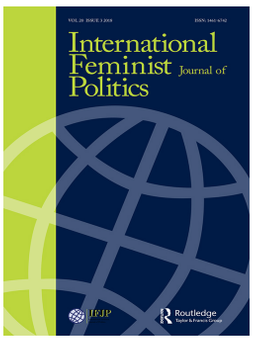

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Revolutionary pills? Feminist abortion, pharmaceuticalization, and reproductive governance

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Revolutionary pills? Feminist abortion, pharmaceuticalization, and reproductive governance

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This article was named the winner of the 2021 Enloe Award. The committee commented:

> This article embodies the spirit of the Enloe Award by helping us conceptualize self-medication abortion as a part of "reproductive governance," or how multiple actors beyond the state participate in providing and facilitating reproductive health care. This framework is crucial to understanding that access to abortion pills certainly can increase bodily autonomy, illustrating the effectiveness of grassroots feminist activists in meeting the needs of those who wish to terminate pregnancies. At the same time, the manufacturing and distribution of the pills also empower a whole host of actors that promote corporatized care, neoliberal agency, and population management. The article stood out to the committee as an original and exciting feminist intervention in global conversations about abortion access, and we commend the author for the strong theoretical framework, robust methodological approach involving ethnographic research in Mexico, and provocative insights.

ABSTRACT

This article examines two pills that are used to induce abortion in the context of feminist "accompaniment" for self-managed abortion practice in Mexico: misoprostol and mifepristone. For many feminist activists, abortion pills facilitate bodily autonomy in contexts where abortion is legally and socially criminalized. However, my ethnographic research demonstrates that pills are also "territorialized" through assemblages of pharmaceuticalized medicine, where private-sector and civil-society organizations have become protagonists in the provision of abortion health care and the governance of reproductive conduct. Feminist abortion accompaniment works to remedy these limitations by "reterritorializing" pills into new assemblages with practices grounded in principles of solidarity, justice, and bodily autonomy. It is only through these practices that abortion pills become truly revolutionary.

RESUMEN

Este artículo analiza dos medicamentos que se utilizan para inducir el aborto en el contexto del acompañamiento feminista en México: misoprostol y mifepristona. Para muchas acompañantes feministas, los medicamentos facilitan la autonomía en contextos donde el aborto es social y legalmente criminalizado. Sin embargo,

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mi investigación etnográfica demuestra que los medicamentos también se territorializan a través de ensamblajes de farmaceuticalización del aborto (assemblages of pharmaceuticalization), donde actores del sector privado y la sociedad civil se vuelven protagonistas tanto en la provisión de servicios de salud sexual y reproductiva como la gobernanza reproductiva. El acompañamiento feminista remedia estas limitaciones reterritorializando los medicamentos en nuevos ensamblajes con prácticas basadas en la sororidad, justicia y autonomía. Es sólo a través de estas prácticas que los medicamentos se vuelven verdaderamente revolucionarias.

KEYWORDS Self-induced abortion; accompaniment; reproductive governance; social marketing; Mexico

PALABRAS CLAVE Aborto con medicamentos; acompañamiento; gobernanza reproductive; marketing social; México

HISTORY Received 30 August 2021; Accepted 5 October 2022

Introduction

Increased access to abortion pills and information about how to induce an abortion safely at home has transformed how abortions are carried out in Mexico and beyond (Berer 2020; Prandini Assis and Erdman 2022). Self-induced abortion using medication (or "medication abortion")[1] has taken place in Latin America since the 1980s, and in recent years it has become a key strategy for many feminist abortion movements in the region to ensure women's[2] rights to abortion alongside lobbying for legislative change (Barbosa and Arilha 1993; Braine and Velarde 2022). In a practice called "accompaniment," feminist groups share information about how to use pills, facilitate access to them, and guide women through the process.

In Mexico, accompaniment occurs at the intersection of feminist grassroots politics and practices, and global sexual and reproductive health and rights (SRHR) programs. Abortion has been decriminalized for pregnancies up to 12 weeks in Mexico City since 2007, and more recently in nine other states (of 32).[3] However, it is criminalized under most circumstances elsewhere in the country, and functioning, good-quality, and economically accessible services are rare outside Mexico City, even in states where abortion is decriminalized (Veldhuis, Sánchez-Ramírez, and Darney 2022). The first accompaniment models in the country emerged in the early 2000s from coalitions between national and global non-governmental organizations (NGOs) and local feminist grassroots networks (Barbosa and Arilha 1993; Braine and Velarde 2022). Since 2018, sparked in part by the highly visible Argentinian abortion rights movement "the Green Tide" ("la Marea Verde"), there has been a dramatic increase in grassroots feminist organizing in Mexico. It is estimated that, in addition to four national NGO-led accompaniment networks, there are currently over 350 independent grassroots accompaniment collectives operating across the country. Women who seek

accompaniment support are diverse in terms of age and socio-economic and cultural backgrounds.

Accompaniment practice is facilitated by widespread access to the drug misoprostol, originally developed as a gastric ulcer medication but also used as a safe and effective abortifacient, which in Mexico can usually be bought over the counter without a prescription (Dzuba, Winikoff, and Peña 2013; Zamberlin, Romero, and Ramos 2012). More recently, the more restricted abortion pill mifepristone has also become available to feminists who practice accompaniment (*acompañantes*) through two global social marketing organizations (SMOs). Mifepristone is combined with misoprostol to create what is known in global health discourse as the "gold standard" of medication abortion (Winikoff and Sheldon 2012).

For many *acompañantes*, pills facilitate what they term "autonomous abortion," which allows new kinds of feminist subjectivities in resistance to patriarchal state systems that control women's bodies (Fernández Vázquez and Szwarc 2018). Similarly, studies beyond Mexico have focused on the ways in which transnational flows of information, technology, and medications have weakened state control and increased women's self-determination and reproductive freedom, as they turn to new methods of abortion to circumvent laws and regulations (Calkin 2019; Fernández Vázquez and Szwarc 2018; Jelinska and Yanow 2018; McReynolds-Pérez 2017). Yet, studies of self-induced medication abortion in Mexico, and elsewhere, have paid less attention to other actors and systems beyond legal frameworks that also influence how abortion is governed.

