texas did not come with a commensurate rise in the birth rate. Whereas the abortion rate fell 20.5% between 2011 and 2014, the birth rate rose by only 2.6% in counties that no longer had an abortion provider within 50 miles.[169] Such a dramatic difference is not explained by the minimal increase in contraceptive purchasing behavior, and in an interview for the *New York Times*, co-author Corey White said: "Our best guess is that for people who didn't give birth, they were going to other sources for abortions."[170] A growing body of literature suggests a role for self-managed abortion.

Demand for Self-Managed MA is on the Rise

Several studies run in Texas have attempted to assess the prevalence self-managed abortion. In a 2012 survey of women seeking abortions in Texas, 7% of respondents reported having attempted to self-induce abortion prior to seeking care at a clinic.[171] This number is supported by data from cross-sectional surveys conducted in 2012 and 2014, which suggest that 6.9% of abortion clients had tried self-managed abortion before going to a clinic.[172] A statewide representative sample women of aged 18-49 was surveyed in 2015, and 1.7% reported that they had ever attempted to terminate a pregnancy on their own, while 22% reported at least knowing someone who had.[173] But just as Texas isn't the only place in the US that has faced a barrage of abortion restrictions, it is not the only place thought to be experiencing a rise in self-managed abortion.

Data analyst Seth Stephens-Davidowitz had the idea to quantify the number of times people turned to Google for information about self-induced abortion, searching phrases such as "how to self-abort." He writes: "Google searches can help us understand what's really going on. They show a hidden demand for self-induced abortion reminiscent of the era before *Roe v. Wade*."[174] Altogether, there were 700,000 searches in 2015[h], including roughly 119,000 for the exact phrase "how to have a miscarriage," 4,000 for directions on coat hanger abortions, and hundreds for even more harmful methods such as bleaching one's uterus and punching one's stomach. There were also 160,000 searches for unofficial sources of abortion pills, like "buy abortion pills online" and "free abortion pills." To determine whether increased interest is related to the onslaught of restrictions since 2011, he compared relative rates of Google searches with the number of major restrictions enacted, using data from Guttmacher (*Figure 11*).

[h] For comparison, he notes, there were 3.4 million searches for abortion clinics in 2015, and according to Guttmacher there are roughly one millions legal abortions annually.

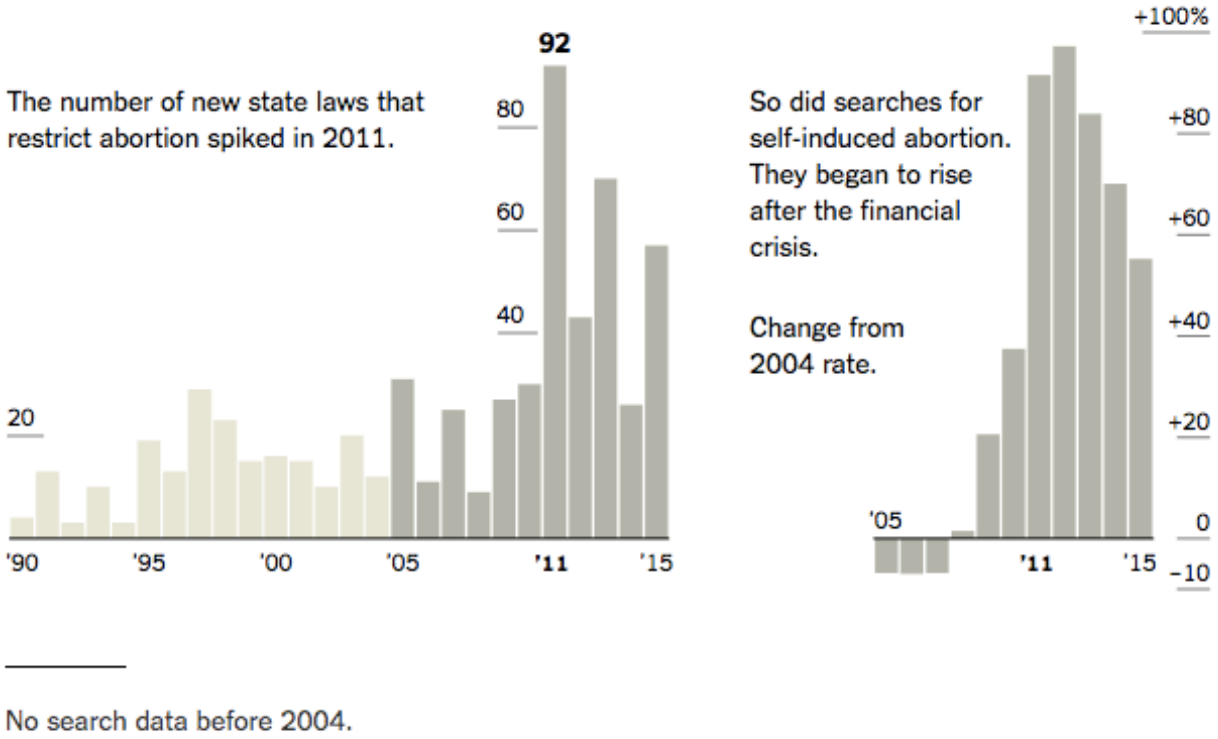

Figure 11. Tougher laws, more searching

Source: The New York Times (state laws by Guttmacher Institute; analysis of Google data by Seth Stephens-Davidowitz)

When he broke this down by state, the results provided further support for an inverse relationship between demand for self-managed abortion and legal barriers to abortion access (*Figure 12*). While eight of the 10 states with the highest Google search rates are classified as either hostile or very hostile to abortion by Guttmacher, the 10 states with the lowest search rates were either middle ground or supportive. The state with the single highest rate was Mississippi—one of the states that, with one clinic standing, is practically an abortion desert today (*Figure 12*).

