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LIBERATING ABORTION PILLS IN LEGALLY RESTRICTED SETTINGS[1]

Activism as Public Criminology

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Introduction

The first weekend of August 2018 was an important one for Brazilian feminists who, for decades now, have mobilized against the criminalization of abortion. The Supreme Court held a public hearing of medical and legal experts, social movements' representatives, religious authorities, and legal practitioners in the context of a lawsuit aiming to declare the criminalization of abortion unconstitutional. During that weekend, activists from all over the country gathered in the capital, Brasília, for a Festival for Women's Lives where we discussed issues ranging from reproductive justice to holistic security in abortion activism. Among the participants were activists from Argentina and Uruguay who shared the history and most recent developments of the struggle for legalizing abortion in their countries. While Uruguay, in 2012, became the first country in South America to make abortion on demand legal up until twelve weeks of gestation, Argentina has a very active network of feminists, known as *Socorristas en Red*,[2] who publicly help women accessing accurate information and medication that can safely and effectively end a pregnancy in the privacy of their homes.

The discovery of pills that can end an unwanted pregnancy was a watershed in access to abortion worldwide. Medication abortion—as the use of drugs to terminate a pregnancy is usually known[3]—is an effective and safe abortion method that can be used outside of the clinical setting (Ramos, Romero, & Aizenberg, 2014), and without the involvement of a healthcare provider (Gerdts, Jayaweera, Baum, & Hudaya, 2018). When performed with medication that is self-sourced and self-used and outside of a clinical context, the procedure is known as self-managed abortion (Erdman, Jelinska, & Yanow, 2018).

After decades of documenting evidence and gradually recognizing the relevance of abortion with medication for addressing inequities in access, the World Health Organization (WHO) has issued a comprehensive guideline on medical management of abortion (WHO, 2018). This guideline (WHO, 2018, p. vii) not only acknowledges that medication abortion "plays a crucial role in providing access to safe, effective and acceptable abortion care," but also recommends this as a safe method for abortion after the first trimester. While currently the medical profession increasingly recognizes the benefits of medication abortion, the discovery of the pills' wonders was not the deed of physicians or researchers. Brazilian women, with the help of pharmacists and

drugstore workers, were the ones who identified the abortive effect of a drug initially prescribed to treat gastric ulcer in the 1980s—Cytotec, the commercial name for misoprostol in the country. And yet, today, women in Brazil are denied access to a technological innovation that they introduced to the world.

In a stark contrast, misoprostol has not been restricted in Argentina to the same extent as in Brazil. Such factual condition has enabled a favorable environment for the development of a network of activists, part of a strand of feminist abortion mobilization that openly provides information and accompaniment to women getting medical abortions. This network has been operating for a decade now, working alongside two other tracks of activism for abortion rights: The National Campaign for Free, Safe and Legal Abortion and the rights and public health strategy pursued by feminist lawyers and public health professionals (Ruibal & Fernandez Anderson, 2018). The positive synergy of these three strands of activism—"political mobilization, public health and rights strategy and direct action and service provision" (p. 4)—has paved the way for the 2018 massive demonstrations in favor of a proposed bill decriminalizing abortion. As abortion advocates chose a green handkerchief as a symbol, their extensive protests became known as *La Marea Verde* (the Green Wave) in the region.

That said, existing criminal restrictions to the medication in Brazil mean that accessing it often entails dealing with the illegal drugs market (Diniz & Madeiro, 2012), an individualized endeavor that may also become perilous. Criminalization endangers access to an essential medicine and poses additional costs to collective action. Contrasting to Argentina, where the three activist strands described above have flourished side by side, public activism for abortion in Brazil has remained largely focused on legal mobilization in its narrow sense (Ruibal & Fernandez Anderson, 2018), amounting to high profile litigation and campaigns targeting the legislature, both aiming at gradual legalization.[4] Unfortunately, there is no clear evidence regarding the specific interests behind the changes in the Brazilian regulation of misoprostol or how exactly these changes came about, leading to its total ban in the formal market.[5] Evident, nonetheless, are the harmful effects of the ban on women's reproductive freedom.

In this chapter, I argue that the criminalization of misoprostol has had damaging effects on abortion activism in Brazil, because it has created grave obstacles to forms of direct action that appropriate a technological discovery to circumvent the effects of criminal restrictions on abortion. The case discussed in this chapter gives a close view into how criminal law works to produce harm (Erdman, 2018), particularly when it is instrumentalized for social and sexual control. While activists in Brazil continue to pursue abortion legalization by fighting the restrictions of the penal code, the ban of the medication deny women and pregnant people access to one of the safest, effective, and most autonomous methods to end an unwanted pregnancy.

