“Towards a Political Geography of Abortion”

Sydney Calkin

Forthcoming in Political Geography (ahead of print version)

Abstract:

This article introduces a political geography of abortion, arguing that abortion access is an essential but overlooked site where gendered mechanisms of state control are enforced and contested. Today, abortion access is currently in the midst of a significant spatial transformation: advances in technology, medicine, and activist tactics are currently changing the geographies of abortion and working to weaken the link between access to abortion and national legal frameworks. In response to these challenges to state control over reproduction, states are responding with new tactics to re-assert authority over pregnancy and abortion. However, these changes remain under-researched in the geographical literature, which tends to sustain a focus on state-law and inter-state travel. The forces currently transforming abortion access exceed these analytical frameworks: we require a multi-scalar and scale-jumping account of the relationship between pro-choice activists and anti-choice states. This article makes the case for a political geography of abortion that moves beyond a state-based framework to account for changing patterns of resistance and restriction on abortion. The arguments are developed through two cases: mobile abortion clinics at sea and telemedicine abortion technology, both of which demonstrate the contestation over abortion rights at the sub- and supra-state levels.

Keywords: Abortion; Reproduction; Feminist Political Geography; Scale; Pregnancy

Reproduction is a core component of nation and state-making processes, in which the alignment between population, territory, and community is deliberately forged. Bodies are territories onto which states project power, but reproductive bodies crucially "make territory" in ways that conform to and resist dominant power structures (Smith, 2012, p.1513). State control of reproduction is inextricable from political claims about the rightful occupants of a particular piece of territory or the categories of citizen entitled to protections by the state. To this end, state interventions to govern reproduction are always marked by the coupling of pro-natalist and anti-natalist policies: to perpetuate religious and/ or ethnic divisions (Smith, 2012; Mayer, 1999; Smyth, 2005); to sustain an economic system by managing the growth of the labour force (Kligman, 1998; Cao, 2015); or to mitigate against racialized demographic change (Repo, 2015; Farris, 2017; Luibheid 2013). Everyday intimacies – sex, pregnancy, birth, care, and family-formation – are foundational to political communities and are therefore managed by more or less restrictive interventions.

What role for abortion in this reproductive political geography? Abortion regulation is a site of social control where prevailing norms about patriarchy, heterosexuality, motherhood, and citizenship are enforced and contested (Woliver, 2010; Fletcher, 2007; Calkin, 2018). Abortion has always been a feature of women's lives, although it acquired its status as a fiercely contested and widely criminalized offence within the last 150 years. The criminalization of abortion took place in the broader context of a turn to biopolitical governance across Europe and North America, where government action targeted the level of the population through interventions to shape the health, survival, and capacities of the state's people (Petchesky, 1984; Solinger, 2007; Miller, 2013). Abortion restrictions are implicated in natalist policies of all varieties: draconian bans on abortion have historically been employed to grow the population of particular national groups and preserve traditional gender roles (see Kligman, 1998; Luibheid, 2013; Solinger, 2005), while coercive and violent programmes of abortion and sterilization have been used to curb population growth and enforce racialized projects of control (Roberts, 1999; Wilson, 2012; Hartman, 2016; King 2002). Opposition to abortion has even come to direct foreign policy objectives, determining global public health goals and driving development spending shifts, as in the Global Gag Rule (Sanger, 2017; Brickell and Cuomo, 2018). Abortion politics must be read alongside broader debates about citizenship, population, and the biopolitics of fertility in which states undertake efforts to encourage particular modes of reproduction at home and abroad.

Abortion access today is in the midst of a significant spatial transformation driven by medical and technological changes. These changes have profound political and geographical implications because they signal the growth of a trans-national and extra-territorial set of actors and flows that are expanding abortion provision outside of state legal frameworks. This paper offers a political geography account of abortion, arguing that the changing spatiality of abortion access reflects a significant shift in the relationship between women, the state, and reproduction. To this end, the paper brings together political geography scholarship on scale and state power with feminist geography of reproduction to augment understandings of both. Political geography scholarship has seriously overlooked abortion, although the issue is central to state-led efforts to manage reproduction, population, and the gender order. The ongoing contestation over abortion access speaks to debates in the discipline about the de- and re-territorialization of state power because control over abortion has come to implicate questions of sovereignty and territorial control. Meanwhile, the extant geographical literature on abortion cannot account for the current spatial transformation of abortion, because this literature sustains an understanding of abortion as a matter of state law and cross-border travel. In order to understand the changing political geography of abortion, the paper argues, our analysis can no longer concentrate on the state as a territorial container for abortion law, but it must take into account a more fluid and multi-scalar infrastructure for abortion access outside of state-sanctioned clinic space.

The article proceeds in four parts: first, it maps the changing spatiality of abortion by tracing the traditional medical and state infrastructures that govern abortion and the emergent patterns of abortion mobility that work outside of these spaces. Second, it turns to the political geography literature on scale to conceptualize the modes of multi-scalar resistance and state re-scaling that characterize this contestation over abortion. Third, it demonstrates that pro-choice activists make use of mobile and digital clinic space to scale-jump and harness scale for political claims. Fourth, it shows that anti-abortion states have instituted a range of spatial techniques to obstruct mobile and scale-jumping forms of pro-choice activism, especially by imposing greater regulation on the doctor-patient interaction. It concludes by mapping future directions in research on the political geography of abortion.

States, Clinics and Reproductive Space

A political geography of abortion starts from the contention that abortion is a spatial phenomenon. Its regulation has traditionally proceeded through state-imposed boundaries on when and where it could take place, granting doctors exclusive authority over legal termination of pregnancy. Across the diverse historical and geographical contexts in which abortion has been criminalized and legalized, this has been enforced through a spatial logic of medical control. The criminalization of abortion was politically driven by state-led projects to manage fertility rates, but in practical terms it was made possible with the support of anti-abortion medical associations and through the increased surveillance of doctors over pregnancy. The legalization of abortion was similarly facilitated with the support of the medical establishment and through the preservation of medical authority (see Reagan, 1998; Petchesky, 1984; Luker, 1985). Across most of the countries where abortion is legally available today, doctors may provide legal abortion inside formal medical spaces but states maintain criminal penalties for abortions obtained outside of this medical context.[1] This is still the case in Britain, for example, where abortion can be legally granted with two doctors' approval under the 1967 Abortion Act but is otherwise criminalized under the 1861 Offences Against the Person Act (Sheldon, 1997). States which permit abortion have generally done so by granting doctors the sole authority over legal abortions and implementing corresponding restrictions through criminal law, medical regulations, and a range of policy domains (Erdman, 2017). Access to legal abortion therefore depends on authorized medical supervision inside designated clinic spaces, while abortions outside of this context are criminalized. States with abortion bans, by contrast, often permit women to go abroad for abortion without prosecuting them upon their return (see for example, Fletcher, 2013). These states attempt to symbolically enact the status of the 'abortion-free territory', albeit with the expectation that neighbouring jurisdictions will provide abortions for women who can travel.

