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Article abstract

Safe abortion access is an essential aspect of reproductive justice and key to reducing global rates of maternal mortality, yet within the global health enterprise, the rhetoric of sexual and reproductive health and rights has not yet been realized in practice. Access to safe legal abortion remains inequitable globally and within nations, and deaths due to unsafe abortion take their highest toll in the Global South in jurisdictions with restrictive laws. Clandestine abortion access activist networks have been filling this gap for decades offering life, dignity and futures to the people who seek their services. What should we make of clandestine activist networks around the world that help people access medication abortion? Such groups have been important players in women’s reproductive health in many jurisdictions for decades but have typically, by necessity and design, flown under the radar. If visibility, accountability and humanitarian appeal are essential characteristics of global health work, how do we acknowledge and understand the work of clandestine abortion access activist networks? Does it count as global health? In this essay I take up the notion of “critique in action” (Biehl 2016) to further an understanding of the work of such networks and also consider the idea of abortion access activist networks as an anti-regime of global health.

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Does Clandestine Abortion Access Activism Count as Global Health?

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Abstract: Safe abortion access is an essential aspect of reproductive justice and key to reducing global rates of maternal mortality, yet within the global health enterprise, the rhetoric of sexual and reproductive health and rights has not yet been realized in practice. Access to safe legal abortion remains inequitable globally and within nations, and deaths due to unsafe abortion take their highest toll in the Global South in jurisdictions with restrictive laws. Clandestine abortion access activist networks have been filling this gap for decades offering life, dignity and futures to the people who seek their services. What should we make of clandestine activist networks around the world that help people access medication abortion? Such groups have been important players in women's reproductive health in many jurisdictions for decades but have typically, by necessity and design, flown under the radar. If visibility, accountability and humanitarian appeal are essential characteristics of global health work, how do we acknowledge and understand the work of clandestine abortion access activist networks? Does it count as global health? In this essay I take up the notion of "critique in action" (Biehl 2016) to further an understanding of the work of such networks and also consider the idea of abortion access activist networks as an anti-regime of global health.

Keywords: medication abortion; global health; global maternal health; pharmaceutical activism; sexual and reproductive health and rights; unsafe abortion; Women on Waves

Résumé: L'accès à l'avortement en toute sécurité est un aspect essentiel de la justice en matière de procréation et une clef pour réduire les taux mondiaux de mortalité maternelle. Pourtant, au sein de l'entreprise mondiale de la santé, la rhétorique de la santé et des droits sexuels et reproductifs ne s'est pas encore concrétisée dans la pratique. L'accès à un avortement légal et sécuritaire reste inégal à l'échelle mondiale et au sein des nations, et les décès dus à des avortements pratiqués dans des conditions dangereuses sont plus

nombreux dans les pays du Sud, dans des juridictions ayant des lois restrictives. Des réseaux clandestins de militants pour l'accès à l'avortement comblent cette lacune depuis des décennies en offrant la vie, la dignité et l'avenir aux personnes qui font appel à leurs services. Que devons-nous penser des réseaux militants clandestins qui, dans le monde entier, aident les gens à accéder à l'avortement médicamenteux ? Depuis des décennies, ces groupes jouent un rôle important dans la santé reproductive des femmes dans de nombreux pays, mais ils sont généralement passés inaperçus, volontairement et intentionnellement. Si la visibilité, la responsabilité et la vocation humanitaire sont des caractéristiques essentielles au domanine de la santé mondiale, comment reconnaître et comprendre le travail des réseaux clandestins de militants pour l'accès à l'avortement ? S'agit-il d'un travail de santé mondiale ? Dans cet essai, je reprends la notion de « critique en action » (Biehl 2016) pour mieux comprendre le travail de ces réseaux et je considère également l'idée des réseaux militants pour l'accès à l'avortement comme un anti-régime de santé mondiale.

Mots clés : avortement médicamenteux ; santé mondiale ; santé maternelle mondiale ; activisme pharmaceutique ; santé sexuelles et droits ; santé reproductive et droits ; avortement à risque ; Women on Waves

Introduction

What should we make of clandestine activist networks around the world that help people access medication abortion? Such groups have been important players in women's reproductive health in many jurisdictions for decades but have typically, by necessity and design, flown under the radar. In this essay, I pose the question: does clandestine medical abortion activism count as global health? I use the question as a heuristic device to think about the work that such groups do vis-à-vis the logic and practices of the formal global health enterprise, especially the global campaigns to reduce maternal mortality. This essay offers some critical observations about "global health" as an idea and set of practices and players; it also offers some ways to think about the work of actors who function outside the formal global health enterprise. I suggest that the work of abortion access activist groups may be understood as "critique in action" (Biehl 2016) and perhaps even an anti-regime of global health for its radical commitment to life in the face of gendered inequity.