Neoliberal economic conditions (such as the deregulation of economies and the liberalization of trade barriers, which have made it easier for corporations to operate across nation-state borders) have increased the mobility of abortion pills and information (Calkin 2019). Yet, neoliberalism has also signaled transformations in the ways in which populations are governed "beyond the state" (Aretxaga 2003; Rose and Miller 2010). Actors and institutions such as NGOs and private corporations have increasing power in the management of populations (Bernal and Grewal 2014; Morgan and Roberts 2012). Neoliberal modes of governance also shape subjectivities as they produce entrepreneurial and self-regulating individuals (Gershon 2011; Rose 1999). Anthropologists Morgan and Roberts (2012) have proposed the term "reproductive governance" to describe the multiple and diverse arrangements of actors, discourses, institutions, and mechanisms that influence population practices and reproductive conduct. Scholars have shown how reproductive governance is operationalized through interactions between clinical staff and patients in government-run abortion clinics in Mexico City (Krauss 2018; Singer 2017). Singer (2018) argues that accompaniment practice for self-induced abortion is a type of direct action that challenges reproductive governance by removing abortion from clinical spaces.

My research builds on these analyses by asking how self-induced abortion may also be enmeshed in reproductive governance mechanisms.

I use the analytic of "assemblage" to interrogate the ways in which the abortion pills mifepristone and misoprostol produce different meanings, possibilities, and effects across "divergent and antagonistic terrains" (Murphy 2012, 12). For *acompañantes*, pills allow new kinds of feminist abortion care and subjectivities. However, they are also part of globalizing capitalist formations and SRHR programs concerned with population management, which promote "responsible" reproductive conduct through individualized neoliberal self-steering agency.

While assemblage thinking has origins in the philosophy of Deleuze and Guattari (1987), I am influenced by the work of anthropologists Collier and Ong (2003), who use the term "global assemblages" to interrogate particular formations on an ethnographic scale. For Collier and Ong (2003), assemblages describe the ways in which globally circulating ideas, matter, and relations are brought together and "territorialized" in specific contexts.[4] In my research, the relevant elements that make up assemblages include SRHR NGOs and SMOs and their political and administrative practices, global health agencies concerned with policymaking such as the World Health Organization (WHO), private philanthropic donors and their agendas, transnational pharmaceutical companies, local pharmacy outlets, feminist activists, and the abortion pills themselves.

These assemblages affect misoprostol and mifepristone in different ways. I describe these divergent effects by referring to the ways in which assemblages can be "territorializing" and "deterritorializing" (Deleuze and Guattari 1987), which in my analysis speaks to power relations. When assemblages are territorializing, certain practices, discourses, and meanings become fixed and rigid, closing down other possibilities for action. The trope of "gold standard" is an example of a highly territorialized assemblage that brings together universalizing global policies, protocols, and discourses about biomedical practice, without considering the diverse social and political contexts in which abortions take place. Assemblages can also be deterritorializing, opening opportunities for new meanings and courses of action. For example, activists use a gastric ulcer medication, misoprostol, that is easily available over the counter to circumvent laws and regulations and to create opportunities for abortion access. Misoprostol is "reterritorialized" by entering a new assemblage that includes accompaniment practice, protocols, and bodies to transform into a safe abortifacient. I argue that the ways in which misoprostol and mifepristone are territorialized through different assemblages affects how easily (or not) they can facilitate *acompañantes'* desires for autonomous abortion. Mifepristone is more difficult to reterritorialize due to its entanglement in logics of reproductive governance.

My analysis using assemblages expands discussions of self-induced abortion, which is often presented as uniformly positive and progressive, as power is diverted away from doctors and the state and into the hands of women. Using the case of Mexico, I show how power *is* shifting through medication abortion, but not only into the hands of women. Rather, it is dispersed, operationalized, and contested in complex assemblages of actors including NGOs, SMOs, philanthropic donors, pharmaceutical companies, and *acompañantes*.

I begin by describing my first encounters with misoprostol while observing accompaniment practice and information shared online by feminist activists. I then trace how mifepristone and misoprostol are produced through assemblages of pharmaceuticalized medicine and global health, including the privatization of basic health care and the control of mifepristone distribution channels by SMOs that circulate pills as part of SRHR programs. I then describe how *acompañantes* reterritorialize misoprostol through feminist practices and my own experience of buying the pills in pharmacies. I conclude by exploring the implications of the centralized control of mifepristone in terms of the governance of women's reproductive conduct and how it affects their bodily autonomy.

The article is informed by two and a half years of fieldwork (from 2019 to 2021) in Mexico using a feminist activist ethnographic (FAE) methodology, a multi-method form of social inquiry (Craven and Davis 2013). FAE offers a framework for "counter-visions" to neoliberal governance by centering the positionality and contributions to knowledge production of feminist activists who work for social change (Craven and Davis 2013, 7). I spent several weeks shadowing *acompañantes* in Tijuana in the northern Mexican state of Baja California and carried out interviews with 28 *acompañantes* who work across 14 states and online.[5] The *acompañantes* whom I interviewed engaged with institutional actors such as NGOs and SMOs in different ways. Some were part of accompaniment networks coordinated by NGOs and reported certain information about the women whom they accompanied as part of program evaluation. Others worked independently of NGOs but relied on SMOs for the supply of mifepristone.