Abortion-travel has therefore been a central feature of abortion access past and present. In political geography terms, this means recognizing that abortion access often implicates the legal contexts of sub- and supra-state entities. Abortion travel is essential for women in federal or devolved systems that produce a patchwork of laws within a single political entity such as Canada, the USA, the UK, Australia, and Mexico (Sethna and Doull 2012; Gilmartin and White 2011; Whitaker and Horgan 2016; Brown, 2013; Berer, 2017). Across international borders,

[1] The only jurisdictions in the world where abortion has been removed from the criminal code are Canada and five Australian states/ territories: the Australian Capital Territory, Victoria, Tasmania, Queensland and the Northern Territory (see Berer 2017).

‘abortion corridors’ arise between neighbouring countries with different legal regimes or similarly restrictive laws but different levels of enforcement: these corridors include Ireland-England, Germany-Poland, USA-Mexico, and Chile-Peru, among others (see Side 2016; Freeman 2017; Fletcher 2016; Brown 2013; Calkin and Freeman, 2018). Women who must travel for abortion face numerous barriers, of which political and economic obstacles often loom the largest. First, crossing borders for an abortion requires a woman to have a passport and visa to freely leave and enter another country. Women who are refugees, asylum seekers, or undocumented migrants often lack this documentation and the money required to obtain it (Side, 2016; Gilmartin and Kennedy, 2018; Haksgaard, 2017). Second, crossing large distances for abortion also requires a woman to have substantial financial means, access to transport, access to childcare, and a social support network to facilitate the trip (Pruitt 2007, 2008; Sethna and Doull, 2012). Because abortion travel obstacles map onto existing socio-economic inequalities and layer up in place-specific ways, distance-based obstacles to abortion are often underestimated in ways that disadvantage poor and rural women (Pruitt and Vanegas, 2015; Statz and Pruitt, 2018). Abortion access via travel depends on numerous inter-linking factors that extend well beyond the laws of nearby jurisdictions: access in practice is contingent on women’s mobility, socio-economic context, social networks and other structural obstacles.

Despite these insights into abortion-travel, the current literature on abortion geographies is limited by its reliance on a conceptual framework that centres state law and imagines abortion access as contingent on a woman’s mobility between different abortion jurisdictions. Though it gives consideration to the gap between the law in theory and in practice, the extant abortion geographies literature is underpinned by the assumption that abortion access depends on a woman’s physical presence in an abortion clinic, thus the emphasis on barriers to abortion travel. This focus can obscure more important trends from view because today abortion access is becoming less connected to physical clinic spaces and, by extension, less tethered to national legal frameworks. The main driver of this change has been medication abortion with pills – mifepristone and misoprostol – that provide a safe non-surgical option for early abortions. Medication abortion pills are already widely available in Latin American on the black market and their impact on reproductive health has been transformative (see Oberman, 2018). First, the safety of self-managed abortion with pills has “turned on its head” the conventional relationship between the safety and legality of abortion (Jelinska and Yanow, 2015, p.87). The narrative of the ‘back alley abortion’ evokes the notion that self-managed or clandestine abortion is, by its very nature, dangerous to a woman’s health. By contrast, the World Health

Organization has found that self-managed abortion with pills, assisted by online medical consultation from a reputable provider, qualifies as a safe abortion (Ganatra quoted in Boseley 2017). Second, the simplicity and safety of medication abortion pills means that lay activists and feminist networks can provide the necessary information for their use where restrictive abortion laws prevent doctors, nurses or midwives from advising patients (Coeytaux et al., 2015; Gomperts et al., 2008). Third, because a medical abortion takes place inside a woman's body and "is not 'carried out' or 'conducted' by someone else", medication abortion can give women autonomy over the process (Berer and Hoggart, 2018, p.1; Winikoff and Sheldon, 2012). The public health and medical literature on medication abortion has welcomed this transformation in clinical practice, but as yet there has been little consideration given to its political and geographical ramifications.

Ireland provides a concise example of the broader changes in abortion mobilities, where self-managed abortion with pills has swiftly transformed access patterns. Under the state's near-total abortion ban in force until 2018, many thousands of Irish women accessed abortion by travelling to England. At the highest point in 2001, eighteen women per day travelled from Ireland to England for abortion; as of 2016, that number had fallen to just under nine per day (IFPA, n.d.). This decrease in travel has been attributed to the increase in access to illegal abortion pills through online pro-choice networks which facilitate the distribution of pills inside Ireland (Sheldon, 2018). One online provider reported that, between 2010 and 2015, three to five women in Ireland requested abortion pills every day (Aiken et al., 2017).[2] The recognition that abortion pills were being widely accessed in Ireland, despite the threat of a fourteen-year prison sentence for their use, was instrumental in pushing the Irish political mainstream towards a more permissive approach to early abortions in the lead up to its 2018 abortion referendum. Given the widespread access to abortion pills in Ireland, laws banning their use have been and would likely continue to be practically and politically unenforceable (Sheldon, 2016). To this end, much of the pro-choice political discourse of mainstream Irish politicians emphasized the danger of clandestine abortion with pills and the need to liberalize the law so these pills could be brought back under medical control (see for example Leahy, 2018). Abortion mobilities in the Irish context are often associated with flows of cross-border abortion-seekers and territorial narratives of 'abortion-free Ireland' but the increased access to

[2] This number represents only a fraction of the actual daily demand for abortion pills, because it reflects requests made to one of several online networks that provide pills in Ireland. In addition, women in Ireland source pills through online pharmacies and informal personal networks.

abortion pills and their impact on the political landscape point to the limitations of a travel-centred account.

The geography of abortion access is in the process of transformation, yet the current efforts to conceptualize these changes tend to focus on the state jurisdiction to the exclusion of other relevant spaces. A geographical orientation to abortion shows us that contestation over abortion is about the management and regulation of space at multiple scales. State control over abortion has governed through the clinic space and the doctor-patient interaction, assuming that the key elements of abortion access were co-location of patient, doctor, clinic, and medical equipment. Consequently, the transformation that abortion pills bring about is an alternative spatial arrangement that moves access beyond the clinic space. This opens up a range of possibilities for pro-choice activists to move abortion access into new spaces while it also poses a serious challenge to the state's ability to limit where and when abortion takes place. Abortion's spatial transformation requires us to think beyond the legal frameworks of states and the mobility of abortion-travellers between jurisdictions, to conceptualize the mobility of abortion pills, information, and delivery technologies in new ways. It demonstrates the need for an alternative and multi-scalar analytical framework that draws on political geography insights into scale and territoriality but also works to challenge political geography to conceptualize the regulation of abortion as a significant site of state-making.