The Global Impact of Unsafe Abortion

An estimated 25 million unsafe abortions take place each year, the majority in the Global South (Ganatra et al, 2017). Unsafe abortion is a leading cause of maternal mortality, accounting for between eight and 13 percent of all maternal deaths globally (Say et al. 2014), with much higher rates in some regions, specifically those with restrictive laws (Shah et al. 2014). While few countries in the world prohibit abortion under any circumstances, many restrict it to cases of rape or medical necessity—when the woman's life is endangered (Centre for Reproductive Rights, n.d.)—subjecting patients to scrutiny and delay, compromising their privacy and health.[1] Distance to facilities, availability of skilled providers, and cost also factor into access to safe legal services (Shah et al. 2014).

Safe abortion access is essential to reducing rates of maternal mortality. Yet, it has not been a significant focus of mainstream global maternal health initiatives and programs; indeed it has been subject to "organized opposition" and side-lining at the highest levels (Shah et al. 2014). The global campaigns to reduce maternal mortality since the 1980s, such as the Safe Motherhood Initiative and its successor, Making Pregnancy Safer, have focused on biomedical interventions and health system fixes: encouraging women to give birth at facilities with skilled attendants, improving access to emergency obstetrical care, and increasing the uptake of contraception. At the International Conference on Population and Development (ICPD) in Cairo in 1994, the delegates articulated a vision that went beyond the politically safe goal of safe motherhood through biomedical means to a vision of sexual and reproductive health and rights—including legal access to safe abortion. But in the decades that followed, high-level commitments to end preventable deaths due to unsafe abortion did not materialize. For example, explicit mention of access to safe abortion as a means to reduce national and global maternal mortality ratios (MMR) was excluded from the Millennium Development Goals (MDGs). And while the 2015 Sustainable Development Goals (SDGs) did commit to "increase the number of states with laws and regulations that guarantee women aged 15 to 49 access to sexual and reproductive healthcare, information, and education," this indicator did not specifically track access to abortion as part of that care it envisioned (McGovern et al. 2020). In addition, a US policy known colloquially as the "global gag rule" enacted in every Republican administration since the 1980s prohibits global health organizations receiving USAID funds from informing, advising, referring, or conducting abortion-related activities—even

in jurisdictions where abortion is legal. The policy has created a scarcity of funding in years when in place and a generally chilly climate for abortion services worldwide, even when rescinded during Democratic administrations.

The sheer number of unsafe abortions worldwide and the mortality and morbidity rates associated with them have nevertheless been declining, largely for three reasons: one, there is a trend towards less restrictive abortion laws globally; two, a consortium of feminist-oriented NGOs has been championing Post Abortion Care (PAC), services that are permitted even in legally restrictive settings because of the clinical similarities between induced abortion and spontaneous miscarriage (Suh 2021); and three, the emergence of medication abortion in both formal and informal settings as a less risky option to ending a pregnancy (Shah et al. 2014). Access to safe, legal abortion, however, remains inequitable and therefore clandestine activist networks remain active. Their work has undoubtedly saved hundreds of thousands of lives and has offered options, dignity and futures to the people who seek their services. These networks have not historically participated in the mainstream global health enterprise. If visibility, accountability and humanitarian appeal are essential to global health work, how do we acknowledge and understand the work of clandestine abortion access activist networks?[2] Does it count as doing global health?

Self Managed Medication Abortion

Let me sketch out the basics of the model of self-managed medication abortion upon which activist networks rely before taking up the question in further depth. Medication abortion is a non-invasive, non-surgical form of ending a pregnancy up to 12 weeks via a pharmaceutical protocol involving two drugs, mifepristone (an anti-progesterone) and misoprostol (a prostaglandin), or misoprostol on its own. The protocol is straightforward, safe, effective (94 percent), and efficient with few side effects (Prata et al. 2008; Dao et al. 2007). When prescribed, patients may take the drug in a doctor's office or later at home and await its effects on their own—cramping and bleeding that signals the end of the pregnancy. Medication abortion is broadly accepted by patients and providers and now accounts for more than half of all legal, documented abortions in the United States (Jones et al 2022) and about 36 percent of all abortions in Canada (CIHI 2021).[3] Misoprostol alone is the most common drug for medication abortion globally because it is the most widely available in jurisdictions with restrictive laws and where mifepristone is harder to get.