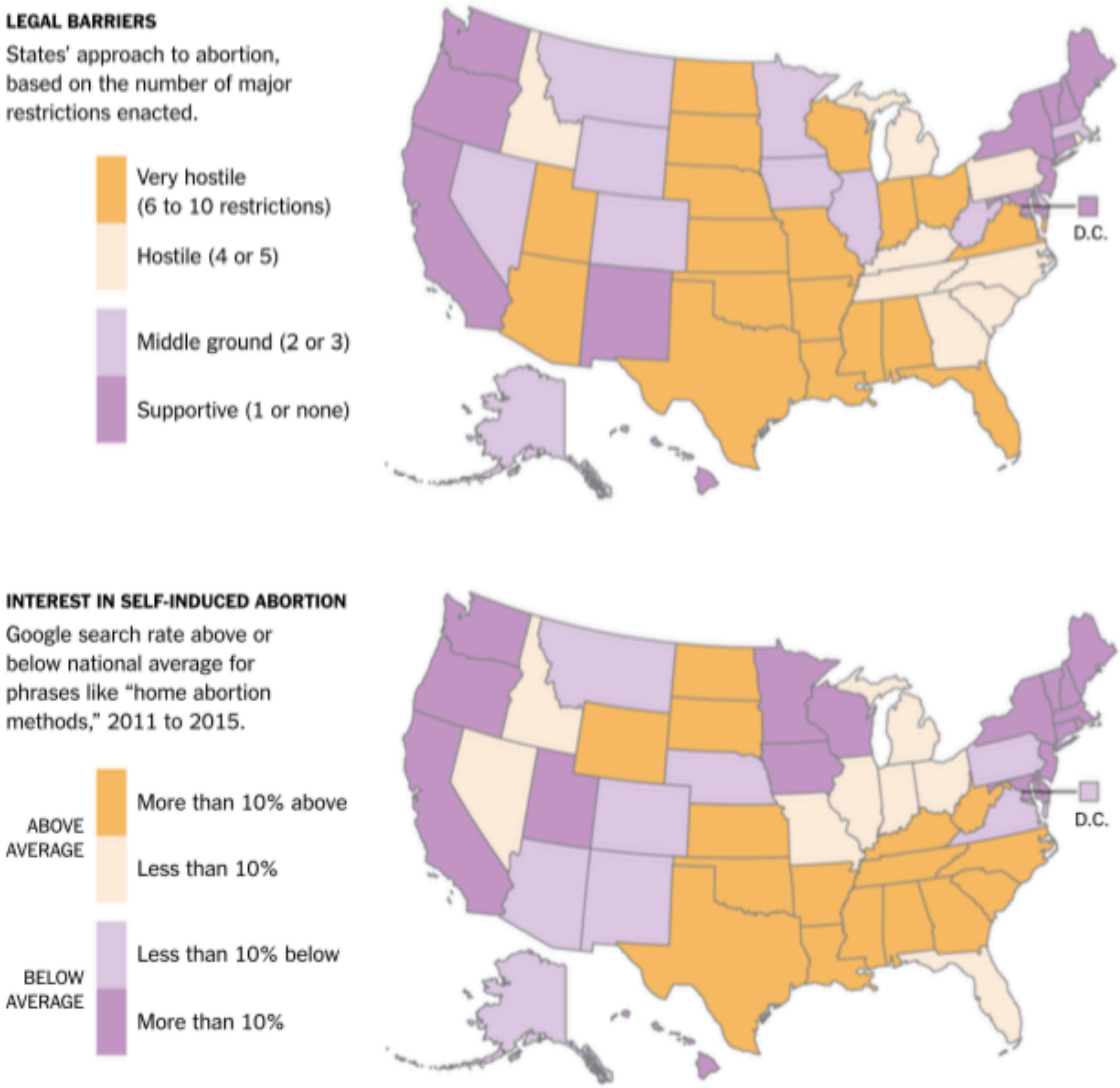

Figure 12. Abortion at Clinics, or Somewhere Else

Source: The New York Times (state laws by Guttmacher Institute; analysis of Google data by Seth Stephens-Davidowitz)

Though these findings certainly indicate that demand for self-managed abortion is increasing, they are not conclusive. We don't actually know whether the people searching Google were pregnant or were planning to use the information to end their own pregnancies. To investigate what their motivations and circumstances might be, researchers designed a Google

Ad that would provide a survey link to people looking for information on self-induced abortions.[175] Over 32 days, the link was shown 210,000 times, clicked on 9,800 times, and 1,235 people completed the survey. Of the respondents, 73% indicated they were searching because they were pregnant and did not want to be and 11% had ever tried to self-induce. Because the samples are not nationally representative, these findings cannot be generalized to all women in the US, and studies that did use such samples found rates much lower than 11%—one found that 2.6% had ever attempted self-management, and another found that 4.6% had.[176] Both of those, however, were conducted before wave of restrictive legislation that followed the 2010 midterm elections. Since that wave darkened the landscape of access, no nationally representative studies have been published.

These studies suggest that self-managed abortion did not go away when *Roe* went into effect, and as its protections are weakened, interest is rising. In states most hostile to abortion, demand seems to be increasing at a rate greater than in less hostile states. This is further supported by findings from a recent study that measured requests for abortion pills through an online telemedicine service, Women on Web (WoW).[177] WoW is a Netherlands-based nonprofit initiative that began providing misoprostol and mifepristone to people living in countries where safe abortion is unavailable in 2006.[178] When contacting WoW, women begin by filling out an online consultation form that asks questions about their medical and pregnancy history, demographic characteristics, and reasons for seeking the service. Because abortion is technically legal throughout the US, WoW does not provide services to its residents,[i] but it still receives requests. Over 10 months in 2018, 6,022 US women reached out to WoW, and from analyzing

[i] WoW responds to women seeking care in the US with information about locally available abortion services and funds, self-management, online pharmacies providing mifepristone, and financial and logistical assistance with accessing services
Source: Aiken et al., 2019.

their consultation forms, Aiken's team found that 76% were living in hostile states.[j] The number of requests WoW received from women in the US increased drastically in the years leading up to this study; in 2015, just over 600 had reached out.[179] Seeing this, WoW founder Dr. Rebecca Gomperts launched a separate service, Aid Access, that works the same way as WoW save for one key piece—it ships to the US.

Demand for the service took off immediately, attracting 21,000 requests in the year following its 2018 launch.[180] Six months later, that number had reached 37,000, and 7,000 packages had been shipped.[181] Around the same time Dr. Gomperts shared these numbers, the Guttmacher Institute reported a 7% decline in the nationwide abortion rate between 2014 and 2017.[182] Guttmacher cited an increase in the number of women electing to self-manage as one of the potential contributing factors, but proving this is a difficult task. Because women do these abortions at home without reporting them, traditional clinic-based surveillance cannot be used to develop national estimates. However, Guttmacher did receive some evidence of increased use of self-managed MA from facility-level reports; in 2017, 18% of nonhospital facilities reporting seeing at least one patient for a missed or incomplete abortion following self-induction, up from 12% in 2014. Furthermore, these proportions were greatest in the South (21%), where access is most limited.[183] It's important to note that these data only capture cases in which women seek rarely-needed follow-up care. Incomplete or missed abortion occurs in less than 15% of abortions using misoprostol only and in 5% using the combined approach. Dr. Linda Prine, a family physician and Medical Director of RHAP[k], says that "99% of the women who self-manage their abortions have no need to seek any medical care afterwards."[184] Thus, we can

[j] For reference, 58% of women aged 13-44 live in states hostile to abortion rights (see page 27).
[k] Reproductive Health Access Project—first discussed on page 52.

reasonably assume that for every self-managed abortion counted in these facility-based reports, many more were successfully completed at home.

Taken together, these findings indicate that rejection from the formal health care system has prompted many to seek alternative sources of abortion care, translating to a surge of interest in self-managed MA. For those who already live in post-*Roe* realities, illegally ordering pills from the internet may be the most viable route to safe and effective abortion, and many are taking this into account as they imagine a post-*Roe* US. As Jill Adams, executive director of the legal nonprofit for reproductive justice If/When/How, explains to The Cut:

> "*It's no longer the Chicken Little narrative, where if you pass restrictions, clinics will close, people will be forced to take matters into their own hands, and it's certain death and destruction from there. Instead, abortion will become even less accessible, and some people will self-manage abortion and most of them will be perfectly fine*."[185]

If *Roe v. Wade* is overturned or rendered ineffective, we will certainly see escalation in the demand for abortion pills on the gray market. Popular press outlets have been churning various versions of the story out one after another, with catchy headlines such as "Abortion After the Clinic," and "Illegal Abortion Will Mean Abortion By Mail."[186,]These stories may be largely correct in their characterization of a post-*Roe* world, but they sometimes fail to catch the nuances of self-managed MA by overemphasizing its usage as a last resort.

Reasons for Seeking Self-Managed MA

Dwindling access is not the only reason people are turning to online sources for abortion services. Though 76% of WoW's requests came from hostile states, the other 24% were sent by women in states considered to have supportive abortion policy climates. Moreover, women in hostile states did not cite barriers to access as their motivation for seeking services significantly more than women in supportive states did; the majority (60%) of women in each group reported seeking pills online because of a combination of barriers and preference.[187] As Aiken states:

"More people are seeking out self-managed abortion as a first choice," she said. "There's more than one model of ideal care for people now: Some people prefer to have their abortion in a clinic, and some prefer to do it at home. We need to meet people where they are."[188] Indeed, there a growing body of evidence suggests that while a number of barriers push women toward self-managed abortion, a variety of unique advantages actually *draw* many toward it. These studies largely use interview-based methods, as personal testimony is the only way to capture the complex decision-making process behind the choice to self-manage.

Among preferences, privacy is often cited first. With self-managed MA, women have the ability to hide the abortion from any family, friends, partners or health care workers who might be opposed or try to interfere. Because the symptoms and treatment mimic early pregnancy loss, and there is no medical test to determine whether someone has taken abortion pills, it is possible to disguise the abortion as a miscarriage.

> "*... I was thinking especially about privacy. Using Cytotec is something that is yours, nobody has to know what you did or didn't do, no one invades your privacy. Even the gynaecologist I went to later didn't know that I had had an abortion*," —Ana Cristina, age 31.[189]

> *"... I didn't want him [boyfriend] to know, and I didn't have the money, even though that wasn't the main reason. I wanted something fast and safe. In fact, I didn't even think of going to a clinic because I'd just got pregnant and I thought that there would be no problem with Cytotec*," —Fatima, age 27.[190]

The convenience of ordering online and the comfortability of going through the entire process at home are also frequently cited motivations.