Re-Scaling Abortion Access

A political geography of abortion takes the feminist critique of scale as a starting point, building from this critique to note the ways in which pro-choice feminist activism has deliberately employed and subverted scalar categories to make political claims about state power and female autonomy. Feminists have demonstrated that scale's categories are inherently political because scholarship on scale often has the effect of re-producing masculinist assumptions about what 'counts' as political, by concentrating analysis on certain processes, places, and actors (Marston, 2000; England, 2003; Pain, 2009). Conventional scalar categories are premised on gender binaries and often reinforce and naturalize the spatial separation of the masculine public realm and feminine private sphere, although scales like the domestic and corporeal are in fact "profoundly entwined" with the geopolitical (Dowler and Sharp, 2001; Pratt and Rosner, 2012). Moreover, because these spaces are inscribed with geographical, political, and legal

significance, a feminist account must strive to overcome the binary thinking that structures the literature and account for the intimate and the geopolitical in "a single complex" (Brickell and Cuomo, 2018, p.2). Pro-natalist policies that restrict abortion serve material and symbolic functions, reflecting efforts to shape population and national identity (see for example Kligman, 1998; Luibheid, 2013); as such, they exemplify the feminist claim that the corporeal and geopolitical are inseparable. Emergent modes of mobile abortion access offer a way to extend this critique: feminist efforts to expand abortion access strategically embrace and politicize scale in order to expose the limits of state interventions to control reproduction.

Geographers have widely critiqued scale, noting its tendency to re-impose conceptual hierarchies and fit different phenomena into a set of pre-existing scalar categories (Marston et al., 2005; Paasi, 2004). Particular scales can easily become entrenched platforms for analysis: this is evident in the over-reliance on state-level analysis in the existing geographical literature on abortion. Amidst these scale debates have been calls for the recuperation of scalar thinking as a tool for analysis, insisting on the possibility of researching through scalar thinking without internalizing and accepting scalar categories as natural. This entails approaching scale not just as a social construct but a *political* construct: how are scales constructed and legitimized by states or other actors? In this view, scales can be understood as political projects that are specifically deployed by actors to "crystallize certain socio-spatial arrangements" or to further political aims (Moore, 2008, p.218). Acknowledging the political uses of scale, scalar analysis can look for its strategic deployments and effects, rather than employing scale purely as an analytical tool that is imposed upon the data. Political actors are generally interested in control over particular areas of activity or policy, "rather than the command of scale *per se"* so they seek to manipulate "discursive and material" aspects of scale to pursue their agendas (MacKinnon, 2011, p.30). This political orientation to scale is a productive path forward in the scale debates, in part because it bypasses the ontological question of scale's existence and offers us a view of scale as a political tool that is created through human action and employed for deliberate ends.

By extension, an account of multi-scalar resistance calls attention to the way that scales are politically constructed, employed, and transformed to produce a desired set of outcomes. Neil Smith has labelled this "jumping" or "bending" scales: it is a form of resistance in which actors deliberately violate socio-spatial boundaries in order to make political claims about space, power, and position. The act of jumping between scales highlights the connection of different

scales, while "dissolving" and "abrogating" the boundaries between them (1992, p.60). Beyond violating spatial boundaries, scale-jumping and bending can work by redefining the power relations between different scales or challenging the assumptions about what activities happen at particular scales (Smith, 2004). Resistance through scale-jumping works to build alliances between actors who are differently placed in relation to the state and use their positions to leverage pressure and produce a new policy or policy reversal. This might mean asserting the importance of particular scales and diminishing the importance of others in relation, forging closer connections between particular scales to achieve an outcome, or contesting dominant power structures by multi-directional scale jumping that challenges the presumption of 'upward' movement (Swyngedouw, 2000; Cox, 1998). Scale-jumping offers activists a way to point out the fictive and constructed nature of scales while using material manifestations of scale to make political statements.

Forms of resistance that creatively violate spatial boundaries may work to subvert the established structures of political power, but they are inevitably contested. Processes of political transformation that contest state power prompt its spatial re-arrangement, rather than its obliteration. Scalar literature on globalization uses this dialectical relationship to explain the interplay between de-territorializing forces of capitalism that seek to compress space and time, against the re-territorializing efforts of political entities that re-configure their power in a variety of spatial forms (Brenner 1999). Where state territorial control is challenged or eroded, states work to reproduce the rationality of territory across diverse scales (Elden 2005; Shah 2012). Multi-scalar modes of resistance that strive to work outside of familiar political entities are still anchored in fixed infrastructures and are always subject to place-based interventions to govern them as such. This critique might be understood as tempering the optimism around multi-scalar resistance, by drawing attention to the way that state power is re-asserted and re-scaled in response to scale-jumping challenges. With reference to abortion access, pro-choice activism that jumps scale to deliberately violate spatial boundaries and offer new platforms for digital or mobile abortion access is interpreted as a challenge to state authority, and states respond as such. The multi-scalar infrastructure of self-managed abortion is continually contested and efforts to govern it are made by states who re-scale their power to enforce abortion restrictions.

The conceptual tools of critical scale literature help to account for the changing relationship between women, the state, and reproduction. The transformation of abortion's spatiality has

been the deliberate result of action by pro-choice activists who have leveraged the mobility of medication abortion pills to subvert state laws and provide wider access through creative scalar strategies. In the different iterations of pro-choice activism, there is an evident re-scaling of abortion that progressively reorganizes abortion to move it outside of state control first by moving it outside of formal medical spaces. In the first instance, the feminist networks that facilitate abortion travel have expanded access by moving women to clinics, providing money, transport, and information to lower the barriers to access. Extending this vision of abortion travel, pro-choice networks have employed mobile medical clinics to invert this relationship and move the abortion clinic space to women in states with highly restrictive laws. Yet, persistent state interventions obstruct the function of mobile clinics by placing territorial obstacles between women and clinic spaces. As such, trans-national digital abortion networks transcend the need to facilitate co-location of women and clinics by offering access to an online clinic space that provides medical consultation via email or video and access to mobile medication abortion pills through the post.

Mobile and Digital Clinics

The spatial re-arrangement of abortion access has come about through calculated efforts to violate state law, expose 'loopholes' in the law, and establish clandestine networks for the distribution of medication and information. The Dutch NGO Women on Waves and its sister organization Women on Web have been central to this endeavour. Since 2001, Women on Waves has staged high-profile campaigns to provide abortions in a mobile clinic aboard a ship in international waters. In its ship campaigns, the organization uses the legal status of ocean space to subvert the abortion laws that operate on land because, under international law, territorial waters only extend 12 miles off the coast beyond which point passing ships are governed by the laws of the country in which they are registered (Jones, 2017). Under this system, a Dutch-flagged ship positioned 13 miles off the Polish coast is governed by the laws of the Netherlands, not Poland; in relation to abortion law, this means physicians can prescribe and dispense medication abortion pills to patients on board, regardless of the patient's nationality (Lambert Beatty, 2008). In its ship campaigns, the organization docks and brings abortion-seekers onto the ship at which point it sails into international waters and the doctor on board dispenses medication abortion pills to the women; no surgical abortions are provided. Women on Waves' ship campaigns exemplify a strategic deployment of scale, because they

creatively jump scales to access the legal regime of one state in ocean space off the coast of another. In doing so, the organization is able to move bodies across metaphorical national spaces without travelling those distances. Women on Waves strategically constructs a space for abortion provision that exists in a state of legal and geographical limbo: the fictive nature of this political scale is part of its innovation. As soon as the ship sails away, taking the mobile clinic with it, the space will cease to exist, as will the mode of abortion access it provided.