Even if unintendedly, through the strong hand of criminal law combined with seemingly protective sanitary regulation, Brazilian authorities have succeeded in forcing public abortion activism to remain tied to an outdated frame of the abortion clinic. This, in turn, moves into the deepest underground any attempt of direct action through harm reduction practices such as medical abortion accompaniment, counseling, and informational hotlines, as has been publicly happening in Argentina. Rather than focusing on the specific prohibition of abortion as stated in criminal law, this chapter focuses on criminalization as a broader set of legal acts with effects specific to self-managed abortion and direct-action strategy.

As such, this chapter is an attempt to develop what I call "grounded public criminology." Much of the work done by scholars engaged in public criminology is set out as a well-intentioned move to bring their "work 'back to the people' (Carrabine, Lee, & South, 2000) by explaining [their] work to the public (Uggen & Inderbitzin, 2010)" (as cited in Nelund, 2014, p. 76). As such, public criminology often operates as a benevolent act of teaching extra-academic publics what academia has learnt about crime control and punishment. This chapter takes

a different approach: it deploys academic skills to address a problem that emerged from within activism for abortion decriminalization in Brazil. The critiques of criminalization articulated here are based on experiencing it on an every-day basis as an activist scholar. They constitute thus an attempt to speak to my partners within the movements and tell them we might be targeting the wrong enemy. But they also address our academic allies and urge them to learn from the struggle, rather than the usual attempt to teach to struggle.

In order to do so, I look back at the historical developments in Brazil regarding medication abortion, from the discovery of the abortive uses of misoprostol by Brazilian women to our current context, marked by a strong criminalization of not only of abortion *per se* but also of any action related to the medication. I compare the Brazilian case to the Argentine one, where criminal laws regulating abortion are similar, but the medication is available in pharmacies with no criminal offense attached to them. My aim with the comparison is to trace the impact of criminalization of the abortion pill—and not abortion *per se*—on social movement building and direct-action activism.

What is novel about the Brazilian case is how criminalization of reproductive freedom has effectively been achieved, in a time of technological advancement, through the production of a legal architecture, rather than a single criminal prohibition. A complicated scheme of sanitary regulations combined with criminal law, supposedly enacted to protect public health and medicine consumers, is in fact doing the opposite. The prohibition is barring women and pregnant people from accessing the safest method to end an unwanted pregnancy, while also criminalizing movement building in an indirect way.

Being a reflexive exercise of how medico-criminal architecture impact both the exercise of women and pregnant people's rights—to health, to innovation, and to information—and the strategies adopted by abortion activists, this chapter is an example of a public criminology that disrupts the "unidirectional transmission of knowledge implied in the public criminology literature" (Nelund, 2014, p. 78). If public criminology is about criminology's engagement with social justice issues, it is time to recognize both the knowledge and actions of activists engaging with criminal law as an integral and equal part of the field, as I intend to do in this chapter.

Discovering the Pill ... Outlawing the Pill ... Liberating the Pill ... the Fate of Abortion Activism in Brazil and Argentina in 200mcg

Abortion is restricted in similar ways in Argentina and Brazil. Both countries outlaw the procedure in their penal codes, charging providers and women who cause or consent to an abortion to imprisonment that ranges from one to four years.[6] There are a few circumstances in which, if performed by a licensed physician, abortion is not to be punished. In both countries, there is an exception for when the pregnancy is the result of rape or when it poses risk to the woman's life. In Argentina, there is also the exception of risk to the "mother's health,"[7] and in Brazil, a physician can also perform the procedure if the fetus is anencephalic.[8] Research shows that abortion remains difficult to access in both countries, even in the narrow circumstances where it is legal (Madeiro & Diniz, 2016; Zurbriggen, Keefe-Oates, & Gerdts, 2018).

Nonetheless, evidence from around the world demonstrates that criminalization does not stop women and pregnant people from procuring an abortion; it, does, however, impact its safety and timing (Zurbriggen et al., 2018). The Guttmacher Institute shows that South America and the Caribbean, which are among the regions with the most restrictive laws on abortion in the world, also had the highest annual rates of abortion in 2010–2014. In the Caribbean, the abortion rate was estimated at 59 per 1,000 women of reproductive age, followed by South America, at 48 (Guttmacher Institute, 2018). Historically, women have resorted to every mean available in order to circumvent restrictive abortion laws and exercise their reproductive freedom, from herbal teas to clandestine clinics. It was in this messy underground world of social experimentation and

criminalization that Brazilian women discovered the use of misoprostol alone to induce an abortion as early as the 1980s (Coeytaux & Wells, 2013).