> "*... I thought about going to a clinic, but it was too expensive and I would have had to plan it, go there, set the date, pay on the date. But not with the medicine, it's there in front of you, either you take it or you don't*," —Dilma, age 19.[191]

> "*In a clinic, it's more—clinical, you know... You have people walking back and forth, you have people opening up the doors when you're in there and there's just no privacy, it's more hard... harsh... As opposed to being at home, you're in your own environment, you're*

surrounded by things that make you feel safe and make you feel comfortable." —Boston 5, age 20.[192]

People who have negative experiences and associations with the health care system, who are afraid of doctors, or who generally prefer to have a less medicalized procedure, may be driven to avoid clinics altogether.

"*I don't want to deal again—and the questioning and to test me for STDs... and it's this big, long process... I don't want to have to go through that [again] if I don't have to*." —San Francisco 1, age 21.[193]

"*I was scared... to actually go to a doctor and maybe they'll do worse than what, you know, I was going to do*," —New York 2, age 18.[194]

For others, taking medication is a less traumatic experience than surgical abortion, both physically —it requires going under anesthesia—and psychologically. The process is often described as feeling more "natural."

"*It's less traumatic, a lot less. You know what the sensation is? The sensation you have is that your period is late and so you take medicine for it to come. That is the feeling I had. I can lie to myself if I want, but I won't. I did it feeling good. I am not a liar to say such a thing, that I simply took some medicine, that I didn't cause an abortion*," —Fatima, age 27.[195]

"*I think that the effects of abortion, even though you are in favour of it, have always bothered me. It's traumatic, it's a real operation. That's what counted. Cytotec was less traumatic*," —Rosana, age 25.[196]

"*I never saw it as an abortion. Using Cytotec felt more like postponing pregnancy at the time, waiting a little longer for a new life to appear. Because if I had gone to a clinic, I would never have forgiven myself. I was already doing this with a lot of regret, with a tight heart, full of insecurity. I wouldn't have been able to face a clinic, not physically or psychologically. I was never in favour of the abortion. I always thought that if I had an abortion, I would carry it with me for the rest of my life*," —Nilce, age 18.[197]

"*It's not a baby already. It's just blood. So I don't feel like it's killing a baby, because it's just developing,*" —Boston 4, age 22.[198]

Yet others are drawn simply to end the unwanted pregnancy as soon as possible. Remember, MA is the only type of abortion that can be used from the moment a woman learns she is pregnant.

"*You can do it fairly quickly… and you just… get your period, and you don't even associate it with a possible pregnancy… There's Plan B [emergency contraception]. I used that just when a condom broke… That was essentially the same thing*," —San Francisco 1, age 21.[199]

"*I couldn't wait for the thing to get too far advanced. When I found out, the pregnancy was already ten days along, so I said, the sooner we solve this problem the better it is for everybody. I'll take Cytotec,*" —Ana Cristina, age 31.[200]

There are endless possibilities, but I'll mention one more preference that is frequently cited and crucial to realize: the feeling of empowerment that comes with being one's own provider, autonomously making one's own health decisions and having an abortion on one's own terms.

"*As a woman, you are the authority on your body. You know the best about what your body should feel like. I think I should be able to make the decision as I see fit. I've successfully used natural or self-care remedies for many other things in the past. That is why having an at-home abortion makes so much sense to me. I definitely think that at-home abortions should be available to all of us*." —Janice, a 29 year-old from Montana.[201]

More often than not, personal preferences factor into the decision to self-manage an abortion.[202] However, barriers to access do seem to be responsible for a larger proportion of increased demand. In both hostile and supportive states, women seeking services from WoW were over four times as likely to report doing so because of barriers only (30%) than because of preferences only (7%).[203] In Aiken et al.'s study, the most commonly cited barriers were the cost of clinic abortion, the need to keep abortion secret, time off work or school, and distance to clinic, followed closely by state laws, perceived abortion stigma, difficulty finding childcare, protester harassment and intimate partner violence. Women have elaborated on these motivations to other researchers, who want to understand why people seek medications online even when legal options exist:

"*... I went to a clinic, but it would have cost a little more than my salary, so I thought: What now? I won't be able to do it that way...*" —Marcia, age 23.[204]

"*I decided on an at-home method for the fact that I didn't want to be going out to a clinic where I know there's a lot of protestors or things like that and I didn't want to be dealing with them telling me that I wasn't doing the right thing ... Even though I did have access ...*

But I guess I didn't want to tell nobody ... I guess I didn't want to make it more public than what I -- because of all the media and stuff like that about like you shouldn't abort and things like that," —30 year-old from Texas.[205]

"It's going to become.... too far along, where the price increases, and I was like I've just got to get it done now. And I just said well, there's only like what—I think there's less than ten clinics in all of Texas now and they're going to be busy. So when I call to make the appointment, you know, I couldn't—I think the earliest they saw me was like a month from when I called because they're so busy, you know." —26-year-old, Corpus Christi.[206]

"*Originally, I had Googled abortion clinics near me, but when I started calling a bunch of them, they were like 'No, we don't do that.' I found out that every clinic in Louisiana except three have been shut down. So, my next thought was 'I need to do this on my own,' and you can buy anything online, so my second thought was basically to order an abortion kit online.... I'm hours away from a clinic, and I would literally have to go through counseling at 8 a.m. and then stay there seven hours to speak to a doctor and get an ultrasound. And after that, I'm gonna have to have another consultation to get the abortion done, and then a third appointment to see how I am physically and emotionally. They are gonna make me listen to the heart-beat, they're going to make me have counseling, and then I have to watch a video, and I just feel like that's a bunch of bullshit. I know what I want, but the laws in the state make it so hard."*[207] *—anonymous*

"*I found it really, really difficult to get information on what clinics provide. It's hard having to call people directly and ask 'Do you guys offer this?' because there's so much stigma attached to it. It would be so much easier if abortion were listed, just like every other service they offer in the clinic. So, I Googled 'medical abortion.' I came across the site [of the online telemedicine service], and it seemed like such a cool service where they would mail the medication*," —Marianela, a 32 year-old from California.[208]

Some people who opt for self-managed abortion truly would prefer clinic-based care. As a 24-year-old from Texas said, "I've got to say the surgical abortion's a lot more comfortable so I would rather do it that way if I had to get another one. But money, it is a big deal and 19 dollars is a hell of a lot better than 400."[209] Cost was the primary prohibitive factor for another woman living in Texas, who ended up using misoprostol at 13 weeks' gestation (at which point MA is no longer recommended) and hemorrhaged, requiring a D&E and blood transfusion. She commented:

"*If I knew all this would happen, I probably still would do it, because I would have had no choice but to do it, because I didn't have the money... But, if I had the money? Well, of*

course, I would go probably to a regular clinic or something. But, if I was put in the same exact situation all over again? I'd probably do it again."[210]

Though a simple harm-reduction framing of self-managed MA is problematic, it *is* true that in some cases, the pills prevent people from turning to more dangerous options:

"*No doubt I would have ended up hurting myself. I honestly would have got the hanger in there. I would have done something physical to myself to get the baby out of my body. I wouldn't have been able to cope with carrying to term. I absolutely would not have been able to,*" —Sonia, 21 year-old from Michigan.[211]

"*I was really desperate. I heard you could try drinking gin. I found YouTube videos that tell you how to do it with a hanger. Once he started explaining what you're literally doing, I was shocked. I'm not gonna lie—it made me cry. Because if you're young and you're desperate, it's like, you live in this space where you will go that extreme*," —Jovita, a 23 year-old from Illinois.[212]

These testimonies only begin to uncover the range of circumstances that compel women to choose self-managed MA, yet it is immediately clear that no single narrative or shared experience exists. This is what sometimes gets lost in the rush of popular press materials that cast it as the starring role in a post-*Roe* world. In doing so, it is easy to insinuate that its primary use is as a last resort only to be used when clinic abortions are unavailable. But this is simply not the case; while it may be a less desirable option for some, it's a first choice for others. Some articles capture this nuance beautifully, such as Emily Shugerman's "What Back Alley? These Women Say DIY Abortion Can Be Empowering."[213] Still, the larger implications of self-managed MA for understandings of safe abortion and reproductive autonomy are missed.