Misoprostol is a drug with a controversial history. It was originally developed for the prevention of gastric ulcers and marketed under the brand name Cytotec. Starting in the 1980s it developed an off-label reputation as an abortifacient; women themselves seem to have discovered this use. Anthropologist Silvia de Zordo (2016) has described the emergence of misoprostol in Latin America (in Brazil, in particular) in the context of some of the most restrictive abortion laws in the world, calling attention to its "double life" in that physicians were able to use the drug off-label in hospitals while activist networks who advised on its procurement and use remained in the shadows. Over-the-counter access to Cytotec was restricted in Brazil in 1991 because of its reputation as an abortifacient and networks turned to the black market (Costa 1998). This is essentially the status quo in jurisdictions with restrictive abortion laws.

As women in locales around the world were sharing information and using misoprostol off-script and under the radar, by the early 2000s, a number of university-based and independent health research organizations began conducting clinical trials to work out the dosage and build up an evidence base for the use of the drug for reproductive indications. Researchers conducted clinical trials for non-controversial indications, including Post Partum Haemorrhage (PPH), labour induction, and Post Abortion Care (PAC), while also creating a protocol for early term medication abortion. This kind of "pharmaceutical activism" (Biehl 2010) eventually led to a place for misoprostol on the WHO's Essential Medicines List (EML) and registration in many countries (MacDonald 2020; Tang et al 2013). Protocols for all these indications now travel via the internet on many public-facing websites, translated into multiple languages, and accompanied by how-to illustrations. As anthropologist Sydney Caulkin has noted, abortion pills " have permanently changed the landscape of abortion care across the world, in countries with or without legal abortion" (2023, 2).

Abortion Access Activist Networks

Let me offer three examples of such work. The first is an abortion hotline in Kenya. In 2016, I attended the Women Deliver Conference in Copenhagen where a young woman named Elizabeth gave a presentation about the abortion hotline she leads with a group of her peers in her neighbourhood in Nairobi. Her inspiration for the group was the death of a friend from an unsafe surgical abortion at a clandestine clinic. Though abortion has been legal in Kenya since 2010, it remains largely inaccessible throughout the country (Centre for

Reproductive Rights, n.d.). When Elizabeth and her friends learned of the death, they conspired to visit the clinic and were so appalled by what they saw that they set out to find an alternative. They found it online: detailed information about misoprostol and how to use it to induce a safer abortion. They set up their own network and cell phone hotline to offer information to women in their community about where to get Cytotec—a common brand of the drug available in Kenya—how to take it, and what to expect. They forged relationships with local pharmacists who were willing to stock the drug and discreetly advise on its use for early-term abortion. Elizabeth's group also offers accompaniment via cell phone, providing moral support to people as they undertake the process at home—what side effects to expect, how to know if it is working (take a pregnancy test afterwards), what complications to look out for, when and how to present to hospital, if necessary (tell them it is a miscarriage). Elizabeth describes her group as a "safe space" of part-time volunteers who are self-taught and use their own cell phones for the network. Her group had no fundraising campaign, no project launch, no website with pull down tabs that say "who we are" or "where we work." They have no monitoring and evaluation specialists, no communications director. They issue no quarterly reports with photos or testimonials from women who have used their services.

The second example is an abortion hotline in Chile. In the city of Concepción, a group of women calling themselves "Lesbians and Feminists for the Right to Information" began a phoneline in 2009 and published a small how-to manual to disseminate knowledge about self-induced abortion using misoprostol. They advertised their work by spray-painting their phone number on sidewalks and billboards near high schools and universities and in less affluent neighbourhoods. They take calls anonymously and impart information on how to obtain the drug and provide accompaniment over the phone during the process. Chilean law prohibits abortion except in cases of rape or fetal non-viability and to save the pregnant woman's life (Centre for Reproductive Rights, n.d.). One of the strategies they use to avoid criminal charges is to read aloud over the phone information already publicly available online about the use of misoprostol for medication abortion, such as the guidelines issued by the WHO (2008). This strategy disconnects scientific knowledge and authority from its traditional regulatory and clinical regimes—a process scholars have variously called domestication (Childerhose and MacDonald 2013) or diversion (see Drabo 2019 and 2021). In other words, activists and patients harness the pharmaceutical power of the drug directly, bypassing the usual gatekeepers,

with exactly the same effects in the body. This group of activists was the subject of the 2016 documentary *Aborto Libre*. Other such hotlines operate in Chile and several other Latin American countries on a similar model.