Cytotec was introduced in Brazil in 1986 for treating gastric and duodenal ulcers, and its use as an abortifacient quickly spread by word of mouth. Cytotec is the commercial name for misoprostol, a synthetic analogue of prostaglandin E,[9] developed by G. D. Searle & Company. In 1988, Biolab, a Brazilian laboratory, began marketing the drug (Barbosa & Arilha, 1993). The pill was inexpensive and easily obtainable in pharmacies all over the country, allowing women to safely and privately end an unwanted pregnancy, without the assistance of a medical professional. In addition, if used buccally or sublingually, misoprostol cannot be detected by the time contractions begin. This means that an induced and a spontaneous miscarriage cannot be distinguished by bodily symptoms, making it nearly impossible for an induced abortion to be prosecuted as such.[10]

By 1991, Cytotec was widely known as an abortifacient throughout Brazil.[11] Knowledge was spread through an informal network that included pharmacists, doctors, the manufacturer, the media and women themselves (Barbosa & Arilha, 1993). Studies show that in the 1980s, when Cytotec was largely available, the number of women reaching the public health system due to complications from induced miscarriage fell drastically (Faúndes, 2010, p. 33) as medical abortion is not only easy, but also effective and safe.[12]

As the drug gained notoriety as an abortifacient, a public controversy followed, and two main public positions on the issue gained traction. Groups and institutions linked with medical surveillance demanded that Cytotec be withdrawn from the market as it was solely being used for inducing abortion. Gynecologists, on the other hand, argued that the drug should remain available as it rendered illegal abortion less risky and unsafe (Barbosa & Arilha, 1993).

Following the public outcry, in 1991, the Ministry of Health altered the regulation under which the drug was marketed, establishing that it could only be sold in authorized drugstores, upon retention of a doctor's prescription (Pazello, 2010). The laboratory reduced the drug's monthly production as part of an agreement reached with the Minister of Health to control its use (Barbosa & Arilha, 1993).

Interviews conducted with Brazilian women in 1992 showed that they had enough knowledge about medication abortion and consciously chose the procedure with Cytotec for three main reasons. First, the drug had a very low cost,[13] especially when compared to other methods, such as surgical abortion. Second, the procedure itself was seen as an easy one because the drug is administered in privacy, it requires less (or even no) outside intervention and is perceived as less traumatizing than other methods. Finally, women saw medication abortion as a safer method, "one that does not kill women" (Barbosa & Arilha, 1993, pp. 238–239).

Interestingly, the first scientific study about the use of misoprostol for obstetric purposes was conducted by a Brazilian professor and published in a scientific journal in 1987 (Faúndes, 2010). Four years later, another study conducted by two Argentine doctors was published in the Lancet (Faúndes, 2010). From then on, there was a rapid diffusion of the use of misoprostol in obstetrics and gynecology, followed by hundreds of publications in the most respected area journals (Faúndes, 2010). Today, misoprostol is recognized as the drug for women: used in abortion, miscarriage management, labor induction, prevention and treatment of postpartum hemorrhage, and cervical dilation in gynecological interventions, it is a game changer for maternal and reproductive health. In 2005, the WHO added misoprostol to its List of Essential Medicines for countries where abortion is not against the law. In 2009, misoprostol was also included for the treatment of incomplete abortion (Zamberlin, Romero, & Ramos, 2012). In 2018, the WHO issued an extensive guideline on medication abortion.

Despite all these progressive developments worldwide, in Brazil, the regulation of misoprostol has continued moving backwards. The controversy over the medication, which led to the aforementioned regulatory change in 1991, grew stronger when, in the same decade, a group of

researchers suggested that misoprostol could have teratogenic effects on the fetus if the dosage was not sufficient to induce abortion (Diniz, 2008). Throughout the next ten years, several clinical research reports attempting to establish a correlation between the use of misoprostol during pregnancy and fetal malformation were published (Diniz, 2008), with the Moebius Syndrome—a very rare congenital neurological disorder—being the alleged most severe outcome.