Ocean space exhibits a “legal pluralism” that results in complex and overlapping modes of governance: activists can make use of this space to subvert the laws in force on shore, although states also employ a variety of legal strategies for extending control over vessels outside coastal waters (Peters, 2011, 2014). Women on Waves’ ship campaigns have been consistently met with state efforts to obstruct them, whether military or bureaucratic in nature. Portugal, for instance, met Women on Waves’ vessel with warships to block its entry to coastal waters while Guatemala used military personnel to prevent the Women on Waves crew from disembarking or sailing out with Guatemalan women (Women on Waves, 2004, 2017). On other campaigns, state withdrawal of the mobile clinic’s medical authorization has prevented the group’s doctors from treating patients (Lambert Beatty, 2008; Sheldon, 2016). These state-imposed obstacles, alongside numerous logistical constraints, mean that Women on Waves’ ship campaigns can serve relatively few women during the brief windows when the ship and its mobile clinic are in use. Nonetheless, these limitations have gone largely unnoticed by media and the public: since its first campaign in 2001, widespread media coverage of the ship campaigns has contributed to the misconception that the ship is a permanent fixture of the abortion landscape, continually sailing from port to port and providing many women with abortion access. This presented an opportunity for the organization:

> “We got a lot of emails from all over the world that [women] needed help, they wanted to know when the ship was there, but of course there was no ship.[3] So that’s why we started Women on Web. It’s just a pill: you must be able to send it, so we found the loopholes to do it” (Interview, Women on Waves, 2018).

[3] The interviewee says “there was no ship” to mean there was no single vessel in continuous operation sailing around the world. For most ship campaigns, Women on Waves rents a ship.

The mobile clinic at sea brings an abortion clinic to women, by creatively interpolating the legal jurisdiction of an abortion-permissive state just outside the territorial control of an abortion-restrictive state. Nonetheless, the venture still depends on its ability to physically bring women on board, off shore, and into the mobile clinic, creating numerous opportunities for state interference. Women on Waves has therefore re-oriented its strategy to capitalize on the mobility of the abortion pill and launched a second organization, Women on Web, whose sole focus is to provide medication abortion pills and medical consultation through the internet. The online service is staffed by a team of doctors, all of whom are registered to practice medicine in jurisdictions where abortion is de-criminalized. When a woman contacts the website, she has an online consultation with a doctor who can then write her a prescription for abortion pills; the pills are sent to the woman who continues to receive medical advice online while she takes them. At one time, Women on Web filled orders for abortion pills with an Indian pharmacy who shipped directly to the destination country, but as customs agencies began to seize packages from online pharmacies, activists developed alternative strategies (Bazelon, 2014; Gomperts, 2017). In some cases, Women on Web affiliates fill the prescriptions legally in European pharmacies and re-package the pills before sending them onwards; sometimes the packages can be sent through to states without legal abortion, while in other cases they are sent to neighboring states and physically smuggled across the border by local activists (Gomperts, 2017; Sheldon, 2016; Sheldon, 2018). Depending on the destination country and its laws, the organization modifies shipping routes or draws on local activist networks to move pills to the women who request them. The trans-national network operates remotely to advise women who contact the website, but the physical work of securing access to pills employs a similar strategy for scale-jumping that strategically sits inside some national jurisdictions in order to subvert the laws of others.

Women on Waves has pioneered a mode of feminist geo-legal resistance that makes use of "digital and floating worlds" where legal infrastructures can be contested and shaped to achieve feminist ends (Brickell and Cuomo, 2018, p.10). The two organizations, Women on Waves and Women on Web, are deliberately based in different jurisdictions whose legal and medical context is best suited to their respective missions (Interview, Women on Waves, 2018). However, their operations are designed to be mutually reinforcing while legally distinct. The logistical shortcomings of ship campaigns mean that on-the-ground provision of pills must take alternate, clandestine routes, but the intense media coverage of ship campaigns can be used to increase awareness of, and demand for, abortion pills. In Morocco, for example, Women on

Waves' ship campaign was designed to leverage the Moroccan authorities' response and media coverage for a greater regional impact. When no Moroccan women were able to board the ship, Women on Waves instead used the attention of Arabic-language regional media like Al Jazeera to explain that medication abortion pills are sold cheaply in local pharmacies as arthritis medication (Gomperts, 2017). This kind of media attention allows for symbolic scale-jumping, spreading information across a region and language community. Similarly, when states respond with military power, Women on Waves uses this to communicate a feminist message about the state's control over women. In Guatemala, authorities locked the Women on Waves crew inside the port and tasked the army with policing their movements. Because it attracted so much local media attention, the state's militarized response sent a useful political message for Women on Waves:

> "The army is not very popular and so the fact that the army would intervene into something that was totally considered as a [marginal] woman's rights issue… people suddenly realized: 'hey, if the army is so interested in this, it's about fundamental freedoms!'" (Interview, Women on Waves, 2018).

Women on Web strategizes to provide women with medication abortion by offering access to a digital clinic, while Women on Waves is oriented more towards political statements that use ships, as well as drones and robots,[4] to move pills across political borders and highlight the arbitrary boundaries that govern abortion. These actions alternately make use of the state's jurisdiction to offer legal cover for some aspects of the work and stage attention-seeking stunts to goad the state into a public response. By treating these scales as discursive *and* material, the forms of multi-scalar resistance exemplified by Women on Waves challenge the normal scalar arrangement of political activities at different levels. Ship campaigns politicize ocean and border space by highlighting the tenuous boundaries between jurisdictions with different abortion laws; when the material limitations of ship campaigns prevent Women on Waves from providing substantial access to large numbers of women in need, the group instead uses the political and media attention directed at the issue to lobby for reform and disseminate information about other modes of access. Ship campaigns offer a discursive platform for the

[4] Since 2015, Women on Waves has conducted several 'drone actions' and 'robot actions' where it uses these technologies to move a few packs of abortion pills across political borders or inside territory where the pills are illegal. These actions do not provide access for local abortion-seekers. Instead, Women on Waves activists take the pills in front of local media to protest restrictive laws (Gomperts, 2017).

critique of state control over reproduction, but a less direct material intervention to transform abortion access. By contrast, Women on Web uses an online platform to provide access to medical consultation and a shifting set of postal routes and local affiliates to move pills into abortion-restrictive territories. Both organizations demonstrate a politicized orientation to scale by drawing attention to the arbitrary nature of state control and the physical limits to its power and a scale-jumping strategy that deliberately combines elements of multiple jurisdictions to construct transnational modes of abortion access.