Part of the challenge of this kind of ethnographic work was tracing the globalizing connections, interactions, and flows of resources, actors, and information, and how they affected practices of *acompañantes* in situ. This required an iterative approach, moving between different sites and scales, both physical and virtual (Erikson 2011). I went from feminist grassroots spaces, to national pharmacy outlets, to multinational NGO and SMO offices. In addition to *acompañantes*, I interviewed representatives from five national and global SRHR NGOs and two global SMOs, a private abortion clinic administrator, and a representative from a pharmaceutical company, all of whom were involved in either the registration, supply, and distribution of mifepristone and misoprostol in Mexico, or in advocacy to improve access

to abortion pills. I conducted visits to pharmacies, borrowing a technique used by feminist NGOs called "mystery shoppers" ("*usuarias simuladas*"). Developed in the private sector to monitor customer service, the technique has been adopted by feminist NGOs in Mexico since the 1990s to monitor public sexual and reproductive health clinics to ensure that young people and women are not refused services. I used the technique to see what it was like to buy misoprostol and how much it cost, and to track the brands sold in different pharmacies. I visited eight different pharmacies in Mexico City.[6] I also monitored 20 feminist social media accounts and participated in several WhatsApp[7] groups in which activists shared information about abortion pills. Finally, I collated online data about the commercial registration of different mifepristone and misoprostol products on the database of the national regulatory body for the control of health products, the Comisión Federal para la Protección contra Riesgos Sanitarios (Mexican Federal Commission for Protection against Health Risks (COFEPRIS)) (Table 1).

Encountering abortion pills: feminist revolution or "Big Pharma"?

At the center of Mexican feminist accompaniment projects for bodily autonomy is a seemingly banal gastric medication that can be widely bought over the counter at pharmacies: misoprostol. Talking with *acompañantes* and observing their political discourse online, I became interested in how they venerated misoprostol, imbuing it with agentic powers in an example of what Fraser, Valentine, and Roberts (2009, 124) call "living drugs." *Acompañantes* shared information from social media accounts created with the names of fictitious personalities such as "Miss Oprostol" and "Hija de tu Misoprostol Padre."[8] They provoked anti-abortion trolls by posting tongue-in-cheek pictures of the Virgin Mary holding generic-brand misoprostol. Using culturally evocative language and imagery, *acompañantes* implied that abortion pills were "revolutionary." For example, Figure 1 shows an image shared by an accompaniment collective of a woman soldier from the 1910 Mexican Revolution, complete with a bandolier of misoprostol tablets. These kinds of images mirror discourse in public health literature and popular media about the "revolutionary" potential of abortion pills, particularly misoprostol (Suh 2021).

Though pills may "perform the abortion" (Berer 2020, 46), it was clear while observing *acompañantes* support women in person that the safety and efficacy of pills are produced within assemblages that incorporate protocols, knowledge, and actions that are part of accompaniment practice. Women typically contacted accompaniment groups over the phone or online through social media. *Acompañantes* then responded with a series of questions related to the pregnancy to gauge whether a medication abortion

Table 1. Brands of misoprostol and mifepristone available in Mexico (Comisión Federal para la Protección contra Riesgos Sanitarios (COFEPRIS) 2020).

Brand	Company that registered it in Mexico	Country of manufacture	Company that makes the active pharmaceutical ingredients (API)	Company that makes the medication	Medical indication
Misoprostol					
Apostecsol	Protein, SA de CV	Canada	Apotex Pharmachem Inc.	Apotex Inc.	Gastric ulcers
Taneciprol	Not listed	China	Everlight Chemical Industrial Corporation (Taiwan)	China Resources Zizhu Pharmaceutical Co., Ltd	Gastric ulcers
Tomispral	Laboratorios Vanquish, SA de CV	Mexico	Yonsung Fine Chemicals Co., Ltd (Korea)	Laboratorios Vanquish, SA de CV	Gastric ulcers
Artrotec	Pfizer, SA de CV	UK	Piramal Healthcare UK Limited	Piramal Healthcare UK Limited	Gastric ulcers
Cytotec	Pfizer, SA de CV	UK	Piramal Healthcare UK Limited	Piramal Healthcare UK Limited	Gastric ulcers
Cyrux[a]	Serral, SA de CV	Korea and Mexico	Yonsung Fine Chemicals Co., Ltd (Korea)	Yonsung Fine Chemicals Co., Ltd/ Serral, SA de CV	Gastric ulcers
Mifepristone					
Zacafemyl	Monticello Drug Company, SA de CV	China	Zhejiang Xianju Pharmaceutical Co., Ltd	Zhejiang Xianju Pharmaceutical Co., Ltd	Fibroids
Mefaprix	Biopharmex, SA de CV	Spain	Crystal Pharma SAU (Spain)	Laboratorios León Farma, SA	Antiprogestin

[a]Cyrux is the base product for own-brand misoprostol sold at Farmacias del Ahorro, Farmacias San Pablo (Aurax), Farmacias Similares (Cyrax), Walmart (Medimart), Superama (Medimart), Farmacias Guadalajara, and Farmacias Yza.