These studies led to an ever-increased public attention to the "underground" practice of misoprostol use for inducing miscarriage. In 1998, as negative publicity about the medication grew, the newly established National Sanitary Agency adopted a regulation on "substances and medications subjected to special control" (Administrative Rule no. 344/1998) as one of its first regulatory actions. Misoprostol was included on the list.[14] According to Administrative Rule no. 344/1998, Article 2, a special authorization from the Sanitary Agency is mandatory in order "to extract, produce, fabricate, distribute, transport, prepare, manipulate, import, export, transform, pack, or repack the substance and its improved versions, or the medications that contain it." Today, there is only one authorized producer of misoprostol in Brazil, which is distributed under the brand name Prostokos.[15] In addition, misoprostol can only the bought and used in healthcare facilities authorized by the Sanitary Agency, and it is obligatory that any medicine containing the substance include a warning about the risk for pregnant women in its package. More recent Administrative Rules have attempted to regulate not only its commerce, but also any form of publicity or dissemination of related information on its use available on the internet and any social media (Administrative Rules no. 911/2006 and 1050/2006, updated by Administrative Rule no. 1534/2011).

If these were the only regulations, violations would be an administrative offense and the consequences would not be so serious. However, the aforementioned sanitary regulation is linked to a specific crime against public health, specified in article 273 of the Penal Code. The crime consists in "importing, selling, exposing, having in deposit to sell, or distributing or delivering to consumption" a medicine that is on the list of "substances and medications subjected to special control" issued by the National Sanitary Agency (Administrative Rule no. 344/1998). The penalty for this crime, which is intended to protect public health and medicine consumers' safety, can range from a minimum of 10 to a maximum of 15 years in jail. Currently, some Brazilian judges, understanding that the penalty is evidently unreasonable based on the offense, have charged people dealing misoprostol with the penalty for drug trafficking, which carries a minimum of 5 and a maximum of 15 years in jail, allowing, therefore, for lower sentences if the circumstances are favorable for the accused.[16] In very few cases, when Courts identify that the drug had been produced in a foreign laboratory and was illegally brought into the country, the charge is contraband, which carries 3 to 5 years in jail.[17]

All of the three criminal offenses applied to all actions related to misoprostol—carrying, having in deposit, selling, giving away, distributing, to mention but a few—have no direct relationship to abortion. One is drug trafficking; another is a crime against public health; and the other is contraband. Therefore, the fact that misoprostol can be used for inducing a miscarriage should not be in the purview of judges deciding on the fate of the medication. Nonetheless, case law shows that the judiciary finds it relevant to mention, and therefore a more reprehensible action, that the illegally sold or contrabanded medication is used for the purpose of inducing a miscarriage. Such line of judicial reasoning evokes the idea that the definition and interpretation of crimes are directed by ideologies and moralities: "almost all aspects of the definition of a 'good' person in society are bound up in constituting crime, criminal law, and the criminal" (Miller, Roseman, & Rizvi, 2019, p. 2). Someone whom in any way may help a woman to have an abortion is not a good person, in these judges' view. Misoprostol, differently from all the other hundreds of drugs included in the list annexed to Administrative Rule no. 344/1998, carries with it a stigma for being "the abortion pill."

While lay people, including women using misoprostol and activists campaigning for the decriminalization of abortion, do not know the intricate and uncertain legal architecture described above, it is widely known that dealing, using, or distributing misoprostol is a crime. Such knowledge creates a number of barriers for women and pregnant people to access the medication: they usually get the pills in the clandestine market, being thus unable to verify the quality of the product; and they pay much more than if the drug was legalized. On the other hand, pro-choice activists who may access the drug through solidarity networks in other countries often fear being caught with the medication, since the penalties are so high. In addition, the criminalization of the medicine creates a feeling of insecurity amongst activists themselves: no one is ever sure about whom they can trust and even talking publicly about abortion with medication, following the WHO guidelines, becomes a risky endeavor.[18] This chilling effect caused by criminalization of misoprostol—and not of abortion *per se*—contributes to misinformation, further violating human rights standards and, particularly, the right to information.

Thirty years later, the use of misoprostol for abortion, which began in Brazil as a natural public health experiment, has been validated by rigorous clinical studies and recommendations of the WHO.[19] Meanwhile, women continue to spread the word. Medication abortion first made it to the international headlines with the work developed by the organization Women on Waves. In June 2001, Women on Waves set out from a Dutch port in a rented ship to provide women with pills that induce miscarriage in countries where abortion is illegal (Bazelon, 2014). Today, at least two large international feminist organizations—Women on Web and Women Help Women—are dedicated to delivering abortion pills and information to women's and pregnant people's hands, no matter where they are, and assisting them throughout the process of self-managed abortion.