The third example is Women on Waves (WoW). Set up in 1999, this group started by equipping a ship with a clinic and sailing it into international waters adjacent to countries where abortion was illegal—Morocco, Portugal, Ireland, Spain—taking women onboard and administering medication abortion tablets. Though a deliberately provocative tactic, they went only where they had been invited by a local women's group. In 2005, the director, Dr. Rebecca Gomperts, a physician, founded Women on Web, a website that provides information, online consultation, access to medication abortion drugs via the post, virtual accompaniment and follow-up. If women cannot pay, they get the service for free. In 2018, they launched a new website called Aid Access to assist women in the United States as abortion laws grew more restricted in many states, a process that began even before the overturning of Roe v Wade in the summer of 2022.[4] Several US states have "shield laws" which protect providers from legal repercussions when they prescribe and ship abortion pills across state lines (Littlefield 2024). This model of greater visibility and unabashed dissemination of information, services and products that circumvent legal context is proliferating (see Caulkin 2023). It is different from the first two examples out of Kenya and Chile in terms of its visibility, but its method is similar: inventing a model of information distribution and care that can manoeuvre around restrictive laws to access pregnant people directly and not waiting for laws to be changed or to be invited to the table at regional, national or global levels.

Does the Work of Abortion Access Activist Networks Count as Global Health?

Here I return to the question: does clandestine medical abortion activism count as global health? Global health is a collective humanitarian project that seeks to reduce suffering and save lives through research, advocacy and interventions; its predecessor "international health" was deeply rooted in the colonial public health project that largely sought to protect Europeans from contagion, facilitate the expansion of territory and resource extraction, and preserve the health of the local labour pool. The contemporary term "global health" signals a change in the understanding of our connectedness—and thus vulnerability—as nations in a globalized world. Ideally, it also signals greater participation from nations who receive global health aid. However, recent calls to decolonize global health

speak loudly to the work yet to be done in this regard (Oti 2021; Richardson 2019). Present-day global health is dominated by an assemblage of experts, tools, knowledge and interventions grounded in biomedical science and clinical care and, despite decades of debate, is still oriented towards targeted diseases and magic bullet solutions such as vaccines (Cueto et al. 2013). In a well-known essay, anthropologist Andrew Lakoff (2010) proposed the model of the "two regimes of global health": *global health security*, a realm of activity focused on tracking and preparedness for emergent infectious diseases; and *humanitarian medicine,* a realm of biomedical and public health activity focused on the treatment of illness, the alleviation of suffering, and the prevention of death in settings marked by crisis.

Critical global health scholars have long critiqued the dominance of biomedical and technical solutions when they ignore the structural violence that creates layers upon layers of suffering (Biehl and Petryna 2013; Farmer 2004; Singer 2020). Scholars point to the roots of global health in colonial hygiene and tropical medicine as well as the rise to dominance of private philanthropic foundations and private corporations (typically through friendly-sounding "public-private partnerships") in funding, policy, and action.

In a 2016 article, anthropologist Joao Biehl offers a different take on how we might understand the work of global health, noting the increasingly crowded practical and analytical landscape. He writes that "critical global health eschews a sense of theory as a totalizing enterprise or as the privileged domain of elite knowledge makers self-appointed to speak on behalf of benighted populations" (2016, 135). Global health today, he continues, involves "new medical technologies, ideas, strategies, rules, distributive schemes, and the practical ethics of health care are being assembled, experimented with, and improvised by a wide array of deeply unequal stakeholders within and across countries" (2016, 135). This is a more open, even chaotic, version of global health activity compared to earlier efforts by scholars to categorize types of highly coordinated, biomedically focused, top-down activities, he argues. This is a model within which abortion access activism might fit. First, abortion access networks attend to human suffering and seek to save lives—similar to what Didier Fassin (2011) calls humanitarian reason—but it does so on a more intimate scale of direct care rather than humanitarian concern for distant others, divided by geography and the apparatus of the global health enterprise. Second, such groups are operating where the state has retreated or fears to tread, filling a void of care and action, something that anthropologist Peter Redfield (2013) has identified as

a fundamental feature of global health activity. Yet, when health development projects or humanitarian interventions that seek to ameliorate maternal and child health fail to build in comprehensive reproductive health services that include safe abortion, this inaction serves to widen and institutionalize that void. Third, the work of abortion access activism is now evidence-based—a key requirement of global health legitimacy today (Adams 2016; Storeng and Behague 2014).