Implications for "Safe Abortion" and Reproductive Autonomy

Back in Chapter One, we saw that new relationships between the terms "self-managed," "safe" and "legal" prompted WHO to redefine their formerly dichotomized concept of safe abortion, now described as a continuum of risk that takes social and legal context into account. In a 2018 commentary, Joanna Erdman, Kinga Jelinska and Susan Yanow expand on these dynamic

relationships by examining, as the title suggests, "Understandings of self-managed abortion as health inequity, harm reduction and social change"— three frameworks through which to view the practice. They explain that inequities in abortion are constructed; outcomes tend to fall along race, age and class lines, but they are not *inherent* to those social markers and cannot be attributed to a lack of wealth or knowledge. Rather, the social resources of wealth and status are only necessary to access formal care due to "legal and policy structures that marginalize people, create vulnerability and impose disadvantage in accessing safe abortion care."[214]

Recognizing this, recent studies have aimed to redefine the causes of inequalities by focusing on barriers to clinic-based abortion care—barriers we've discussed at length along with their disproportionate effects. Though important research, Erdman, Jelinska and Yanow critique these studies for retaining the clinical setting as the standard and desired place of care. In doing so, they "[ignore] the too common mistreatment and abuse of abortion seekers within formal health care systems, where providers may believe they have a moral if not legal right to accuse, judge and condemn."[215] As we learned from testimonies in the previous section, clinic-based abortion care can also entail rounds of questioning, STD testing and encounters with anti-abortion protesters that are felt as dehumanizing. Moreover, women have described their experienced safety of abortion care in terms of social and economic security in addition to physical safety.[216] Thus, by making it possible to avoid the indignities of formal settings and associated feelings of shame and powerlessness, self-managed MA can offer a unique, enhanced experience of safety. Safe abortion interventions that aim to combat health inequities by reducing barriers to clinic-based care have yet to take this into account.

I've cautioned against narrowly framing self-managed MA as harm reduction, but it *is* an important application of the practice. After all, WHO decided to recommend the miso-only

protocol (when mifepristone is inaccessible) in its updated guidelines for safe abortion because its use had *already* been linked to reductions in complications from unsafe abortion. Our brief journey into the history of self-managed abortion revealed the lengths to which women have willingly gone to end unwanted pregnancies, and the advent of MA means that no one should have to suffer or die from these efforts. Within the harm reduction framework, safe abortion interventions are designed to increase access to accurate information and quality medicines.[217] These include professionalized information programs, which are measured and assessed by public health impact, as well as feminist-run websites and hotlines. Networks of volunteers also provide in-person support by accompanying people as they buy and use the medications.

In addition to providing practical information about the regimens and counseling on how to manage the side effects, these interventions aim to help people avoid legal consequences. This is perhaps their most significant role given that the risks of self-managed MA are primarily legal rather than health-related. These interventions include security measures of encrypted or anonymous information as well as informing women that MA cannot be medically distinguished from miscarriage, allowing them to seek follow-up care without the fear of arrest. Furthermore, they are rooted in the principles of reproductive justice, best explained by Erdman, Jelinska and Yanow:

> "These harm reduction interventions do not simply respond to structures of inequity that render SMA risky or unsafe. They seek to actively disrupt these structures and to minimise if not eradicate the social inequities sustained by them. These interventions are grounded in the basic human rights to seek, receive and disseminate information and ideas on sexual and reproductive health, and to enjoy the benefits of scientific progress, specifically in access to misoprostol and mifepristone as essential medicines. These are claims not merely of freedom from state restraint, but collective rights for all, including disadvantaged and marginalised groups, to a full range of sexual and reproductive health care, including technological advances and innovations in the provision of sexual and reproductive health services, such as medication for abortion."[218]

Because marginalized groups are most at risk from regulatory laws that can be used with discretion, harm reduction interventions fundamentally support legal reform and decriminalization.

Social change is thus a third frame in which we must consider the implications of self-managed MA. Physicians, feminists and researchers have called for changes to restrictions that serve no medical purpose and violate women's constitutional and human rights. Much like the Jane collective did in the years leading up to *Roe*, feminist groups organizing around self-managed MA operate independently from the health and state institutions whose power derives from the suppression of women's reproductive control. Medical and state-based authority has limited the terms and conditions of abortion access and suppressed demedicalized conceptualizations of abortion. Conversely, grassroots efforts to spread information flatten hierarchies of authoritative knowledge and subvert unbalanced power dynamics: "[self-managed MA] is subversive precisely because it challenges assumptions about service delivery requirements, definitions of who/what is a provider of care and the power dynamics of care."[219] When a woman becomes the "provider," she is able to control the process with the level of support she deems appropriate from those sharing information about how to use and access the pills; her capacity to act autonomously is greatly increased.

The practice of self-managed MA can also be empowering for everyone who participates in the collective activism that makes it possible. Learning the science behind MA and being able to support others as they self-manage is self-empowering, which translates into local activism that in turn helps to normalize abortion, advocate for its decriminalization and break taboos around women's sexuality.[220] The local ownership established by those who assume roles in distributing the pills is also a powerful act of resilience, and by inspiring local activism while

connecting national and regional advocates, it "creates the potential for systemic change and increases sustainability."[221] We can again see parallels to the Jane collective here, whose members described picking up medical instruments, the tools of their own liberation, and feeling a sense of transformative power that they strived to share with other women.[222] Over hundreds of years, women have again and again demonstrated their ability to take matters into their own hands—as well as their awareness of the consequences and willingness to live with the worst of them—yet they still are not trusted to make decisions for themselves. As Laura Woliver writes in *The Political Geographies of Pregnancy*, "The idea that women are experts on their own experiences has typically been dismissed."[223] The feminist groups organizing around self-managed MA, however, understand that each individual has a unique set of values and priorities that leads to entirely unique experiences, and they "refuse to label and to thereby judge the act of abortion by any terms other than how an individual experiences it."[224] Thus, their actions both liberate abortion from medical control and redefine expertise as experiential rather than legal or medical.

There is no question that self-managed abortion is happening now and is here to stay. Indeed, it is likely to increase in popularity over the coming years, and if we do find ourselves living in a post-*Roe* US, collective efforts to spread information will be crucial to minimizing the damages of unsafe abortion. Even—and especially—in this context, it is crucial that we are able to understand self-managed MA as harm reduction without thinking of it as "less unsafe" or a "last resort," as some would choose to self-manage even if barriers to clinic-based care did not exist. Such a framing should also consider the ways in which the practice can enhance safety for those who have traumatic associations with the formal health care system, and it weakens the potential for social change by diminishing the subversive power inherent to the operation. But is

this capacity any match for the institutionalized power currently governing access to abortion and MA? At the end of the day, who really controls access to abortion pills, and what are their motives? In the following chapter, I will characterize various actors with a stake in this landscape and attempt to assess the nature of pivotal power dynamics.

Chapter Five

Who *Really* Controls Access to Abortion Pills?

"Using a slogan from ANT, you have 'to follow the actors themselves', that is try to catch up with their often wild innovations in order to learn from them what the collective existence has become in their hands, which methods they have elaborated to make it fit together, which accounts could best define the new associations that they have been forced to establish,"[225]

—Bruno Latour, *Reassembling the Social*

Today, a movement exists with the potential to substantially shift unbalanced power dynamics central to the struggle for reproductive control. Even when self-managed MA is not an explicitly political act, it challenges medical and state-based control of abortion as well as traditional understandings of "safe" in relation to "legal." As more and more and more people are successfully navigating their way around medically unnecessary barriers imposed by REMS, the FDA's authority as a regulatory agency is arguably threatened. Criminalization remains a risk for those who purchase the pills from unofficial sources, but as we know, activist networks are working tirelessly to spread information on how to minimize that likelihood. Will the subversive power of self-managed MA meet the same fate as that generated by the Jane collective, which faded once medical control was reestablished in *Roe*? If not, how might it manifest in the coming years? Answers to these questions hinge on power dynamics far more complex than those between woman and physician, or woman and state. The framework of ANT is useful here, as it exists to investigate networks of human and non-human actors that form associations around scientific innovations such as MA. We'll "follow the actors," in this chapter, identifying some of the major players that influence use and distribution of MA and the interests that compel them to act. Because I am particularly interested in how power is exerted within this network, I use one case study, an ongoing legal battle between two such actors, to inspect these dynamics in action before attempting to assess their stability.