In Latin America, in contexts of restrictive and resistant-to-change abortion laws, local activist groups have had a central role in promoting medication abortion as a safer choice for women (Mc-Reynolds-Pérez, 2017), through telephone and internet hotlines, and in-person accompaniment. Argentina is a good example of successful mobilization, where young activists have turned to direct action and service provision since the late 2000s (Mc-Reynolds-Pérez, 2017, p. 362). Such strategy is one of the three strands of abortion mobilization in the country, one that understands its "practices as complying with legal norms", even when it is "indeed defying the official interpretation of the current [criminal] law" (Ruibal & Fernandez Anderson, 2018, p. 8).

One such group is *Socorristas en Red*, a network of feminist activists that provide information, medication, and support to women seeking abortion. Since its foundation in 2010, the network has quickly grown and currently includes 39 collectives from across the country (Zurbriggen et al., 2018). The model of *Socorrista* action encompasses: (1) a telephone hotline; (2) in-person group meetings; (3) telephone support throughout the process of home abortion; (4) in-person accompaniment, especially in second-trimester cases, including the provision of misoprostol or the full course of pharmaceutical abortion drugs, acquired through transnational activist contacts (Mc-Reynolds-Pérez, 2016); and (5) post-abortion medical treatment. The network has also developed extensive informational material on how to use abortion medication, which has a large distribution beyond Argentine borders.

Most *Socorristas* do not have formal medical training, but they undergo intensive feminist guidance on principles and medical guidelines to be able to fully support women and pregnant people. As such, *Socorristas* not only challenge the privileges of expert knowledge, but by appropriating and subverting it, they also question criminal regulation of abortion, which includes practicing medicine without a license. As the *Socorristas* (Zurbriggen et al., 2018, p. 109) have described their training:

> This training consists of studying materials that describe safe medication abortion practices, shadowing and being supported by other *Socorristas* who have more experience accompanying abortions, training by other regional and international organizations that

provide medication abortion, and contact with medical professionals who help train *Socorristas* to identify when and how women should seek medical care if necessary.

Particularly important for these activists is to stress that they are providing women and pregnant people something qualitatively different from any kind of care they could access elsewhere; it is a feminist model of care that will remain in place even if abortion is legalized (Ruibal & Fernandez Anderson, 2018). As such, *Socorrismo* is a direct confrontation with "a patriarchal society by guaranteeing that women are not forced to become mothers if they choose not to" (Zurbriggen et al., 2018, p. 113), while it is also a disruption of existing interpretations about abortion laws.

There is no doubt that *Socorristas en Red* are a brave group of women willing to put themselves at risk through direct action that has completely changed the landscape of abortion care in Argentina. It is important to acknowledge though that the women and pregnant people they accompany and counsel, as well as themselves, have easy access to the means of controlling a safe and effective abortion experience. The pill is the game changer (Mc-Reynolds-Pérez, 2017, pp. 358–359), which make the criminalization of abortion contained in the penal code completely outdated:

> I especially want to underscore that the direct-action misoprostol activist strategy that I describe could not have become so widespread without the availability of the drug itself. Misoprostol allows Argentine activists to facilitate abortion while maintaining a distance from the actual procedure. The pill allows women to be the agents of their own abortions, with activists advising and "accompanying" them, but at a distance through the hotline and Internet-based communication. The distance created by both the pharmaceutical and telecommunications technology allows the activists to avoid prosecution, since they really are only providing information and not abortions. It also makes it possible to provide these services over long distances, not just to a population within the same metropolitan area as the activists.

For a long time, misoprostol was sold in Argentina mixed with diclofenac under the brand name Oxaprost, a medicine officially prescribed for stomach issues (Booth, 2018). Women could have access to this drug in pharmacies with a specific medical prescription that would be kept by the retailer and controlled by the sanitary authority. In October 2018, the Argentine feminist movement won another victory. The National Administration for Medication, Food and Technology (ANMAT) authorized[20] the sale of misoprostol in pharmacies for the purpose of legal abortion. The procedure for accessing the drug is uncomplicated: The doctor prescribes misoprostol to their patient for a legal abortion, and the prescription is retained by the pharmacy. With the growth of self-managed abortion rates in the country and the social legitimacy the discourse of reproductive rights has acquired as shown by the popular adherence to the *Marea Verde*, this latest step taken by Argentine institutions amounts to decriminalization through other means.[21]

In the case of Argentina, social decriminalization was achieved through the everyday work of activists who were doing "public criminology" even though they did not frame it in those terms. Activists' ongoing commitment to ensure that women and pregnant people have access to safe and autonomous abortion without fearing criminal persecution, while at the same time, changing drastically public opinion about reproductive freedom, is an exercise of public criminology at its core.