Despite these similarities to the mainstream global health enterprise, clandestine abortion access activism contrasts with its logic and practice in several important ways. First, the work is improvised. Even as more formal, funded organizations such as WoW and Aid Access are becoming the most visible manifestations, they bear the imprint and the basic protocol of original community-level ways of working. And there are certainly many clandestine networks still working—out of sight and under the radar.

Second, even as they use scientifically generated evidence about safe dosage, clandestine networks sidestep the regimes of institutional expertise and authority to engage with the power of pharmaceuticals directly and for their own purposes. Even experts who are at the front lines of the work, such as Dr. Rebecca Gomperts, appear the opposite of a gatekeeper when it comes to her authority to diagnose and treat; she states again and again in her interviews and writing that women themselves are capable of knowing how far along they are in pregnancy and of following the protocol. One of her improvised tactics is to shout over detractors in sit-down media interviews and media scrums on the street, in order to broadcast the name of her organization, the name of the drug and the basic protocol for its use, even how to present to hospital should you encounter a complication.[5] Sympathetic physicians, midwives and nurses are certainly involved in such networks, facilitating access to medication, but if they are selling misoprostol at inflated prices, or vetting the worthiness of women who seek their supplies, they are no more members of access networks than black market drug suppliers (See Drabo 2019 and 2022).

Third, abortion access activism networks have long bypassed global policy agendas, agreements and grand initiatives; their work began long before high-level commitments to sexual and reproductive health and rights and the self-care agenda (WHO 2023); their work bypasses political stagnation on the issue of abortion legality and equitable access. They did not wait for the WHO to issue guidelines or for a donor to publicly support their work.

Fourth, safe abortion access activism is explicitly feminist, enacting an agenda of sexual and reproductive health and rights in practice and rhetoric. It is in the name and mission statement of the Concepción network, "Lesbians and Feminists for the Right to Information." Women on Waves states that their mission is

> to prevent unsafe abortions and empower women to exercise their human rights to physical and mental autonomy. We trust that women can do a medical abortion themselves and make sure that women have access to medical abortion and information through innovative strategies. But ultimately it is about giving women the tools to resist repressive cultures and laws (WoW).

The existence of this model of reproductive healthcare is radical, reminiscent of the Jane networks of the 1960s and 1970s in Canada and the United States.[6] This is, of course, a western liberal feminism linked to notions of individual choice and rights—a feminism which can sit uncomfortably with conservative religious values which shape and give meaning to women's reproductive lives in many places. Though we cannot know precisely the animating values of every clandestine network, the ones featured here are clear in their intent to offer a measure of choice and care for individuals about whether or not to continue a pregnancy and thereby shape their own futures. I think it is fair to say that global health has not historically been characterized by a feminist orientation towards women's health but rather by paternalism and sexism operationalized in policies and practices designed to limit and reform women's authoritative knowledge and existing care practices (Kumar, Birn and McDonough 2016; Johnson 2021).

Fifth, and finally, abortion access activist networks tend not to have metrics—a fundamental requirement of global health operations and a means by which organizations and agencies establish their issue as a worthy cause, enumerate their activities, and track the progress of their work (Adams 2016). Recall the story of Elizabeth who organized her network in Nairobi on the basis of one friend who died of an unsafe abortion. That single story is a form of data but it is not a metric. Clandestine abortion access activist groups do not collect data (or if they do, they do not publicize them) on how many women are in need or how many women they have served. People who use misoprostol at home to cause the end of a pregnancy are not, by design, counted. We do not know how many lives have been saved because someone had recourse to safe medical abortion drugs and some measure of support to undertake the process.

Conclusion

In this essay, I have marshalled some evidence and approached some ways to think about abortion access activism vis-à-vis global health. These critiques reveal the incompleteness of global health as an enterprise when it comes to reproductive and sexual health and the gendered nature of this incompleteness. The idea of safe abortion access activist work as "critique in action"—words that have been used to describe Partners in Health (PIH), the organization co-founded by the late Dr. Paul Farmer—is compelling (Biehl 2016). PIH created research and treatment programs where none existed, trained teams of community health workers to use the accompaniment model of care, and sent them out to visit patients one by one. They did not wait for global-level policy or scientific studies to validate their priorities or their models of care to begin treating the poor and marginalized. The work of abortion access activist groups most certainly counts as critique in action, inventing a model of care outside the systems of law and biomedicine in order to bring safer, more dignified, and life-saving services for a severely neglected reproductive health need and thereby "taking a social justice approach to patient care." (Biehl 2016).