Telemedicine and Medical Surveillance

If the regulation of abortion has historically relied on the medical authority and legal liability of doctors to enforce the state's laws, how can those laws be enforced when a pregnancy can be safely terminated at home with pills obtained online? This question is a geographical one: flows of medication abortion pills and access to abortion outside of formal clinic settings has destabilized the state's ability to strictly control the conditions of termination of pregnancy. As pro-choice activists employ politicized scale-jumping strategies that work to expand provision in practice, they offer an alternative geography of abortion access. In response, some abortion-restrictive states have approached the issue as one of serious territorial violation that requires criminalization and prosecution of clandestine abortion.[5] Multi-scalar modes of pro-choice resistance harness mobile abortion technologies to subvert state abortion law, but these efforts are inescapably anchored in some place-based infrastructures and vulnerable to intervention. When abortion mobilities offer new modes of access, state authorities have sought to re-assert the power to govern (and prevent) abortion by instituting a range of spatial counter-strategies that control the space of the clinic, the medical consultation process, and the body. The entwined processes of activist scale-jumping and state re-scaling are illustrated in the contestation over telemedicine abortion in the United States of America where states have taken steps to control the flow of medication abortion pills by imposing regulations on doctor-patient consultations and mandating surveillance of pregnancy and miscarriage.

[5] However, state responses to the influx of illegal abortion pills are not uniform. Some states, like the Republic of Ireland, have responded with a "choreographed ignorance" and unwillingness to prosecute individual women (Sheldon, 2018). By contrast, authorities in Northern Ireland have prosecuted several people for the crime of procuring abortion pills. More research is needed to account for the differences in official responses to the proliferation of abortion pills, because they vary significantly depending on context.

Although the right to access abortion is constitutionally protected in the USA, in practice access varies dramatically across the country as it is subject to increasingly draconian state-level restrictions. American opponents of abortion have concentrated their efforts on "chipping away" at access on the ground rather than mounting constitutional challenges (Siegel, 2007; Sanger, 2017). Numerous measures to restrict abortion have been introduced at the state (rather than federal) level, using a variety of regulatory strategies to ban certain procedures, regulate medical care, and impose restrictions on abortion clinics. Most prominently, laws known as Targeted Restrictions of Abortion Providers (TRAP) have tried to regulate clinics out of existence by requiring onerous administrative and structural changes to the clinic (see Guttmacher 2018). Although some TRAP laws were ruled unconstitutional by the Supreme Court's 2016 ruling in *Whole Women's Health vs. Hellerstedt*, this decision did not automatically invalidate TRAP laws in force in 24 other states (Yang and Kozhimannil, 2017). As such, abortion restrictions continue to close clinics and restrict their operation: for example, there are twenty-seven cities in the US that qualify as "abortion deserts" because their nearest clinic is over 100 miles away (Cartwright et al. 2018). In practice, these geographical barriers become class-based obstacles: the absence of public transport in rural areas, for instance, means that travel to a far-away clinic requires an abundance of money and time that poor and rural women disproportionately lack (Pruitt and Vanegas, 2015).

In response to these obstacles, and in an effort to make abortion more accessible to women who live far from abortion clinics, pro-choice organizations have sought to increase access through telemedicine technology. In telemedicine abortion, a woman's consultation with her doctor is conducted by video, phone, or online chat and medication abortion pills are prescribed remotely. This can involve varying levels of technology: in the most basic circumstances, telemedicine can mean a phone call or web chat between a pregnant woman and a lay activist who advises her on the safe use of medication abortion pills (Aiken et al., 2017). In the most formal and technologically advanced settings, telemedicine involves a remote communication between a doctor and patient, where the patient receives basic care and preliminary tests at a local medical facility but her prescription is provided by a doctor via video chat. In some Planned Parenthood facilities in the USA, the doctor can remotely unlock a medicine drawer in front of the patient and watch while she takes the prescribed pills (Yang and Kozhimannil, 2016). There is an important distinction between these different forms of telemedicine: the informal online telemedicine service provided by groups like Women on Web is generally

regarded as illegal, because it provides abortion pills to women in states where abortion is a criminal offence (Sheldon, 2018). By contrast, legal telemedicine services like those in the USA operate in states were abortion is legally permitted but difficult to access. Telemedicine abortion has been found to improve access for rural women, but it can also address clinic closures and staffing shortages that leave urban and sub-urban women hundreds of miles from the nearest clinic (Grossman and Grindlay, 2017; Aiken et al., 2017; Pruitt and Vanegas, 2015). By providing a technological workaround for the growing distances between American women and abortion providers, telemedicine offers a spatial fix for a geographical problem.

This spatial transformation of abortion has serious implications for the state's ability to permit or prohibit it and provokes a range of state responses that aim to re-territorialize power. One such response is the move to prohibit legal telemedicine in a formal medical setting: state efforts to exert control over legal telemedicine abortion are generally scaled at the level of the medical facility, demonstrating an effort to re-assert clinical control over abortion and state control over clinics. Some states have taken a direct route, legislating an outright ban on telemedicine by mandating in-person contact between doctor and patient and prohibiting "the use of telehealth or telemedicine services" (quoted in Kreutzfeld, 2016, p.79). Others have sought to effectively ban telemedicine by requiring multiple in-person visits with a doctor for the prescription of medication abortion pills (see Hooper, 2015).[6] Prior to 2016, states could do this by requiring medication abortion be provided according to a federal protocol that mandated three in-person visits to the doctor for the use of medication abortion pills, including two visits to take the pills at separate times and one additional visit for follow-up care (Pruitt and Vanegas, 2015). Separate from this protocol, some states specifically require in-person visits for pre-abortion counselling or require an ultrasound which must be performed by the doctor who will perform the abortion (Lindgren, 2017). Many restrictions on telemedicine work by mandating the space of the physician-patient interaction: twenty-one states currently have these laws in force. Fourteen states specifically require the doctor be "physically present" or "in the physical presence" of the patient when the medication abortion pills are dispensed; nine of these states additionally specify they must be "in the same room" (Guttmacher 2018).[7] Most recently, Arkansas introduced a measure to require doctors who prescribe medication

[6] As with so many other abortion restrictions, the prohibitions against telemedicine are often framed as "woman protective" restrictions (Siegel 2007). Anti-choice groups and legislators refer to telemedicine as 'webcam abortion' to emphasize the perceived danger of women taking abortion pills outside of a designated clinic space.
[7] See, for example: Arkansas, A.C.A. § 20-16- 603 (2016); Kansas, K.S.A. § 65-4a10 (2011); Mississippi, MS S.B. 2795 (2013); Wisconsin, Wis. Stat. Ann. § 253.105 (2015-6).

abortion pills to have reciprocal privileges at nearby hospitals, although this requirement is notoriously onerous and medically unecessary (see Cartwright et al., 2018). In short, the legal workaround of mobile abortion technology has been met by anti-choice states with territorial strategies to regulate clinic spaces, circumscribe physical interaction between doctor and patient, and reimpose geographical obstacles to care.