It is true that "the use of criminal law to regulate sex, gender, and reproduction is decidedly not new; such regulation has been the hallmark of the modern state" (Miller et al., 2019, p. 2). What is novel about the Brazilian case, however, and in contrast to the Argentine one, is how criminalization of reproduction has been achieved through a complicated scheme of sanitary

regulations combined with criminal law supposedly enacted to protect public health and medicine consumption. Technology has played a transformative role in defining how much a person seeking an abortion needs to interact with the state or other institutional actors. Medical abortion pills mean that the individual is sovereign in their decision and does not need to interact either with state institutions or the medical profession. And yet, this transformative role can be blocked by simply placing a criminal wall between the person (or their supporters) and the pill.

While in several other countries, including Argentina, "women's health advocates have utilized a harm-reduction model to combat mortality and morbidity from unsafe abortion by providing women with counselling and information about early medication abortion (<12 weeks' gestation) through websites, hotlines, and social media platforms" (Gerdts et al., 2018, p. 2), such actions are much riskier in Brazil. Facing charges of a criminal offense that may lead to incarceration for fifteen years might not be an activist choice for many, particularly in a country with a highly class and racially selective criminal justice system.

Such fears create barriers even to the production and dissemination of knowledge such as the one represented in this chapter. Even if we see the engagement with the criminalization of misoprostol in Brazil as a public criminology exercise, we are afraid that the public exposure of it might lead to actual enforcement of existing laws, further jeopardizing the work of activists. But the realization of the barriers created by fear should actually work to transform silence into language and action (Lorde, 1984). This is where I see a grounded public criminology taking shape: silence is not an option, nor a protection; speaking and acting is a necessity in order to move forward.

Producing Political and Embodied Harm through Medico-Criminal Regulation

Abortion criminalization worldwide is a relatively recent phenomenon, dating back to the 19th century. Criminalization of many social practices is usually justified through hegemonic frameworks that suggest a public values' defense, and critiques of such criminalization often rest on pointing out the inefficacy of criminal laws. In the case of medical/social issues, however, the critique to criminalization should go a step further. It is essential to attend to how existing inequalities interact with these criminal shifts, creating uneven effects upon particular sectors of the population.

In the case of criminal abortion laws, these disproportionate effects are evident. The fact that access to abortion or, most importantly for this chapter, to misoprostol is a crime in Brazil does not mean that women stopped seeking abortion. Women still look for ways to terminate an unwanted pregnancy, but criminalization often pulls them towards lesser safe methods. Data from the Ministry of Health show that, every year, an average of 250,000 women visit public hospitals to undergo curettage after an unsafe abortion procedure (Arilha, 2012). The fact that most of these women are young, poor, and Black exposes how access to abortion in legally restrictive settings is a social justice issue, one that sits at the intersection of law, poverty and race.

A dual system of clandestine abortion is a common feature of countries where the procedure is illegal: Upper-class women can quietly access abortion in private, often expensive clinics run by trained physicians or travel overseas to have the procedure. Poor and working-class women risk their lives when having back-alley procedures, which include unsafe clinical procedures, the use of all kinds of herbs, and even the introduction of objects in their bodies. For this reason, Black feminists in Brazil, in similar ways as in the United States and other parts of the world, have claimed that the struggle must be framed around the notion of reproductive justice, which also addresses other vectors of structural inequality and not only reproductive rights. For them, decriminalization efforts entail fighting structural racism that criminalizes Black lives as such: they

want to be able to end an unwanted pregnancy as much as they want to be mothers and raise their children without fearing they will be assassinated by the police.

Misoprostol has changed the landscape of reproductive justice as a technological discovery. Brazil and Argentina are no exception. Today, with medication abortion, clandestine practices do not need to be unsafe. However, the histories of public abortion activism in Argentina and Brazil took very different paths, in part due to the regulation of access to abortion medication. In Argentina, feminist groups are actively engaged in an open and visible direct-action strategy, which paved the way for the legislative reform debated in parliament in 2018; in Brazil, direct action is hidden and underground, marked by fear and insecurity.