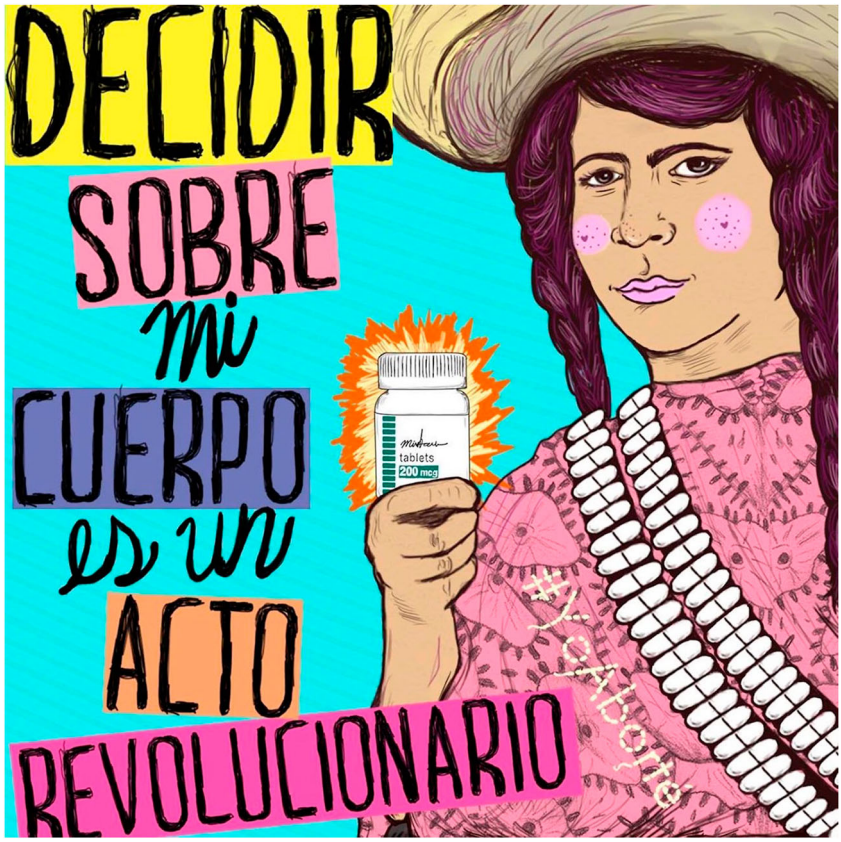

Figure 1. Image of a Mexican woman revolutionary soldier, complete with a bandolier of misoprostol tablets, shared on a feminist accompaniment group's Facebook page. The text reads: "To decide about my body is a revolutionary act" (Ddeser jóvenes Quéretaro 2019).

was viable. All of the *acompañantes* whom I observed and interviewed cited the WHO protocols that guide their practice. They explained the dosages required depending on the duration of the gestation period.[9] Accompaniment also included talking to women about the law, their rights, how the pills worked, the physical process that would take place, how to manage pain, and what to look out for as warning signs. As women took the pills, *acompañantes* remained in contact to ensure that the process was completed safely and to answer any questions. Sometimes, if women were concerned about the amount of blood, they sent pictures taken on their phones so the *acompañantes* could reassure them that everything was proceeding as normal.

Miraculous though the pills seemed, revolutionary narratives about abortion pills have been tempered by critiques of pharmaceuticalized medicine,

including the ways in which it is inseparably linked to the capitalist expansion of the pharmaceutical industry, neoliberal reformations of the state, and the responsibilizing of individuals for their own health care (Bell and Figert 2012; Biehl 2007; Lie-Spahn 2019; Suh 2021). When speaking with *acompañantes*, I found that many had also been thinking about and debating similar critiques. One *acompañante* from Mexicali in Baja California told me:

> I have questioned myself about the power we give to the big pharmaceutical companies with the use of misoprostol as the "great panacea." Of course, it helps us a lot, it gives women other opportunities, but it still does not sit well with me (*no me deja de hacer ruido*). [Pharmaceutical companies] do not do anything for free (*no dan paso sin huarache*),[10] so what we are looking for [as feminists] also benefits the companies that distribute misoprostol, and they obviously know what we are using it for.

The concerns of this *acompañante* – that promoting the use of pills was boosting the profits of pharmaceutical companies – led me to think about the tensions between the globalizing forces that make pills possible and feminist projects for bodily autonomy through abortion care. Consequently, stuck in my apartment at the beginning of the COVID-19 pandemic, I turned my attention to processes beyond the accompaniment activities of feminists, to the for-profit and non-profit actors and systems that are involved in the supply and distribution of abortion medication. I decided to "follow the pills" (Marcus 1995).

Tracing abortion pills through assemblages of pharmaceuticalized medicine and global SRHR programs

Following the pills proved to be a challenging ethnographic task. As Erikson (2015, s306) found when "following the money" in global health finance, the operationalization of global flows of abortion-related resources and products also occurs in "a normatively secretized social space." The secrecy surrounding abortion pills is related to both economic factors (protecting commercial interests) and moral controversies (avoiding scandals). In an interview in August 2020, a representative of an advocacy coalition that works to improve supply chains confirmed the difficulties that I faced when researching these issues: "In the end it's a business. It's difficult; it's delicate. All this information is delicate; it's sensitive. Everyone is walking on tip toes with ballet slippers on because [sharing information] can cause problems." This image of tiptoeing around in ballet slippers would return to me again and again when I interviewed representatives of SMOs and others involved in the supply and distribution of mifepristone and misoprostol. I soon came to realize that investigating (and then writing about) the political and economic life of abortion pills was a kind of "dangertalk" – risky and difficult to do, but politically important. I borrow the term "dangertalk" from Martin et al.

(2017), who use it to describe the complex narratives of abortion providers' experiences that run counter to normative pro-choice movement discourse. In my research, dangertalk is risky because it involves critiquing systems that provide women with one of the only viable avenues to abortion, as well as revealing information that may be politically misused by anti-abortion actors. However, from a feminsit perspective, tracing these assemblages is politically important because it interrogates who has power in these systems versus whose lives are most affected (Erikson 2015).

While monopolies held by pharmaceutical giants occupy the public imagination as emblematic of "Big Pharma," the "pharmaceutical assemblages" (Kloos 2017) that produce mifepristone and misoprostol are more complex. Actors in the production and distribution of abortion pills include what Hayden (2007, 476) calls "nonhegemonic or 'Little Pharma' – small domestic generics labs, pharmacy chains and other actors and institutions." The generic pharmaceutical industry is a significant force in the expansion of pharmaceuticalized medicine in Mexico (Hayden 2007). The other major actors in the global distribution of pills, particularly mifepristone, are SMOs, philanthropists, and SRHR NGOs, all of which operate through a rhetorical framework of guaranteeing access to abortion as a human right.

SMOs operate in a hybrid space between civil society and the private sector. They include for-profit and non-profit actors that use market mechanisms to promote and distribute reproductive health products and services, often at subsidized rates, through global SRHR programs. SMOs use a technique called "social marketing," which includes campaigns and capacity-building activities to "create" markets for reproductive health products. The social impact of SMOs is measured in terms of "behavior change," often through an indicator that tracks the take-up of long-acting reversible contraception. These "entanglements" (Murphy 2012) of techniques for biopolitical management with market mechanisms produce different effects when brought into relationship (and tension) with accompaniment practices.

Globalizing models of pharmaceuticalized abortion care rely on the assumption that rational market techniques deliver optimal health care and that there is a natural pipeline that moves pills effortlessly from production to distribution, to doctors who prescribe them, and then finally to patients who ingest them. Yet, mifepristone and misoprostol are territorialized through different assemblages of for-profit pharmaceutical companies, state regulatory bodies, global health policies and actors, market forces, moral agendas, and citizen demands that affect the two drugs differently. As Hardon and Sanabria (2017, 118) point out, no pharmaceutical object precedes interpretation; "molecules are not 'discovered' but made and remade" and constantly evolve in relation to their context.