For women who cannot access medication abortion pills through legal channels, other routes exist. American women can access informal telemedicine services through online networks that provide advice on safely self-managing abortion or they can buy medication abortion pills through online pharmacies (Murtagh et al., 2017; Aiken, 2018). Both of these routes are illegal and carry significant legal risk for pregnant women: many states explicitly criminalize women who perform their own abortions and characterize abortions outside of a formal medical context as feticide (Kreutzfeld, 2016; Lindgren, 2017; Rowan, 2015). The prohibitions against self-induced abortion are scaled at the level of the medical clinic and the doctor-patient interaction, so women face the greatest risk of detection when they come into contact with medical services. Online telemedicine services generally advise women that doctors cannot definitively detect whether a miscarriage has occurred naturally or has been induced with pills, so long as the pills are administered orally and not vaginally. Nonetheless, law enforcement increasingly "relies on medical professionals' reporting to the authorities women whom they suspect may have had a self-induced abortion" (Rowan, 2015, p.73). This includes reporting women who admit to having attempted abortion as well as women who present at hospitals with symptoms of miscarriage, but whom a doctor suspects has an attempted abortion. Prosecutions of women for self-induced abortion are on the rise in the USA (Diaz-Tello et al., 2018).[8] This is, in part, because medical staff are also criminally liable for reporting suspected abortions: medical staff who fail to report self-induced abortions have been charged with tampering with evidence, obstruction of justice, and failing to report an abortion (Ibid, 2018).

Advances in telemedicine abortion technology and the legal moves to curtail telemedicine abortion provide vivid examples of abortion politics as a struggle over the spatiality of state power. Activist efforts to jump scale and bridge space are met with reciprocal efforts by states to institute new obstacles that re-territorialize power, albeit at different scales. When

[8] Such criminal surveillance of pregnant women by medical staff has long been a part of the American 'War on Drugs' (see Roberts 1999).

lawmakers cannot ban abortion within a given state, they take steps to create laws that effectively prevent it by eliminating any legal spaces for clinics and doctors to operate. The state's ability to regulate clinic space is eroded when mobile clinics at sea can provide temporary access offshore and telemedicine technology can provide remote medical advice over long distances. States have responded by re-scaling state power in the space of the doctor-patient consultation, requiring in-person interaction and requiring the doctor-patient relationship to involve components of surveillance and appraisal of criminal activities. The surveillance of pregnant women and women presenting with miscarriages or symptoms of pharmaceutical abortion functions as yet another way that states can re-scale their power at the level of the clinic or the pregnant woman, when medical advances allow women to access abortion in autonomous ways that work outside of state laws and medical infrastructure. Changing patterns of abortion access develop through the contestation between pro- and anti-choice actors for the control of abortion-related spaces at multiple scales.

Conclusion

A political geography of abortion calls for an alternative conception of both abortion politics and political geography. Political geography must contend with abortion (among other natalist policies) as a primary site of state-making, where gendered power relations are enforced and opposed. Feminist scholarship on abortion access must reconceptualize it as a multi-scalar process of contestation and resistance that implicates a variety of legal, medical, and social domains, rather than as a right permitted or denied by the nation-state. Such a reconceptualization is needed because abortion's geography is currently undergoing a rapid transformation through the increased availability of abortion pills. While abortion is generally governed by a spatial logic of medical supervision and criminalization that restricts access in practice, medication abortion pills rupture this spatial arrangement by allowing for autonomous abortions in unsanctioned, non-clinic spaces facilitated by transnational networks. As a break with existing modes of spatial organization, it is evident that non-clinic abortion presents a challenge to traditional forms of regulation and meets with varying levels of state intervention to re-assert control over abortion, whether in an attempt to eradicate it from a territory entirely or to re-position it under state-sanctioned medical supervision.

This paper offers a political geography of abortion that accounts for some of the most important consequences of abortion's spatial transformation, but there is much more to be done. In concluding, it suggests three future directions for the study of transnational reproductive freedoms. As a starting point, we require a geographically informed account of how different states respond to flows of abortion pills and abortion travellers, because each political context is shaped by distinct geopolitical relationships, border regimes, diaspora communities, supra-national governance arrangements, and physical infrastructure for cross-border mobility by people and medical technologies. Each of these factors has major consequences for the abortion geographies that arise there. By extension, the impact of growing abortion pill flows raises the question of legal reform: the proliferation of abortion pills evidently undermines existing abortion restrictions, but we require more research to understand whether and where this provokes liberalization or further criminalization.

The next step for research in this area is to think beyond the law: although legal reform is a goal for pro-choice pill networks, it is only an intermediate step on the path to full decriminalization and demedicalization of abortion. A long-standing feminist reproductive health ethos on autonomy through self-managed care and knowledge sharing (see Murphy 2012) animates much of the movement and inspires its vision of the future for reproductive freedom. As restrictive laws have forced the creation of clandestine abortion pill networks, pro-choice feminist networks have come to the realisation that women who undertake self-managed abortion often experience more control over their experience than do women who access abortion through the formal healthcare system (Jelinska and Yanow, 2017, p.2). The forces transforming abortion access will continue to destabilize the political and medical frameworks that attempt to contain it. Extant models for legal abortion provision will also be transformed by the emergence of medication abortion, as the recent regulatory changes in England and Canada demonstrate: self-managed care outside of a clinical setting is not only a stopgap measure for women in states with highly restrictive laws.

Further research in this area should examine the technologies that facilitate transnational abortion geographies, thinking outside of existing literatures on fertility tourism and reproductive economies. Because much of the cross-border knowledge transmission on medication abortion takes place over the phone and internet, changing abortion geographies are increasingly bound up with other digital flows. This means that the governance of abortion implicates the emergent economies in digital and crypto-currencies, data privacy and online

security issues, state-led efforts at internet censorship, geo-fencing technologies, and 'dark web' drug markets. Research on these digital economies and technologies largely ignores abortion as a relevant site for study, but the present and future of abortion access makes use of a range of digital infrastructures to circulate information and material. Transformative advances in abortion access will be determined by political struggles about the cross-border regulation of information, technology, and mobility, rather than by further advances in reproductive medicine.

Works Cited

Aiken, A., Gomperts, R., & Trussell, J. (2017). Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(8), 1208–1215.

Aiken, A. R. (2018). Self-sourced online and self-directed at home: a new frontier for abortion in the United States. *Contraception*, *97*(4), 285–286.

Bazelon, E. (2014, January 19). The Dawn of the Post-Clinic Abortion. *The New York Times*. https://www.nytimes.com/2014/08/31/magazine/the-dawn-of-the-post-clinic-abortion.html

Berer, M. (2017). Abortion Law and Policy Around the World. *Health and Human Rights*, *19*(1), 13–27.

Berer, M., & Hoggart, L. (2018). Medical abortion pills have the potential to change everything about abortion. *Contraception*, *97*(2), 79–81.