Mifepristone and Misoprostol

There are a number of qualities inherent to mifepristone and misoprostol, the abortion pills themselves, that are relevant to the roles played by surrounding actors. First, they allow for variation and flexibility in the administration protocol. WHO approves six different variations at less than 12 weeks' gestation, depending on the availability of mifepristone and the preferred route of misoprostol administration (buccal, vaginal or sublingual). There are another six versions for pregnancies over 12 weeks' gestation, with slightly different dosages.[226] Efficacy is greatest at the optimal dosages recommended, but there is some leeway, as studies have shown similar efficacy at different doses of mifepristone and misoprostol, with some variation in side effects.[227] This makes it illogical to require compliance with a singular protocol and important to spread information about the various options.

These medications make the uterus do the work of expelling pregnancy tissue. The mechanism may be perceived as natural, as it mimics miscarriage and works from the inside out. Vacuum and D&E abortion rely on medical instruments and clinicians' hands, whereas medical professionals have very limited access to the body parts involved in MA and no control over its progression. It is also important to note that pain is a normal by-product of the procedure and cannot be used as an indicator of how well or poorly it is progressing, which can be stressful if the woman does not know what to expect. Thus, communication with people knowledgeable about the process is crucial to care, and without a support network, the adverse effects of any complication can multiply.

Women are never passive recipients of MA care, even when it is distributed in clinics. They must always be somewhat involved in the process, managing symptoms and monitoring the substances expelled from the body. Thus, the process is always self-managed to a degree, which

means that it will always be experienced as empowering by some, and it will always advance a more "natural," demedicalized understanding of abortion. Because the pills do not work immediately, they enable the user to be mobile during the early stages, thus operating somewhat invisibly and privately. The physical pills are also quite mobile, as they are small and easily shipped or transported. Finally, they are very low tech and do not take significant training or expertise to administer, facilitating the shift of care from physicians' hands to those of women and their support networks, the people most affected by the abortion.

Women Who Seek MA

Women play the crucial role of determining demand for MA. In addition to the growing practice of self-managed MA, the number of legal MAs provided in formal facilities has also risen steadily, as many of the same advantages apply (noninvasiveness, efficacy at very early

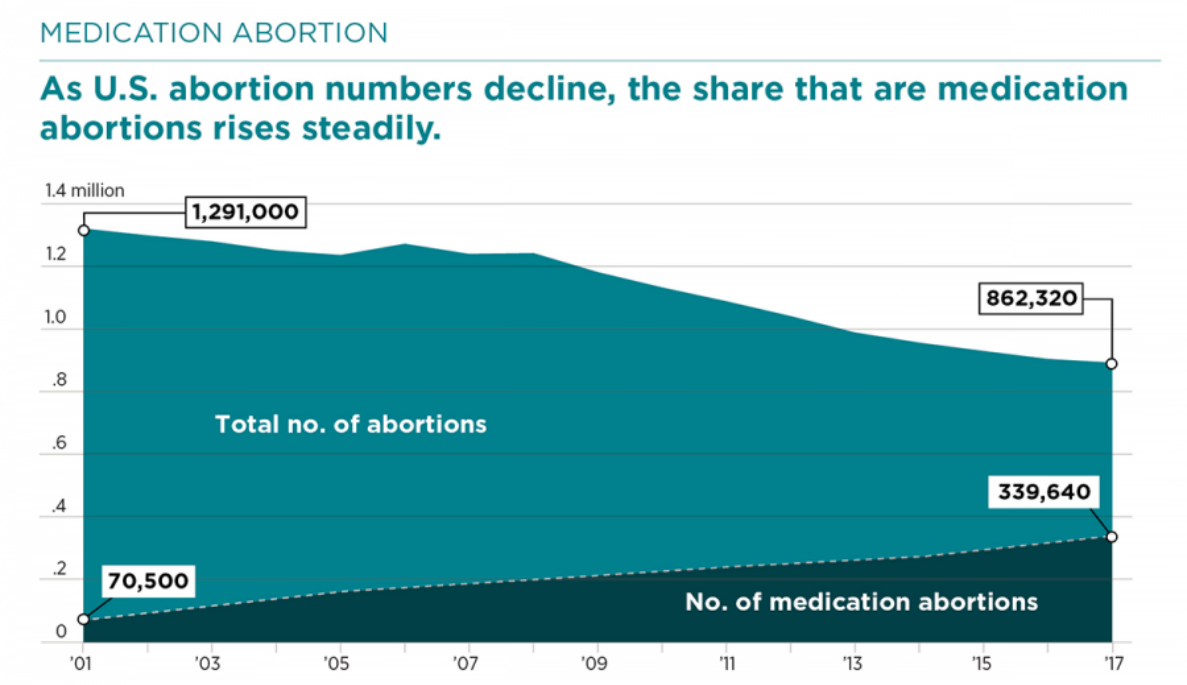

Figure 13. MA increased from 5% of abortions in 2001 to 39% in 2017, even as overall abortion numbers declined

Source: Guttmacher Institute, 2019

gestations, and lack of risks of uterine perforation, etc.). By 2017, MA accounted for 39% of all clinic-based abortions, which is still striking given the burdensome restrictions guarding access to MA (*Figure 13*).[228] As we know, many more women have turned to online pharmacies and other unofficial sources to purchase abortion pills. By successfully self-managing their abortions—or at the very least, managing the symptoms and side effects at home—women are proving that safe abortion can exist beyond the walls of formal settings. Interest and demand for MA, both self-managed and not, is further increased as these women share their experiences by word of mouth, whether through activism or casual conversation.

State Laws

Clinic-based MA care is subject to the same state-level abortion restrictions as vacuum and D&E abortions, which we discussed in Chapter Three within the context of the history of reproductive control. Because it is a relatively new technology, the majority of abortion laws were written before MA became available. Consequently, many of these laws do not make sense in the context of MA but are enforced nonetheless. For example, though physician assistants and nurses are authorized to provide MA in some states, 33 states limit provision to physicians despite clear evidence that other health care workers are equally competent. In 18 states, the physician is required to be in the same room as the patient when providing the pills, effectively banning telemedicine abortion.[229]

Additionally, a variety of targeted regulation of abortion providers (TRAP) laws single out abortion facilities by imposing regulations that do not apply to other health centers or physician offices. These laws that go beyond what is needed to ensure safety, imposing burdens that have forced hundreds of providers to shut down in recent years. For example, 11 states require that providers have some affiliation with a local hospital, nine states specify the size of procedure

rooms, eight specify corridor width and eight require facilities be within a certain distance from a hospital.[230] TRAP laws deter facilities from providing MA when they would otherwise be able to do so.

All forced parental involvement, counseling and mandatory delay laws apply to MA, requiring waiting periods to occur before mifepristone is administered.[231] Recently, an increasing number of states have followed Arkansas's lead in requiring providers to tell patients about MA "reversal"—a medically unsupported treatment that involves taking a high dose of progesterone after the first dose of mifepristone, allegedly to "save" the pregnancy. Proponents of this counseling claim it provides patients with options, but it in fact "uses flawed research to undermine personal reproductive health choices.[232]

Twenty-six states have added to the standard crop of abortion laws to explicitly regulate MA (*Figure 14).*[233] Some have updated legislation to formally include it in the legal definition of abortion, and others have either passed or are considering additional regulations that specifically target MA.[234] Though medical consensus, which includes studies run by WHO, recognizes that the current FDA protocol is outdated, North Dakota, Ohio and Texas require physicians to follow its instructions precisely. Arkansas and Oklahoma passed similar laws that have been blocked by courts. There are also a number of states that have explicitly criminalized self-managed abortion, while others have laws that could be used to prosecute women for self-managing, ranging from fetal homicide laws to those that criminalize failure to report an abortion to the coroner.[235]