Mifepristone: the "gold standard"

Mifepristone, originally known as RU-486, is controlled through highly territorialized assemblages of regulation and monopoly. Developed in France in the 1980s specifically as an abortifacient, mifepristone blocks the receptors that receive progesterone, the hormone that maintains a pregnancy (Clarke and Montini 2016). From the beginning, mifepristone's development was "fraught with drama" due to its controversial nature (Ulmann 2000, 117), and it was only through the involvement of NGOs, philanthropists, and multilateral organizations that Roussel Uclaf, the pharmaceutical company behind its development, was convinced to commercialize it (Baulieu and Rosenblum 1991; Ulmann 2000).

Mifepristone is the perfect example of a commodity that proves that markets are not naturally rational. Rather than a seamless pipeline from production to consumption, the path of mifepristone is full of obstacles. Globally, abortion laws and national regimes of drug regulation continue to control the registration of mifepristone and determine that it is excessively surveilled once registered. At the time of my research, mifepristone was only available in six of 14 countries in Latin America.[11] In Mexico, mifepristone was registered with the regulatory body COFEPRIS as a fibroid medication in 2011, after two failed attempts. At the time of my research, there were only two mifepristone products registered. The first, Zacafemyl, is a Chinese generic imported by a small Mexican pharmaceutical company that was involved in lobbying efforts to decriminalize abortion in Mexico City in 2007.[12] In an interview in September 2020, the company's director described the process of registering mifepristone. Along with the dossier of scientific evidence about the drug's safety and efficacy, the company presented arguments about how mifepristone would "advance" the Mexican health system by guaranteeing health care to Mexican women using the latest technology. As I interpret it, "gold standard" in this case was not only related to mifepristone's claimed higher rates of efficacy, but also to concepts of biotechnological advancement linked to projects of "modernization" and "development" with regard to reproduction.

In 2013, another mifepristone product, Mefaprix, was registered by a global SMO as part of their SRHR programs and clinical operations in Mexico. A second SMO entered into an agreement to distribute this same product while trying to register their own.[13] While globally it is common for SMOs to also register what is called a "combipack" – a combined presentation of misoprostol and mifepristone – none have, as yet, done so in Mexico. Mifepristone is registered as a Category Six pharmaceutical, the highest level of regulation, which means that its sale is restricted and monitored by the government and so it is rarely stocked by pharmacies. Doctors are often unwilling to prescribe mifepristone due to their own prejudices, creating

further obstacles. All of these elements coalesce to create a market for mifepristone that is extremely volatile and unattractive for most for-profit pharmaceutical companies. Therefore, the supply of mifepristone globally relies heavily on the distribution networks of a limited number of NGOs and SMOs that depend on a combination of philanthropic support and consumer paid models to remain economically viable. These entities often operate with exclusive contracts with a limited number of pharmaceutical companies that produce mifepristone in China, India, and Europe, generating monopolistic conditions. Over the last decade, NGOs that coordinate accompaniment networks as part of SRHR programs and SMOs have increasingly promoted the use of the combined regime among *acompañantes* as best practice, while also being the only suppliers of mifepristone available to *acompañantes* in Mexico.

When I interviewed a commercial director of one of the SMOs that distribute mifepristone in Mexico, he spoke about the social advantages of using market models. He argued that the way to improve health outcomes was by expanding markets:

> It's not a big market [for mifepristone], but it could be. I don't mean in the sense that it could be a juicy market (*mercado jugoso*), just that it could be bigger and get to more people and doctors who benefit from these products.

However, these benefits are framed by SMOs primarily in terms of meeting objectives more closely aligned with population programs, such as increased take-up of contraceptive methods, rather than enhancing reproductive autonomy. The director told me:

> We are a company that is focused 100 percent on family planning. What I mean is 99 percent of our efforts are focused on the use of contraceptives. We [sell abortion medication] because it is the best way to reduce maternal mortality.

While reducing maternal mortality is a worthy goal, the director's comment is an example of the ongoing stigma of abortion in global SRHR policy (Suh 2018). Social marketing is deeply embedded in the rationalist paradigm of global SRHR programs that stigmatizes women who seek abortions for failing to manage their own reproductive conduct (Krause and De Zordo 2012). Abortion is framed as a last resort, necessary only to prevent death. The combination of market logics and global health policies that stigmatize abortion have a territorializing effect on mifepristone, making it more difficult for the drug to enter new assemblages for feminist abortion practices.

Misoprostol: the "generic shapeshifter"

Misoprostol, on the other hand, was not developed as an abortifacient, making it more difficult for regulatory regimes to control. It was originally

synthesized by US pharmaceutical company G. D. Searle & Company (now part of Pfizer Inc.) and marketed under the brand name Cytotec as a medication for gastric ulcers caused by non-steroidal anti-inflammatory drugs used in the treatment of arthritis. However, misoprostol also has uterotonic properties, meaning that it causes the cervix to soften and the uterus to contract. Taken in different doses, it can induce labor or an abortion, or stop postpartum hemorrhaging (Allen and O'Brien 2009). It is a single drug that has multiple effects in relation to the body.

By the 1990s, activists and NGOs knew of the underground use of misoprostol and began developing informal protocols for self-induced abortion (De Zordo 2016; Fernández Vázquez and Szwarc 2018). Misoprostol developed a reputation as a "pharmaceutical outlaw," generating controversy among NGOs and health professionals regarding who should be able to use it and for what means (MacDonald 2020, 2). Some global public health NGOs worked to formalize the safe use of misoprostol by testing protocols through scientific research (MacDonald 2020). However, pharmaceutical companies that held the patent for misoprostol distanced themselves from the drug's use as an abortifacient, refusing to register it for any reproductive health indications to avoid the political controversies and boycotts that had occurred with mifepristone (Hale and Zinberg 2001; MacDonald 2020). Global health advocates criticized companies for not testing and registering misoprostol as an abortifacient (Weeks, Fiala, and Safar 2005). Yet, my research shows that misoprostol remains accessible in part because it is territorialized as a gastric ulcer medication and so avoids excessive regulation, but corporations continue to manufacture it at levels that indicate that it is for the abortion market.