Boseley, Sarah. (2017, September 27). Almost half of all abortions performed worldwide are unsafe, reveals WHO. *The Guardian*. http://www.theguardian.com/world/2017/sep/27/almost-half-of-all-abortions-performed-worldwide-are-unsafe-reveals-who

Brenner, N. (1999). Beyond state-centrism? Space, territoriality, and geographical scale in globalization studies. *Theory and Society*, *28*(1), 39–78.

Brickell, K., & Cuomo, D. (2018). Feminist Geolegality. *Progress in Human Geography*. Ahead of print.

Brown, L. A. (2013). *Contested Spaces: Abortion Clinics, Women's Shelters and Hospitals: Politicizing the Female Body*. Routledge.

Calkin, S. (2018). Healthcare, Not Airfare! Art, Abortion and Political Agency in Ireland. *Gender, Place & Culture*, Forthcoming: ahead of print.

Calkin, S. and Freeman, C. (2018). Trails and technology: social and cultural geographies of abortion access. *Social and Cultural Geography.* (Ahead of print).

Cao, W. (2015). Exploring 'Glorious Motherhood' in Chinese Abortion Law and Policy. *Feminist Legal Studies*, *23*(3), 295–318.

Cartwright, A. F., Karunaratne, M., Barr-Walker, J., Johns, N. E., & Upadhyay, U. D. (2018). Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search. *Journal of Medical Internet Research*, *20*(5).

Coeytaux, F., Hessini, L., & Allina, A. (2015). Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands. *Women's Health Issues*, *25*(6), 608–611.

Cox, K. R. (1998). Spaces of dependence, spaces of engagement and the politics of scale, or: looking for local politics. *Political Geography*, *17*(1), 1–23.

Diaz-Trello, F., Mikesell, M., & Adams, J. (2018). *Roe's Unifinished Promise: Decriminalizing Abortion Once and for All*. Berkeley CA: SIA Legal Team.

Dowler, L., & Sharp, J. (2001). A Feminist Geopolitics? *Space and Polity*, *5*(3), 165–176.

Elden, S. (2005). Missing the point: globalization, deterritorialization and the space of the world. *Transactions of the Institute of British Geographers*, *30*(1), 8–19.

England, K. (2003). Towards a feminist political geography? *Political Geography*, *22*(6), 611–616.

Erdman, J. (2017, November 1). The global abortion policies database—legal knowledge as a health intervention. https://blogs.bmj.com/bmj/2017/11/01/joanna-erdman-the-global-abortion-policies-database-legal-knowledge-as-a-health-intervention/

Farris, S. R. (2017). *In the Name of Women s Rights: The Rise of Femonationalism*. Duke University Press.

Fletcher, R. (2007). Reproducing Irishness: Race, Gender, and Abortion Law. *Canadian Journal of Women and the Law*, *17*(2), 365–404.

Fletcher, R. (2013). Peripheral governance: administering transnational health-care flows. *International Journal of Law in Context*, *9*(2), 160–191.

Fletcher, R. (2016). Negotiating strangeness on the abortion trail. In R. Harding, R. Fletcher, & C. Beasley (Eds.), *ReValuing Care in Theory, Law and Policy: Cycles and Connections* (pp. 14–30). London: Routledge.

Freeman, C. (2017). The crime of choice: abortion border crossings from Chile to Peru. *Gender, Place & Culture*, *24*(6), 851–868.

Gilmartin, M., & Kennedy, S. (2018). Mobility, migrants and abortion in Ireland. In *Crossing Troubled Waters: Abortion in Ireland, Northern Ireland, and Prince Edward Island* (Ahead of print). Prince Edward Island, Canada: Island Studies Press.

Gilmartin, M., & White, A. (2011). Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights. *Signs*, *36*(2), 275–280.

Gomperts, R. (2017, February). *Putting Abortion Pills in Women's Hands: Ships, Apps, Drones, and the Web*. Gruber Distinguished Lecture in Global Justice, Yale University. https://law.yale.edu/centers-workshops/gruber-program-global-justice-and-womens-rights/gruber-lectures/dr-rebecca-gomperts

Gomperts, R. J., Jelinska, K., Davies, S., Gemzell-Danielsson, K., & Kleiverda, G. (2008). Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. *BJOG: An International Journal of Obstetrics & Gynaecology*, *115*(9), 1171–1178.

Grossman, D., & Grindlay, K. (2017). Safety of Medical Abortion Provided Through Telemedicine Compared tith In Person. *Obstetrics and Gynecology*, *130*(4), 778–782.

Guttmacher Institute. (2018, June 19). Targeted Regulation of Abortion Providers. https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers

Haksgaard, H. (2017). Rural Women and Developments in the Undue Burden Analysis: The Effect of Whole Woman's Health v. Hellerstedt. *Drake Law Review*, *65*, 663–718.

Hartmann, B. (2016). *Reproductive Rights and Wrongs: The Global Politics of Population Control*. Haymarket Books.

Hooper, B. A. (2014). The Negative Effects of Cumulative Abortion Regulations: Why the 5th Circuit Was Wrong in Upholding Regulations on Medication Abortions (Planned Parenthood of Greater Texas Surgical Health Services v. Abbott) Comments and Casenotes. *University of Cincinnati Law Review*, *83*, 1489–1510.

IFPA. (2018). Abortion in Ireland: Statistics. Irish Family Planning Association. https://www.ifpa.ie/Hot-Topics/Abortion/Statistics

Jelinska, K., & Yanow, S. (2018). Putting abortion pills into women's hands: realizing the full potential of medical abortion. *Contraception*, *97*(2), 86–89.

Jones, R. (2016). *Violent Borders: Refugees and the Right to Move*. London New York: Verso.

King, L. (2002). Demographic trends, pronatalism, and nationalist ideologies in the late twentieth century. *Ethnic and Racial Studies*, *25*(3), 367–389.

Kligman, G. (1998). *The Politics of Duplicity: Controlling Reproduction in Ceausescu's Romania*. University of California Press.

Kreutzfeld, M. (2016). An Unduly Burdensome Reality: The Unconstitutionality of State Feticide Laws That Criminalize Self-Induced Abortion in the Age of Extreme Abortion Restrictions. *Women's Rts. L. Rep.*, *38*, 55.

Lambert-Beatty, C. (2008). Twelve Miles: Boundaries of the New Art/Activism. *Signs: Journal of Women in Culture and Society*, *33*(2), 309–327.

Leahy, P. (2018, April 12). Women in Ireland should not take abortion pills, says Harris. https://www.irishtimes.com/news/politics/women-in-ireland-should-not-take-abortion-pills-says-harris-1.3459882

Lindgren, Y. (2017). The Doctor Requirement: Grisworld, Privacy, and at-Home Reproductive Care. *Const. Comment.*, *32*, 341.

Luibheid, E. (2013). *Pregnant on Arrival*. University of Minnesota Press.