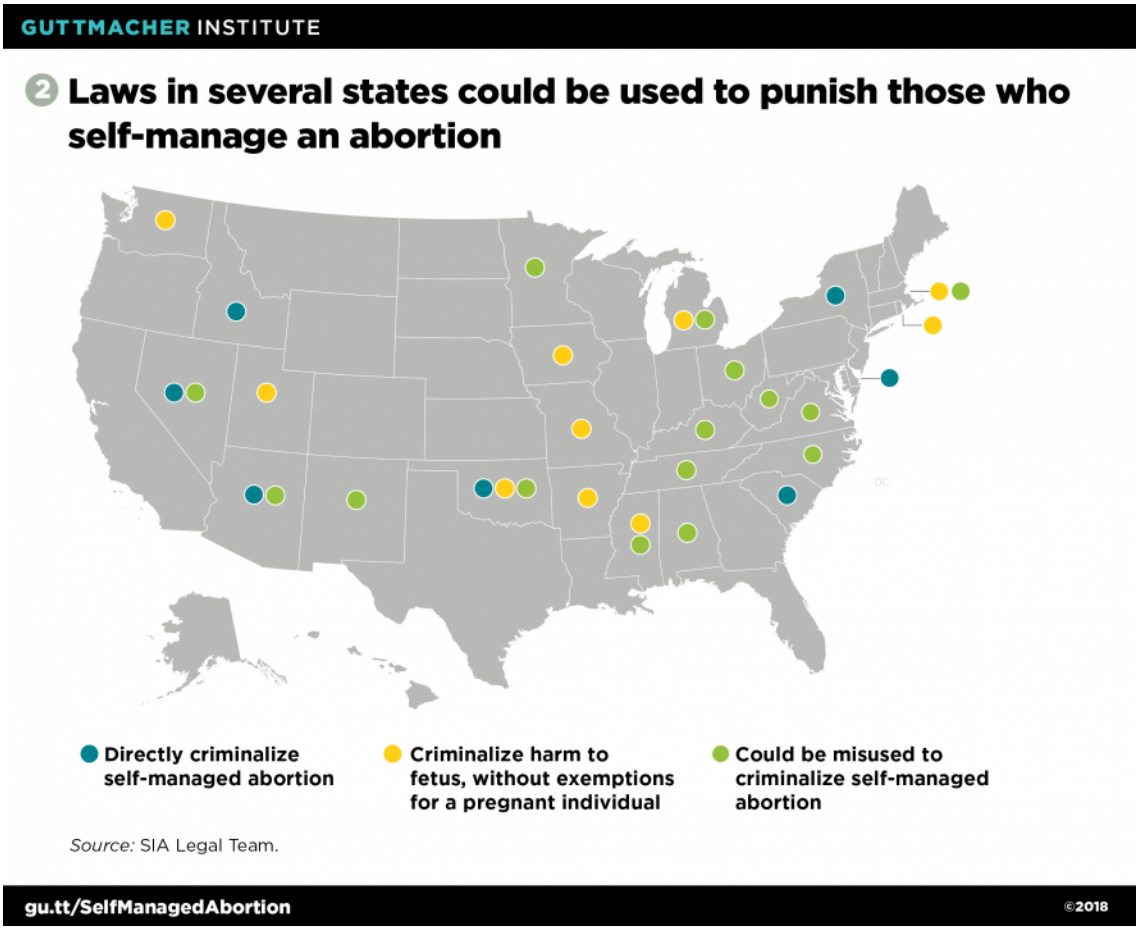

Figure 14. Legal landscape around self-managed abortion

Source: Guttmacher Institute, 2018

Enforcement of many of these laws largely falls on medical professionals to report women they suspect of self-inducing to authorities, and though understanding the legal landscape around self-managed MA can be both useful and empowering, where one is in the country might not make much of a difference. Susan Yanow uses the analogy of driving while black here—hundreds of thousands of people have been wrongfully arrested and ended up in jail anyway. Similarly, marginalized groups are more likely to be accused of taking abortion pills in the ER or otherwise targeted; if there's a will to criminalize self-managed abortion, there's a law they'll try to twist to serve the purpose. At least 20 women have been arrested and charged after an attempted self-managed abortion, but it remains very uncommon.[236]According to Jill Adams,

there is still no known case of someone in the US being arrested or investigated for the sole act of purchasing abortion pills online. She explains, "Importation of drugs is technically prohibited under federal law, but in practice it is not enforced against individuals for personal use."[237]

Physicians and Medical Groups

As we know, access to MA could be greatly expanded through primary care were it not for laws that make it unappealing to prescribe. Burdens are imposed by TRAP and "physician-only" laws as well as the requirements that a doctor complete certification and enroll in a public registry of abortion providers. Dr. Linda Prine has helped RHAP train hundreds of clinicians through MA workshops. In just 90 minutes, the group is able to cover all of the necessary medicine, which she describes as straightforward. Yet, not everyone who gets trained actually goes on to become a provider. The difficulty, she explains, comes from implementation barriers such as state regulation and administrative blocking—if one coworker is against it, all of their efforts could be lost.[238]

Access could similarly be expanded through telemedicine, but the REMS and many state laws prohibit this use. As was mentioned in Chapter One, several leading medical organizations such as ACOG, AMA and AAFP have publicly opposed the REMS, and the expert panel of the Mifeprex Study Group came to the same conclusion. Dr. Prine says that she has yet to run across a medical professional who truly believes they're in place to protect women's health and safety. "They don't serve any medical purpose," she adds, "they're just a barrier."[239] This position has emerged as the general consensus among physicians and medical groups.

There are certainly many physicians who oppose MA on religious or political grounds or disapprove of self-manage MA. Marge Berer writes: "some doctors just do not want to hand over the power of decision-making over who gets an abortion, and many, especially in the private

sector, will potentially lose a lot of income if they can no longer provide most abortions."[240] It is impossible to know just how much "business" would be lost to self-managed MA, but personal preferences would maintain a large degree of demand for clinic-based care nonetheless. Though there are still physicians who prioritize personal gain over the reproductive rights and autonomy of women, the emerging consensus and support of leading medical organizations suggests this proportion is lower than ever before.

The US Food and Drug Administration (FDA)

In 2000, the FDA first approved mifepristone under the brand-name Mifeprex for use up to 49 days gestation. The agency updated the labeling in 2016, extending eligibility to 70 days gestation and modifying the dose of Mifeprex as well as the dosing regimen for Mifeprex and misoprostol.[241] Since then, it has approved a generic version produced by GenBioPro, Inc. (2019), which is subject to the same Risk Evaluation and Mitigation Strategy (REMS) as Mifeprex.

As previously discussed, a REMS is essentially a set of restrictions beyond the drug's label that the FDA is authorized to impose only when it is necessary to ensure that the benefits of a drug outweigh its risks. The Mifeprex REMS has three core provisions. First, distribution is limited to providers in clinics, medical offices and hospitals. This prohibits pharmacies (both online and in-person) from dispensing the pills as they would for most other safe and effective medications. Second, the providers must become certified, which entails filling out a form saying they are qualified to assess pregnancy duration, diagnose ectopic pregnancy and provide or be able to refer the patient to surgical intervention if necessary.[242] To complete certification, clinicians are required to enroll in a national registry. Third, patients prescribed Mifeprex must

sign an FDA-approved patient agreement that summarizes instructions on the label and potential risks.[243]

At the time of approval in 2000, documented clinical experience with MA was limited, thus the REMS precautions were perhaps justifiable. However, as we've already discussed, a strong and extensive safety record has since been established for Mifeprex. Our earlier comparison of risk and regulation confirmed that the risk strategy serves no medical purpose, leading to the conclusion that the REMS are maintained due to political interest; "playing politics" has suppressed MA's potential to mitigate abortion inequities.

Most of the FDA's regulatory authority comes from the 1938 Food, Drug & Cosmetics Act, which empowered the agency to regulate testing, manufacturing, labeling, marketing, efficacy, safety and just about every other aspect of prescription drugs.[244] Its enforcement powers include seizure, criminal prosecution, injunctions, warning letters and administrative procedures.[245] The FDA is led by the Commissioner of Food and Drugs, presently Dr. Stephen Hahn, who reports to the Secretary of Health and Human Services, Alex Azar. Hahn stepped into the job with no prior political experience, and Azar is a former pharmaceutical executive who also served under the George W. Bush administration.[246] Both were appointed by Trump, and both could be removed at his will.