If it is true that "the widespread use of Cytotec in Brazil highlights contradictions of the illegal situation of abortion and has, at the same time, generated a favorable atmosphere in which to promote discussion of the need to legalize abortion" (Barbosa & Arilha, 1993, p. 239), the criminalization of the drug has also produced what I call political and social harm. As we learn early on in law school, criminal law is a regime that allows the state to use force against actions that it deems harmful enough to justify the imposition of criminal consequences (Erdman, 2019).

In the case of the criminalization of abortion pills, this is happening the other way around. It is criminal law, through the condemnation of the medication, that is creating "its own order of harm more real and certain than any it seeks to prevent" (Erdman, 2019, p. 249).

The two cases discussed in this chapter show that the kinds of intricate, indirect harm produced by criminal law can only be captured through grounded forms of public criminology, which I use to make visible the knowledge produced by everyday experiences against criminalization. While criminalization attempts to silence activists, a grounded public criminology perspective recognizes that such silence does not mean protection. As such, it is necessary to turn silence into language and action.

Notes

1 This work was supported by the Canadian Institutes of Health Research [grant number 153012], to which I am grateful. I also thank Sara Larrea, Susan Yanow, Kinga Jelinska, and Joanna Erdman for their helpful comments. My acknowledgment goes to the feminist activists for reproductive justice in Latin America who are making this world more liveable for us all.

2 While *Socorristas en Red* is only one of the various groups engaging in direct action and service provision in the context of abortion activism in Argentina (Ruibal & Fernandez Anderson, 2018), they have become widely influential throughout the region by spreading their political vision, known as *socorrismo*. As such, *socorrismo* aims not only to provide women with access to safe abortion right now, but also to de-stigmatize and demystify the practice, centering it around women, their needs and their desires (Ruibal & Fernandez Anderson, 2018). *Socorristas* see themselves continuing the political work they do even after (and if) abortion is legalized in the country, as one of their members told me in a workshop.

3 Other terminologies, such as medical abortion or abortion with pills, are also used.

4 Here, it is important to make the distinction between legalization and decriminalization. The former entails keeping abortion in criminal law while identifying the grounds on which it is allowed. The latter means removing all the existing criminal sanctions against abortion from the books (Berer, 2017). Even though the definitions seem to be clear enough, activists still struggle with them, and often use one for the other. Up until today, Canada is the only country in the world that has decriminalized abortion, through a Supreme Court decision.

5 From conversations that I have had with activists and researchers who lived through the changes, I learned that three events in the 1990s intersected to produce the extremely restrictive regulation of misoprostol now in place in Brazil. First, the publication of various clinical case reports associating the use of misoprostol during pregnancy and the development of Moebius Syndrome, a very rare congenital neurological disorder (Corrêa & Mastrella, 2012). Second, the ecofeminist condemnation of the pharmaceutical control over women's bodies, particularly during the United Nations Meeting on the Environment in Rio, known as Eco 92. Finally, the need of newly established National Sanitary Agency to assert its power by regulating restrictions on specific substances.