Cytotec, the original brand of misoprostol, has been sold in Mexico since the 1980s. After the decriminalization of abortion in Mexico City, generic brands began to appear on the market. Misoprostol is available and economically accessible in part because of Mexico's booming generics market. Generic pharmaceuticals are widely popular, facilitating access to cheap health care, and make up 40 percent of the drug market in Mexico (Carranza and María 2020, 203). At the time of my research, there were five generic misoprostol products registered with COFEPRIS (Table 1). While the active pharmaceutical ingredients come from overseas, most misoprostol is produced in Mexico by one generic pharmaceutical laboratory whose product is sold under several different brands, including pharmacy-own brands for several major chains. There is also one brand, Taneciprol, registered by an SMO, but it has a much smaller market share and is mostly distributed through the same channels as mifepristone.

All misoprostol products on the Mexican market are registered for use as gastric ulcer medication, making it a Category Four medication. This means that though misoprostol technically requires a prescription, it is common

practice for pharmacies to sell it without one.[14] This enables the drug to circumvent "moral and regulatory blockages" (Hardon and Sanabria 2017, 126). Less regulation, a booming generics market, and pharmacies that do not usually ask for prescription allow misoprostol to be easily reterritorialized into new assemblages with feminist practices and protocols for self-induced abortion.

Reterritorializing misoprostol through accompaniment practice

The purpose of tracing global assemblages is to find the points that intersect with people's everyday lives and affect their lived experiences (Erikson 2011). How do these economic and political processes that produce mifepristone and misoprostol intersect, or create tensions with feminist goals for accompaniment practice and the lived experiences of the women whom they supported? To answer this, I asked *acompañantes* how they obtained the pills and how they facilitated women's access to the pills. I also used this knowledge to visit several pharmacies to buy misoprostol myself.

Many *acompañantes* whom I interviewed preferred misoprostol over the combined regime with mifepristone due to misoprostol's affordability and the relative ease with which women could buy the product over the counter in pharmacies. Women's ability to buy pills themselves was important for practical reasons; it was quicker and easier than waiting for an SMO to send mifepristone, which is important in a time-sensitive process like abortion. One *acompañante* whom I shadowed in Tijuana explained:

> If a woman contacts us at 7pm and there is a pharmacy open until 9pm, she can go in that moment and buy the pills. She doesn't need a prescription – she can do it without intermediaries, including without us [*acompañantes*].

It was also important for political reasons. *Acompañantes* argued that it was easier to decentralize control of the information and resources required to induce an abortion by using misoprostol, which in turn increased women's bodily autonomy. For example, when I spent time shadowing *acompañantes* in Tijuana, I participated in what they called "brigades" ("*brigadas*") to disseminate information about how to induce an abortion at home using misoprostol. The collective's work was guided by the slogan "Any number of abortions, any number of weeks, any number of tries" ("*N abortos, n semanas, n intentos*"). They aimed to destigmatize abortion by actively promoting the practice as a right and an act of bodily autonomy under any circumstances. They created small fold-out wallet-sized leaflets that contained clear step-by-step instructions about how to induce an abortion using misoprostol. The leaflet's design was simple, containing only text so that it could be printed zine-style cheaply in black and white on any

photocopier. At least twice a month, the collective organized a brigade to hand out leaflets in public places, including in central plazas, in shopping centers, and at bus stops. The activists would only hand leaflets to women and would sometimes give them more than one, asking them to leave the rest in a public place or pass them on to friends and neighbors. The collective used the brigades to reach more marginalized areas of the city where people did not have reliable access to the internet. They also served to reach people outside feminist social circles and beyond the limiting algorithms of social media. Brigades were a common strategy among other accompaniment collectives whose members I interviewed. One collective in the southern state of Chiapas frequently traveled to Tapachula, a town on the border with Guatemala, to hand out protocols to Central American and Haitian migrant women. An *acompañante* from the collective told me that handing out information on a small slip of paper meant that women could easily carry it with them on their journey north towards the United States and pass it on to others along the way. Women could go to the pharmacy for misoprostol themselves, or they could contact *acompañantes* if they wanted, or needed, support.

To understand more about women's experiences of obtaining abortion pills, I used the knowledge obtained from *acompañantes* to visit pharmacies and buy misoprostol myself. Cytotec and at least one other generic brand were available in all of the pharmacies that I visited. All pharmacy assistants knew without checking their inventory system that they had misoprostol in stock and turned directly to the shelf where it was stored behind the counter. Prices for generic brands ranged from 417 to 629 Mexican pesos (20 to 31 USD), a marked difference to the original brand Cytotec at 2,531 pesos (126 USD). In Farmacias Similares, the largest generic-brand pharmacy in Mexico, the pharmacy assistant also told me that on Mondays they had a discount on misoprostol, reducing the price to 350 pesos (17 USD). Only one assistant, in a pharmacy inside a major supermarket, asked me for a prescription. As misoprostol is taken daily when used to relieve gastric ulcers, it is sold in large quantities, usually 28 tablets per pack (Weeks, Fiala, and Safar 2005). Later, an *acompañante* from Campeche told me that one packet of misoprostol contained enough for two "kits" – that is, two doses of 12 pills each to induce two abortions. This meant that should a first attempt with 12 pills be unsuccessful, a woman could try a second time with some of the additional pills. It also meant that if a woman did not need all of the pills, she could donate them to someone else. Donating unused pills was common and politically important for many *acompañantes*, who saw it as a way to build solidarity and redistribute resources to women who needed them. Posts that facilitated pill sharing were common on feminist social media pages, either by *acompañantes* looking for unused misoprostol or women offering some for donation. *Acompañantes* also shared information about pharmacies where the pills were cheap, pharmacies where they

Figure 2. Image titled "How much does Misoprostol cost?" showing pharmacy and supermarket logos and corresponding prices, shared on a feminist accompaniment group's Facebook page (Socorristas y Acompañamiento Feminista LATAM 2020).

could be bought without prescription, which days had discounts, and which pharmacies were selling pills at elevated prices or refusing to sell them without a prescription. Groups acted as watchdogs, both monitoring pharmacies and sharing information that helped to keep misoprostol accessible. Figure 2 provides an example of this, showing a Facebook post by a group comparing costs of misoprostol across outlets.