Luker, K. (1985). *Abortion and the Politics of Motherhood*. University of California Press.

Marston, S. (2000). The Social Construction of Scale. *Progress in Human Geography* 24 (2):219–42.

Marston, S., J. Jones, and K. Woodward. (2005). Human Geography without Scale. *Transactions of the Institute of British Geographers* 30 (4):416–32.

Mayer, T. (Ed.). (1999). *Gender Ironies of Nationalism: Sexing the Nation*. London ; New York: Routledge.

MacKinnon, D. (2011). Reconstructing scale: Towards a new scalar politics. *Progress in Human Geography*, *35*(1), 21–36.

Miller, R. (2013). *The Limits of Bodily Integrity: Abortion, Adultery, and Rape Legislation in Comparative Perspective*. Ashgate Publishing, Ltd.

Moore, A. (2008). Rethinking scale as a geographical category: from analysis to practice. *Progress in Human Geography*, *32*(2), 203–225.

Murtagh, C., Wells, E., Raymond, E. G., Coeytaux, F., & Winikoff, B. (2018). Exploring the feasibility of obtaining mifepristone and misoprostol from the internet. *Contraception*, *97*(4), 287–291.

Murphy, M. (2012). *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience*. Duke University Press.

Oberman, M. (2018). *Her Body, Our Laws: On the Front Lines of the Abortion War, from El Salvador to Oklahoma*. Beacon Press.

Paasi, A. (2004). Place and Region: Looking through the Prism of Scale. *Progress in Human Geography* 28 (4):536–46.

Pain, R. (2009). Globalized fear? Towards an emotional geopolitics. *Progress in Human Geography*, *33*(4), 466–486.

Petchesky, R. P. (1984). *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom*. Longman.

Peters, K. (2011). Sinking the radio 'pirates': exploring British strategies of governance in the North Sea, 1964–1991. *Area*, *43*(3), 281–287.

Peters, K. (2014). Tracking (Im)mobilities at Sea: Ships, Boats and Surveillance Strategies. *Mobilities*, *9*(3), 414–431.

Pratt, G., & Rosner, V. (2012). *The Global and the Intimate: Feminism in Our Time*. Columbia University Press.

Pruitt, L. R. (2007). Toward a Feminist Theory of the Rural. *Utah Law Review*, *2007*, 421–488.

Pruitt, L. R. (2008). Gender, Geography &(and) Rural Justice. *Berkeley Journal of Gender, Law & Justice*, *23*, 338–391.

Pruitt, L. R., & Vanegas, M. R. (2015). Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law. *Berkeley Journal of Gender, Law & Justice*, *30*, 76–153.

Reagan, L. J. (1998). *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973*. University of California Press.

Repo, J. (2015). *The Biopolitics of Gender*. Oxford: Oxford University Press.

Roberts, D. E. (1999). *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage.

Rowan, A. (2015). Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion. *Guttmacher Policy Review*, *18*(3), 70–76.

Sanger, C. (2017). *About Abortion: Terminating Pregnancy in Twenty-First Century America*. Cambridge, MA: Harvard University Press.

Sethna, C., & Doull, M. (2012). Accidental Tourists: Canadian Women, Abortion Tourism, and Travel. *Women's Studies*, *41*(4), 457–475.

Shah, N. (2012). The Territorial Trap of the Territorial Trap: Global Transformation and the Problem of the State's Two Territories. *International Political Sociology*, *6*(1), 57–76.

Sheldon, S. (1997). *Beyond control: medical power and abortion law*. Pluto Press.

Sheldon, S. (2016). How can a state control swallowing? The home use of abortion pills in Ireland. *Reproductive Health Matters*.

Sheldon, S. (2018). Empowerment and Privacy? Home Use of Abortion Pills in the Republic of Ireland. *Signs*, *43*(4), 823–849.

Side, K. (2016). A geopolitics of migrant women, mobility and abortion access in the Republic of Ireland. *Gender, Place & Culture*, *23*(12), 1788–1799.

Siegel, R. B. (2007). The New Politics of Abortion: An Quality Analysis of Woman-Protective Abortion Restrictions. *University of Illinois Law Review*, *2007*, 991.

Smith, N. (1992). Contours of a Spatialized Politics: Homeless Vehicles and the Production of Geographical Scale. *Social Text*, (33), 55–81.

Smith, N. (2004). Scale bending and the fate of the national. In E. Sheppard & R. McMaster (Eds.), *Scale and geographic inquiry: Nature, society, and method* (pp. 192–212). Malden, MA: Blackwell.

Smith, S. (2012). Intimate geopolitics: Religion, marriage, and reproductive bodies in Leh, Ladakh. *Annals of the Association of American Geographers*, *102*(6), 1511–1528.

Smyth, L. (2005). *Abortion and Nation: The Politics of Reproduction in Contemporary Ireland*. Abingdon: Routledge.

Solinger, R. (2005). *Pregnancy and Power: A Short History of Reproductive Politics in America*. NYU Press.

Statz, M., & Pruitt, L. R. (2018). To recognize the tyranny of distance: A spatial reading of Whole Woman's Health v. Hellerstedt. *Environment and Planning A: Economy and Space*, Ahead of print, available online.

Swyngedouw, E. (2000). Authoritarian Governance, Power, and the Politics of Rescaling. *Environment and Planning D: Society and Space*, *18*(1), 63–76.

Whitaker, R., & Horgan, G. (2016). Abortion Governance in the New Northern Ireland. In S. D. Zordo, J. Mishtal, & L. Anton (Eds.), *A Fragmented Landscape: Abortion Governance and Protest Logics in Europe*. New York: Berghahn Books.

Wilson, K. (2012). *Race, Racism and Development: Interrogating history, discourse and practice*. London ; New York : New York: Zed Books.

Winikoff, B., & Sheldon, W. (2012). Use of Medicines Changing the Face of Abortion. *International Perspectives on Sexual and Reproductive Health*, *38*(3), 164–166.

Woliver, L. R. (2010). *The Political Geographies of Pregnancy*. University of Illinois Press.

Women on Waves. (n.d.) "Guatemala 2017." Women on Waves. http://www.womenonwaves.org/en/page/6686/abortion-ship-in-guatemala--february-2017.

———. (n.d.) "Morocco 2012." Women on Waves. http://www.womenonwaves.org/en/page/3416/morocco-2012.

———. (n.d.) "Portugal 2004." Women on Waves. http://www.womenonwaves.org/en/page/3131/what-happened-in-portugal.

———. (n.d.) “Ship Campaigns.” Women on Waves. http://www.womenonwaves.org/en/page/2582/ship-campaigns.

Yang, Y. T., & Kozhimannil, K. B. (2017). Whole Woman’s Health v. Hellerstedt and the Current Implications for Abortion Access. *Birth*, *44*(1), 3–6.

———. (2016). Medication Abortion Through Telemedicine: Implications of a Ruling by the Iowa Supreme Court. *Obstetrics and Gynecology*, *127*(2), 313–316.