Online Unregulated Pharmacies

The ability to obtain prescription medications online is a relatively recent phenomenon that has grown exponentially in the past couple of decades. In 2015, the Federal Bureau of Investigation (FBI) estimated that over 80,000 illegal sites exist.[247] Though some online pharmacies adhere to federal regulations, a random sampling by the FDA found that 97% do not. Meanwhile, one in four Americans buy their prescription drugs online for reasons such as

accessibility, time constraints and cost savings.[248] Several studies have concluded that while international regulations and laws exist for online pharmacies, it is difficult, if not impossible, to effectively achieve regulatory oversight and enforcement.[249]

The main concern with obtaining medications via such pharmacies is the possibility that the drugs received will not contain the correct active ingredient in the proper amount. This is not a risk that proponents of self-managed MA have shrugged off. Rather, researchers associated with the activist network Plan C, which informs and supports those seeking abortion pills, tackled the issue head-on. Beginning in early 2017, they conducted a study to test the reliability of online pharmacies claiming to sell mifepristone and misoprostol. The team successfully obtained 18 combination products and two misoprostol products from 16 sites, documenting the price, shipping time and product quality. In each case, the mifepristone tablets contained within 8% of the advertised amount and the misoprostol tablets usually contained less than advertised, but enough to be effective.[250] Since then, Plan C has kept an ongoing "Report Card" of tested online pill providers. Eight high-quality providers are currently listed with grades ranging from A-C, prices ranging from $90-$430 (median $262) and ship times of two weeks or less. Only one website is overseen by a physician who fills prescriptions based on information provided: Aid Access, the only site to receive an "A." It also charges the lowest fee per shipment ($90), which is often waived for patients who are unable to come up with the money.

Activist Networks

Though Aid Access provides patients with all the information they'd need to safely and effectively carry out their own abortion, most online pharmacies do not. Several activist networks have taken the initiative to fill in these gaps. Plan C not only educates the public and researches new routes of access in the US but also mobilizes a grassroots network of activists

fighting to make self-managed care a mainstream option.[251] Women Help Women (WHW) similarly works to change social norms and increase access to abortion through direct action. The group partners and collaborates with organizations around the world to train activists, conduct research needed for evidence-based advocacy and establish hotlines for those self-managing.[252] In 2017, the group launched Self-Managed Abortion; Safe and Supported (SASS) to help people navigate the confusing patchwork of laws surrounding abortion pills and minimize legal risk. WHW is a member of several networks working to destigmatize, demystify, decriminalize and demedicalize abortion pills. Spreading information to rural and underprivileged populations is both a challenge and a priority for activists. Susan Yanow, cofounder of WHW describes the group's attempts to utilize social media, Google and Facebook ads as expensive and not particularly successful. On the other hand, she is encouraged by quantity of people WHW has reached through train-the-trainer workshops.[253]

There are many more organizations like WHW and Plan C, within the US and around the world, working to spread knowledge and power in every language possible to complement the services provided by online pharmacies. These organizations are not fighting for a world in which *all* abortion is self-managed but for a world in which all women have the *option*. As Yanow explains, "There's no 'one size fits all.' Self-managed abortion is not a silver bullet, it's not a panacea."[254] The movement recognizes that many people, for a wide variety of reasons, will still choose to receive care from a provider, but believes it is their human right to make the decision for themselves. It calls for access to self-managed MA within the full spectrum of abortion care, as research supports its safety for use through telemedicine and pharmacies. Pointing to the people using the pills safely all around the world, Yanow asserts that regulations governing their use are not necessary from a medical safety perspective. The only regulations

necessary, she adds, are those which guarantee the quality of medicines and accuracy of information channels—there is a difference between free speech and intentional misinformation.[255]

Case Study: FDA v. Aid Access

As a regulatory agency of the federal government, the FDA's authority is called into question by online unregulated pharmacies shipping abortion pills to the US. This has recently manifested in a legal battle between the two actors, initiated by the FDA in March of 2019 with a warning letter. In the latter, Aid Access is accused of violating federal law and ordered to immediately cease the "sale of misbranded and unapproved new drugs [which pose] an inherent risk to consumers who purchase those products" or face the consequences of "regulatory action."[256] The letter was applauded by 117 members of Congress, all of whom are Republican and 92% are male.[257] In response, Dr. Gomperts stopped prescribing the pills to US patients for roughly two months before resuming business as usual. As she said in an interview with NPR, "The FDA is a huge institution. It's very powerful, and it's a form of intimidation that is quite severe… I would say a form of bullying. And so I think it's very important to stand up against it."[258]

Not only did Dr. Gomperts defy the FDA's orders, but she and her lawyer Richard Hearn retaliated. Hearn responded to the warning letter, denouncing the FDA for writing it and thereby violating the constitutional rights of Dr. Gomperts's patients. He claims the FDA lacks jurisdiction over Dr. Gomperts' practice and concludes that "[u]ntil the REMS restrictions imposed by the FDA on access to misoprostol and mifepristone are lifted, women seeking to terminate their pre-viable pregnancies in the U.S will be forced to exercise their constitutional right to choose by way of the internet."[259] Soon after, several of her shipments were seized and

payments blocked, and Dr. Gomperts responded by suing the FDA. The lawsuit states that (1) for many women, the only practical option for women seeking to terminate unwanted pregnancies is found on the internet, (2) Aid Access helps such women exercise their constitutional right to safe abortion prior to viability, and (3) the FDA is actively using the power of the US federal government to deny this right.[260] Hearn said the goal of the lawsuit is to force the FDA to stop interfering and to prevent Gomperts or her patients from being prosecuted under federal law.[261]

Clearly, Aid Access's argument relies on the status of *Roe v. Wade* and will crumble if the constitutional right to abortion is abolished. What might happen to this case otherwise is less clear. Most experts, including Dr. Prine and Susan Yanow, are not worried about the FDA forcing Aid Access to shut down. They see it as unlikely in the first place, characterizing it as harassment rather than a legitimate case, and say that even if the FDA succeeds, online prescription of mifepristone and misoprostol will continue one way or another. Aid Access is just one source among a large and growing selection. According to a 2018 fact sheet published by the Charlotte Lozier Institute, at least 72 websites sell one or both abortion pills at an average price of $167 for one kit (and less per kit in bundles). While some (30) are focused on abortion pills, others (42) sell them among a wide variety of drugs. Though most of these sites only prescribe the drugs through the 10th week of pregnancy, 20 have no gestational limit.[262] Thus, the role of information networks is crucial to ensuring safe use.

Because effective regulatory oversight and enforcement of online pharmacies is an impossible task for the FDA, the agency will not be able to shut down the practice of self-sourcing abortion pills via the internet. If it succeeds in forcing Aid Access to stop providing to US patients, women will simply turn to other, lower quality websites that care less about patient safety. In doing so, they are putting themselves at risk of prosecution, though this threat is now

nearly negligible and is much less intimidating than the potential complications of unsafe abortion. If the FDA suddenly decided to crack down on self-managed MA—using effort they might otherwise be directing to the opioid epidemic, teen vaping or cocaine import—the legal risks could absolutely become something to worry about. Until then, or until the legal landscape surrounding the medications is seriously reformed, the practice will continue more or less as is.

What then of the confrontation between subversive and institutionalized power at play? It is true that self-managed MA threatens the regulatory authority of the FDA as well as the state-based and medical control of abortion. It is also true that the futility of stopping the practice means it will continue to grow in popularity, augmenting its subversive power. Though an enlightening approach, our actors do not operate with nearly enough simplicity outside the realm of theory to boil it down to one epic showdown. It's not a battle between women and doctors for who gets to control abortion as the "provider"—as the true goal of the self-managed movement is to *add* to the spectrum of abortion services available, not to overtake it. Furthermore, institutionalized power doesn't *have* to respond. The FDA may very well engage in a game of whack-a-mole with online pharmacies, but it is unlikely they will suddenly begin enforcing against the importation of drugs for personal use, or that abortion pills would be the priority in that scenario. Unless future administrations can undo Trump's impact on the courts, unless state legislatures decide to embrace the priorities of public health and women's rights, it is most likely that self-managed MA will continue underground for quite some time. Thus, community-based efforts to spread information about the pills, in conjunction with fundraising to help women cover the online pharmacy costs, will be crucial to maximizing the technology's potential in immediate circumstances.