Misoprostol was very easy to obtain in most of the pharmacies that I visited. While it is likely that buying it was easier for me because I am a white, cis-gendered woman in my late 30s, and I went to pharmacies in mostly middle-income areas of Mexico City,[15] it is easy to buy misoprostol in most contexts according to most *acompañantes* whom I interviewed. However, sometimes there were barriers for young women, Indigenous women, or women in rural contexts or more conservative states. For

example, an *acompañante* from an Indigenous community in Oaxaca state told me that women whom she accompanied had to travel to the nearest city as misoprostol was not sold in any of the local pharmacies. A representative of a reproductive health supplies advocacy network also shared with me that a middle-aged woman is more likely to buy pills for gastric ulcers. If it is a young woman, it is probable that the intended use is for abortion and so pharmacists sometimes refuse. In these cases, *acompañantes* recommended that women ask a male friend or partner to try. They also encouraged women in urban areas to order misoprostol using a courier service. Having a (usually male) courier pick up misoprostol at the pharmacy meant no questions were asked. In rural contexts, *acompañantes* often sent pills to women directly.

Misoprostol was more easily reterritorialized than mifepristone as a tool for bodily autonomy through accompaniment practice, including activities to decentralize control of information and sources for pills. When there were barriers, part of accompaniment practice was to overcome these by sharing information and resources, including pills. For *acompañantes*, bodily autonomy was also about justice, including addressing the ways in which pharmaceuticalized medicine reproduces systemic inequalities and intensifies surveillance over some bodies more than others. While it is difficult to tackle these issues through grassroots practices alone, accompaniment served to mitigate some of the effects through collective care and economic solidarity.

Territorializing mifepristone through assemblages of reproductive governance

Mifepristone was also used by many *acompañantes*. However, the ways in which it is territorialized through assemblages of SRHR programs and market rationalities generated friction with some *acompañantes*' political projects for bodily autonomy. At the beginning of my research (in 2019), most of the *acompañantes* whom I interviewed who used the combined regime had access to mifepristone through NGO-led abortion programs in partnership with SMOs. Most did not supply women seeking abortion directly with mifepristone but rather acted as intermediaries between them and SMOs. *Acompañantes* provided information and support, but women paid for the pills directly and the medication was delivered to them in what *acompañantes* called a "kit," which contained the exact dose of mifepristone and misoprostol, a pregnancy test, an extra-absorbent sanitary pad, and some ibuprofen. The logistics of distributing kits were centralized to protect *acompañantes* in criminalized contexts, yet this also sometimes caused delays when pills got lost en route or took days or weeks to arrive. In such a time-sensitive situation, this generated anxiety for women and *acompañantes*, or sometimes resulted in women having to travel to Mexico City if

it was a later-term pregnancy.[16] If the women were in remote communities, *acompañantes* often received the packages themselves and sent them on via local transport, which some felt put them at legal risk.

Some *acompañantes* were critical of the NGO monopoly on mifepristone because they felt that it contradicted feminist values of decentralizing control of the resources to make abortions possible and had implications for women's bodily autonomy. One *acompañante* from the city of Oaxaca explained to me in an interview:

> Autonomous abortion is when you have an abortion with a companion/peer (*compañera*), not an institution. Even among feminist *acompañantes* and networks, sometimes there isn't total autonomy – for example, when a woman has to buy the kit specifically from [an SMO]. I don't accompany [abortions with mifepristone] because I feel that it takes away a woman's autonomy … Autonomous abortion means that there isn't an organization in between that conditions it (*que lo condicione*) or makes [it] possible.

This *acompañante* referred to a kind of conditionality that mediated women's access to mifepristone and impeded their reproductive autonomy. I later came to understand this conditionality as a mechanism of reproductive governance based on economic exchange.

At the time of my research, a kit cost 500 pesos (approximately 25 USD) from SMOs. The representatives of SMOs whom I interviewed called this a "recuperation cost" ("*cuota de recuperación*"), as it was lower than the market price. However, some *acompañantes* felt that this price was still elevated and prohibitive for many women with limited economic resources such as high-school students and women from Indigenous or rural communities or low-income urban areas, particularly if they did not have a support network of friends or family who could contribute or lend money. Sometimes, NGOs paid the fee for the medication for women on a case-by-case basis as part of philanthropically supported abortion programs. However, this put *acompañantes* in the position of gatekeepers, determining who could afford an abortion or who was deserving of free or discounted pills.

Among NGO-led accompaniment networks, this vetting process was often couched in language of "empowerment." By asking women to pay, even if it was difficult for them, NGO representatives whom I interviewed felt that women were given the chance to activate their own resources and networks to find the money for the pills, helping them to become what they termed "co-responsible" in the process. They saw this as a feminist value, as it avoided turning accompaniment into an act of paternalistic charity. However, encouraging women to pay for mifepristone was also connected to moralizing discourses about appropriate reproductive conduct. For example, if women had more than one abortion, this was labeled as "recidivism" ("*reincidencia*") and was discouraged. Economic disincentives meant that women were less likely to return for another abortion. Such policies

imply that women should take up contraception as an ideal outcome without taking into consideration context or personal choice.

NGO discourses and practices that encouraged women's reproductive responsibility through economic means are part of the rationalist paradigm of global SRHR social marketing programs that promote "behavior change." Controlling one's own reproductive conduct by preventing pregnancy is promoted as key to being a self-actualized and empowered individual. Consistent with neoliberal governmentality, institutions "govern at a distance" by influencing behavior through apparent freedoms (Rose 1999, 49). Rather than being subjected to centralized state power through legislative mechanisms, individuals are given choices, while also being "enwrapped within new forms of control" through "responsibilization" (Rose 1999, xxiii). Other scholars have found responsibilization to be a key mechanism of reproductive governance in Mexican public abortion services where women are disciplined for failing to use contraception through doctor–patient interactions (Singer 2017). My research shows that women are also responsibilized through global SRHR programs that promote abortion rights but territorialize access to mifepristone through rhetoric that frames empowerment in terms of reproductive and economic responsibility.