In earlier drafts of this essay, I found myself wanting to argue for the clandestine work of activists to "count" in global health—my own feminist impulse, perhaps, to make a case for inclusion and recognition of the unseen expertise and care work of women. But even as they deploy pieces of scientific knowledge and biomedical technology to their own ends, such networks remain on the outside. And so I propose the idea of abortion access activism as an anti-regime of global health—a term inspired by the contrast with Lakoff's "two regimes" that are so firmly focused on institutional players and key issues (2010) and that tend not to incorporate local context. As an anti-regime of global health, clandestine abortion access activist networks are not waiting for a legally and materially just world, or for the transformation of institutions to attend to their cause—though other near allies are working on those fronts. Their work, day in and day out, materializes a world in which life-saving care exists for those who need it. Not rendering themselves visible or legible to the state in order to "count" is part of what allows them to continue.

Clandestine abortion activist networks are nevertheless inequitable and imperfect solutions to the problem of maternal suffering and death. Anthropologist Seydou Drabo (2019) describes how access to misoprostol in Ouagadougou, Burkina Faso, may be safer than surgical abortion but carries its own risks depending on one's social class, connections, and ability to pay.

Lowy and Correa (2020) describe the negative experiences of some Brazilian women with the drug in clandestine circuits—women who suffer alone strong side effects for which they were not prepared, or having to present to hospital after the drugs appear to have failed.

Might the work of clandestine abortion access activists hold states and global agencies to account? It is not unprecedented for models of care designed and practiced outside the law and formal biomedicine to earn respect and recognition over time. Many patient groups and emerging professions who have devoted themselves to neglected causes, marginalized groups or stigmatized illnesses have made such “lay incursions” into formal healthcare systems (Epstein 1995) with revolutionary benefits for patients. Such “experiments in care” sometimes get taken up by the mainstream (MacDonald 2017). Indeed, as of 2020, comprehensive abortion care is included in the WHO’s list of essential health care services. The guidelines state that medication abortion can be performed in the first 12 weeks of pregnancy and can be safely self-managed by an individual outside a healthcare facility if one has access to accurate information, quality medicines, and support from a trained health worker (WHO 2020). These guidelines signal a new level of acceptability for self-managed, even home-based medication abortion, at the level of global policy. But without broad implementation we are still left with a “second best” world (Redfield 2013; Terry 2002). Clandestine abortion access activist networks are not the solution to ending suffering and death due to unwanted pregnancy in any jurisdiction: safe, legal, affordable, accessible, non-stigmatised services are.

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Notes

1 For a comprehensive list of the legal status of abortion around the world see https://reproductiverights.org/maps/worlds-abortion-laws/.

2 Abortion access activism is happening on many fronts, including groups working on policy change within their professions (medicine or law for example); organizations such as Marie Stopes International and International Planned Parenthood working to improve access to abortion services in the Global South where permitted by law alongside access to contraception campaigns and services. See Littlefield 2024.

3 A note on terminology. A surgical abortion involves dilatation of the cervix and curettage of the uterus to remove its contents. This procedure, often called a D and C, can be performed under general or local anesthetic. Manual Vacuum Aspiration (MVA) is another surgical method involving the dilatation of the cervix and the extraction of the contents of the uterus by suction. Less invasive than a D and C, it is nevertheless considered a surgical procedure and thus the domain of a trained medical professional. Medication abortion (sometimes referred to as medical abortion) is non-surgical and non-invasive in that it does not require the insertion of a medical device into the body.

4 Roe v Wade is the 1973 landmark US Supreme Court decision enshrining the right to abortion in the Constitution. Yet, over the years, individual states introduced laws to make access as restrictive as possible. In June 2022, Roe v Wade was overturned, drastically reducing access and potentially criminalizing other reproductive healthcare services, such as treatment for spontaneous miscarriage.

5 See https://www.youtube.com/watch?v=0y6rd7Vd3fE and https://www.youtube.com/watch?v=x75kE2gaVu8

6 The Jane Collective began as a word-of-mouth operation in Chicago in 1969. They distributed leaflets which read, "Pregnant? Need Help? Call Jane" and referred women to sympathetic physicians before eventually training themselves to do the procedure (Bart 1987; Kaplan 1997).

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