Conclusion

"A big part of people's resistance to self-managed abortion stems from their uninterrogated allegiance to the medical model of care, and to believing that we are not capable of knowing our bodies and caring for bodies, and that we must rely on people in white coats to tell us what to do."[263]

—Jill Adams

For as long as the medical profession has existed in the US, unbalanced power dynamics have stood between women with reproductive health rights and actors who feel justified in constraining their ability to make autonomous decisions. Abortion restrictions, under the guise of public health and safety, have served to preserve these power dynamics and maintain a gap between "choice" and "access," one which may either materialize as a wide abyss or hardly register as a crack depending on one's social and economic resources. This assemblage was served by the conventional alignment of "safe" abortion with "legal" and has been undermined by the divorce necessitated by MA's development.

Self-managed MA invites questioning the status quo. As Jill Adams suggests above, we are conditioned to put blind faith in the medical model of care, to trust its expert authority on what our own bodies need. It follows that we become dependent on the medical institution without even realizing it. The Jane collective's demedicalization campaign was so radical because it simultaneously woke women up to their reliance and released them from it. History is now repeating itself, as more women learn about abortion pills and gain experiential expertise from using them. Jamilla Perritt, an OB-GYN, explains, "This is a really unique opportunity to say, 'What are the things that we're doing that are not grounded in medical evidence, that are actually limiting access to care?' It may be that we have an opportunity to demedicalize the way abortion care is provided in this country."[264] Self-managed MA has challenged the authority of

institutional power, and its safety, ease and efficacy have subverted medical hierarchies long taken for granted.

Not only is the practice disruptive, but so too is the technology it employs. Despite the uphill task of implementation and burdensome barriers to access, MA has transformed the way abortion care is provided in the US and around the world. It will never *fully* replace vacuum and D&E methods, but it already accounts for nearly 40% of all clinic-based abortions and is well on its way to becoming the norm for early pregnancy termination.[265] In conjunction with telemedicine, MA could facilitate provision of abortion care in the most underserved areas, and doctors and scientists are currently working on a research agenda for moving the pills OTC.[266] MA has thus enabled entirely new capacities with enormous promise for meaningfully expanding access, and certain characteristics of the technology itself increase its disruptive potential. The physical form of the pills, for example, makes them easy to ship and transport, and their gradual effects also afford a layer of mobility to the user. Additionally, the mechanism's similarity to that of miscarriage makes it easier to disguise and more likely to feel like a natural process. MA, then, has also subverted traditional assumptions about the experience of abortion.

The disruptive qualities of self-managed MA are exactly what make it powerful as a tool for achieving reproductive justice. Telemedicine and OTC abortion's ability to narrow the gap between choice and access could restore meaning to the legal right to abortion for the young, rural, undocumented and low-income women, disproportionately of color, who are most impacted by abortion restrictions. Cultural ignorance and discrimination by providers lead many marginalized women to distrust the medical system, and those women may feel safer when self-managing. Furthermore, the safe, effective and low-tech nature of abortion pills lends itself to self-empowerment. Susan Yanow and Kinga Jelinska elaborate:

> "Supporting the use of pills on one's own and putting the tools for safe abortion directly in the hands of those who want and need them is an empowerment strategy. This is a challenge to the prevailing narrative that stigmatizes abortion and frames it as safe only when supervised by a trained medical professional. By claiming this knowledge for ourselves, self-managed abortion is an expression of the fundamental feminist principle and basic human right to bodily autonomy, and to our right to control our own health care: core tenets of reproductive justice."[267]

Information-sharing and support networks surround the practice; DIY becomes "do it together," and empowerment extends to each party and wherever they take it next. In this way, community-level efforts destigmatize abortion and build collective power.

Widespread access to self-managed MA would quickly reduce complications from unsafe abortion, mitigate the consequences of inequitable barriers to access and facilitate women's realization of their human right to reproductive justice. Over the years, as allegiance to the medical model of abortion wanes, power could gradually shift from state and medical institutions to women and their support networks—those most affected by abortion. Moving forward, the goals are clear, but the road is congested.

The full potential of MA is trapped in the same political playground that first tried to swallow it decades ago. In 1990, Cory Richards and Rachel Benson Gold wrote:

> "The FDA must stop playing politics with RU 486. If this drug is ever to be brought to the U.S. market, the agency will need to convince American women and, even more important, the pharmaceutical industry that it will evaluate RU 486 on the basis of safety and efficacy only. The current politically motivated ban on importing RU 486 for personal use under a physician's supervision must be rescinded… The medical and scientific communities are uniquely positioned to help bring about these needed policy changes… They should be motivated not only by concern for the well-being of virtually all Americans, but by the need to preserve scientific integrity."[268]

The struggle has certainly evolved over the years. Prominent medical organizations and scientific communities have now taken their place in the social debate, on the side of evidence and against the REMS. They have also identified several research gaps, pertaining to women's preferences and experiences with self-use of MA, the distribution and provision of MA information and

drugs, and clinical outcomes following self-use.[269] Filling these gaps will require rigorous research and collaborative work, and as we know, science embroiled in the politicized abortion debate is held to wildly different standards by different actors; one sees consensus where the other sees deception. All evidence suggests we will one day see mifepristone and misoprostol beside Tylenol and Viagra in pharmacies, and before that it will be available through telemedicine—but still too late for many.

The suppression of MA's potential in the meantime will have serious consequences. Due to COVID-19, we are currently seeing the worst of them play out at an unprecedented velocity. Anti-abortion politicians have attempted to use the pandemic as an excuse to ban abortion altogether by falsely categorizing it as "nonessential." To affirm the necessity of abortion, ACOG released a statement in collaboration with other leading OB-GYN organizations, declaring it "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible."[270] While many of the bans have been struck down, others have successfully imposed additional barriers to access. "The consequences of being unable to obtain an abortion," ACOG states, "profoundly impact a person's life, health, and well-being."[271] Stay-at-home orders and additional childcare responsibilities already make clinic-based care harder to access, and while evidence would support abortion's inclusion in the broad shift to telemedicine, state laws and the REMS prohibit this from happening. The FDA could, at least temporarily, change the REMS classification to allow telemedicine abortion, yet it has not and shows no signs of doing so.

Meanwhile, the international supply chain of online pharmacies has been disrupted due to halts on trade. Essentially, self-managed MA has become incredibly difficult to access in the moment it's needed most. "Our leaders should be working to support the nation's full network of

safety-net health care providers during these uncertain times. Instead, the Senate bill targets Planned Parenthood and expands the harmful and discriminatory Hyde amendment, putting up even more barriers to care for women, people with low incomes, and communities of color,"[272] said Alexis McGill Johnson, acting president of Planned Parenthood Action Fund. In her own statement, Kelsey Ryland, director of federal strategies for the reproductive justice group All* Above All, adds, "Our communities across the country are doing everything we can to keep ourselves and our families safe, and our elected officials should be doing the same—not blocking health care for communities that already face significant barriers. Once again we're seeing how far Trump and anti-abortion politicians will go to push their political agenda."[273] That is, they are exploiting a global emergency to consolidate institutional power at the expense of personal rights and liberties.

Activists prepared for a post-*Roe* world, but they couldn't have anticipated a pandemic, let alone ensure unofficial supplies of the pills throughout its duration. With fewer feasible routes to safe abortion than ever, more people may return to unsafe self-induced methods in the coming weeks, months or however long it takes to return to "normal." But the crisis has also presented an opportunity to reflect on what "normal" even meant —as George Packer wrote in The Atlantic, "The coronavirus didn't break America. It revealed what was already broken."[274] In many ways, "normal" still meant accessing care *despite* systems built to maintain the axes of subordination preserving institutionalized power; it still meant political gain over public health and equitable care. For reproductive autonomy and justice, going back to "normal" is not an option. As talk of the UK legalizing at-home MA circulates, as demand for telemedicine abortion in the US escalates, the crisis may bring to light what's been held hostage for decades: the little

pills that could. If unleashed, the full potential of MA could transform the landscape of access and power into one more conducive to achieving reproductive justice.

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