Conclusion

Feminist projects for autonomous abortion are entangled in multiple social, political, and economic processes that have transformed how abortion is provided and how reproductive conduct is governed in Mexico. I have analyzed the ways in which these processes shape subjectivities and possibilities for action by tracing abortion pills through the divergent assemblages of feminist accompaniment practice and pharmaceuticalized abortion care.

I have shown how mifepristone is controlled through overregulation and limited distribution channels by global SMOs that use market mechanisms to distribute pills as part of global SRHR programs. Mifepristone is territorialized through these assemblages, which include the neoliberalization of reproductive health care, where abortion rights are narrowly enacted through consumer choice. Encouraging women to pay for their abortion pills ignores the ways in which privatized medicine perpetuates and exacerbates inequalities. Couching the practice in the language of "co-responsibility" is also a kind of moralizing that disciplines women for perceived failures in responsible reproductive conduct. Co-responsibility contradicts the way in which many *acompañantes* define bodily autonomy. Not charging for accompaniment support, making the pills available for free whenever possible, and supporting women's abortions under any circumstance are all means of validating abortion as an inalienable and unconditional right to bodily autonomy.

Misoprostol is more easily reterritorialized into new assemblages that promote reproductive freedom. While I recognize critiques that buying misoprostol from the pharmacy presents a similar kind of self-steering neoliberal agency, which in other contexts does little to reduce inequalities in abortion access (Suh 2021), my research shows that the ways in which *acompañantes* bring misoprostol into relationship with other practices, principles, and discourses creates the potential for more structurally transformative outcomes.

Acompañantes – whose praxis is based in solidarity, justice, and collective care – constantly negotiate the assemblages that control and define abortion medications, bringing them into new assemblages for feminist practice. While some *acompañantes* to whom I spoke aspire to be free from the conditions of institutions, such as NGOs, SMOs, or pharmaceutical companies, pills are made available in Mexico through assemblages that necessarily involve these actors. *Acompañantes* therefore negotiate these tensions, seeking out opportunities to create favorable conditions using the tools and technologies available to them.

My research contributes to calls to expand studies on the mechanisms of reproductive governance beyond notions of centralized and ubiquitous state power (Mishtal and De Zordo 2021; Morgan 2017). It shows that while pills have afforded opportunities outside the punitive logics of state control, pharmaceuticalized medicine is not necessarily a departure from reproductive discipline in abortion care. I have used the analytic of assemblages to show that globalizing processes of neoliberal governance are not fixed or totalizing, but rather ongoing, partial, and contested. As Erikson (2011, 37) asserts, assemblages also provide "maps with which we can strategize how to undo socially constituted arrangements that hurt people or impinge on people's reproductive choices." My critique is written in the spirit of improving equitable access to abortion pills and ensuring women's reproductive autonomy. I recognize that danger-talk is a tricky and risky exercise, but agree with Martin et al. (2017, 82) that it can be productive when there is "a gap between rhetoric and lived experience." The revolutionary potential of pills is not a given; rather, it requires the deliberate adoption of the politics and practices of collective care and reproductive justice to disrupt systems of power that currently reinforce reproductive governance.

Notes

1. There is some debate about the appropriate term for an abortion using medication (Weitz et al. 2004). In Spanish, it is usually referred to as "*aborto con medicamentos*." I use the term "medication abortion" as the closest translation. Though "medication abortion" can also refer to situations in which abortion pills are prescribed by doctors, this article refers specifically to the practice of

self-inducing an abortion using medication under the guidance of trained feminist activists.

2. I acknowledge that people who do not identify as women also have abortions and that there is an important push in global feminist abortion spaces to use inclusive language. However, I have chosen the term "women" as it is the language used by my interlocutors.
3. Since 2019, abortion has been decriminalized in the states of Oaxaca, Hidalgo, Veracruz, Baja California, Colima, Sinaloa, Guerrero, Baja California Sur, and Quintana Roo (in chronological order). Access to public health services continues to be extremely limited in these states.
4. Collier and Ong (2003) also emphasize the open-ended, fluid, unstable, and partial nature of such arrangements, in contrast to Deleuze and Guattari's focus on the totalizing inevitability of capitalist expansion.
5. The states in which my interview participants reside and work are Baja California, Campeche, Chiapas, Guerrero, Hidalgo, Jalisco, Mexico City, Mexico State, Michoacán, Morelos, Oaxaca, Puebla, Tabasco, and Yucatán.
6. I acknowledge this is a small sample, compared to the approximately 6,900 pharmacies registered in the city (Instituto Nacional de Estadística y Geografía (INEGI) 2020).
7. WhatsApp is a free messaging service app.
8. This is a play on the common expletive "son of your mother," transformed here as "daughter of your misoprostol father."
9. Those who accompanied abortions after 24 weeks referred to the dosages recommended by the Socorristas en Red accompaniment network that has published research on later-term abortions using medication (Zurbriggen, Keefe-Oates, and Gerdts 2018).
10. The literal translation is "they don't take a step without a sandal."
11. These are Cuba, Mexico, Uruguay, Colombia, Chile, and Bolivia.
12. The director organized what he described as "missions" to Mexico City with Emielle-Etienne Baulieu, who led efforts to develop the original RU-486 molecule. They spoke with government officials, law makers, and health authorities about the benefits of mifepristone (see also Baulieu and Rosenblum 1991).
13. At the time of writing, this registration had still not been approved.
14. Reforms implemented in 2011 placed stricter controls on prescription requirements for Category Four and higher medications. However, it seems that in practice they are usually only applied to antibiotics (Lara et al. 2011).
15. The geographical scope of my visits was limited due to the COVID-19 pandemic.
16. While it is becoming more common for *acompañantes* to assist women with later-term abortions using pills, many do not, preferring to send women to Mexico City where some clinics provide later-term abortions.

Notes on contributor

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