6 Abortion is criminalized in articles 85–88 of the Argentine Penal Code and articles 124–127 of the Brazilian Penal Code. Both penal codes, as one would expect, employ a highly gendered language: the person who undergoes an abortion is a woman and/or a mother.
7 The health exception has been widely explored by the public health and rights strategy in Argentina, where activists achieved the important outcome of having the Minister of Health issue a guide explaining how to interpret article 86 of the penal code. This guide embraced the WHO's comprehensive definition of health, including psychological health, and established the woman's decision over the risk she would be willing to take as the decisive factor to request a legal abortion (Ruibal & Fernandez Anderson, 2018).
8 This exception was introduced by a Supreme Court decision, in 2012.
9 Misoprostol causes the cervix to soften and the uterus to contract, resulting in the expulsion of the uterine contents. The physical process that the body undergoes is the same as natural birth or miscarriage. First trimester medical abortion is a highly safe and effective procedure. Up to 9 weeks gestation, the effectiveness of the misoprostol alone regime is between 75% and 90%.
10 What happens though is that women who induce an abortion with misoprostol and seek post-abortion care in health facilities are often psychologically and physically tortured to confess they had used the pill. Cases like these are common in the Brazilian healthcare system, and even though in violation of basic patient's rights, such as the right of professional secrecy, lead to the women's criminal persecution.
11 One study from the mid-1990s shows that among the women hospitalized for abortion, 76.1% had knowledge of misoprostol or of a medication for inducing abortion whose name they could remember (Diniz, 2008, p. 29).
12 One study conducted in the 1990s established a correlation between the three phases of misoprostol commercialization in Brazil and the number of women reaching the public health system for complications with induced miscarriage. These three phases were the beginning of commercialization in pharmacies, the peak of diffusion of the information on the abortifacient property of the drug and the period immediately after the prohibition of commerce. The study shows that there was an increase of nearly 50% in infectious and hemorrhagic complications between the period of the peak of the drug's commercialization and the prohibition (Diniz, 2008, p. 24).
13 One study conducted in the 1990s showed that the medium price for misoprostol was US$6.00, while an abortion in private clinic cost US$144.00 (Diniz, 2008).
14 In a seemingly contradictory move, the National Sanitary Agency has listed misoprostol in the National List of Essential Medicines since 2010.
15 Interestingly, Brazil was one of the pioneer countries in the independent production of drugs containing misoprostol for obstetric purposes (Faúndes, 2010), under the brand name ®Prostokos.
16 Article 33 of Federal Act no. 11.343/06.
17 Article 334-A of the Penal Code.
18 In August 2019, a group of activists in Southern Brazil who distributed pamphlets containing the WHO guidelines for medication abortion was notified by the local public prosecutor to explain their actions. These activists were obviously exercising their constitutional right to information but, in the prosecutor's view, they were advertising abortion.
19 WHO recommends a combination of the drugs misoprostol and mifepristone for medical abortion or, where mifepristone is not available, misoprostol alone. It is important to notice, though, that it was very recently when the Organization showed interest about informal use of misoprostol outside the clinical setting or the telemedicine paradigm.
20 Regulation no. 946, from October 12, 2018.
21 The Argentine case of abortion is a paradigmatic example of social decriminalization achieved through "transformative illegality". The term has been coined by Enright and Cloatre (2018) to describe the long-term illegal distribution of condoms in Ireland by activists, which has led to their transformation into a different legal object—"from abject to commonplace, challenging existing restrictive laws" (p. 283). Similarly, in Argentina, feminist direct-action strategy has attacked and de-stabilized existing understandings about abortion, "replacing them with more liveable alternatives" (p. 279) that connect to actual women's reproductive experiences.

References

Arilha, M. M. (2012). Misoprostol: Percursos, mediações e redes sociais para o acesso ao aborto medicamentoso em contextos de ilegalidade no Estado de São Paulo. *Ciência e Saúde Coletiva*, *17*(7), 1785–1794.

Barbosa, R. M., & Arilha, M. (1993). The Brazilian experience with Cytotec. *Studies in Family Planning*, *24*(4), 236–240.

Bazelon, E. (2014, August 31). The dawn of the post-clinic abortion. *The New Times Magazine*. Retrieved from 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: In search of decriminalization. *Health and Human Rights Journal*, *19*(1), 13–27.

Booth, A. (2018, June 25). The drug that's transforming abortion in Argentina. *Medium*. Retrieved from https://medium.com/s/story/the-drug-thats-transforming-abortion-in-argentina-182189d48b39

Carrabine, E., Lee, M., & South, N. (2000). Social wrongs and human rights in late modern Britain: Social exclusion, crime control, and prospects for a public criminology. *Social Justice*, *27*(2 (80), 193–211.

Coeytaux, F., & Wells, E. (2013, May 28). Misoprostol is a game-changer for safe abortion and maternal health care. Why isn't it more widely available? *Rewire News*. Retrieved from https://rewire.news/article/2013/05/28/why-arent-we-taking-advantage-of-the-potentially-game-changing-drug-misoprostol

Corrêa, M. C. D. V., & Mastrella, M. (2012). Aborto e misoprostol: usos médicos, práticas de saúde e controvérsia científica. *Ciência & Saúde Coletiva*, *17*(7), 1777–1784.

Diniz, D. (2008). *Aborto e saúde pública: 20 anos de pesquisas no Brasil*. Rio de Janeiro: UERJ. Brasília: UnB.

Diniz, D., & Madeiro, A. (2012). Cytotec e aborto: a polícia, os vendedores e as mulheres. *Ciência & Saúde Coletiva*, *17*(1), 1795–1804.

Enright, M., & Cloatre, E. (2018). Transformative illegality: How condoms "became legal" in Ireland, 1991–1993. *Feminist Legal Studies*, *26*, 261–284.

Erdman, J. N. (2019). Harm production: An argument for decriminalization. In A. M. Miller & M. J. Roseman (Eds.), *Beyond virtue and vice: Rethinking human rights and criminal law* (pp. 248–267). Philadelphia, PA: University of Pennsylvania Press.

Erdman, J. N., Jelinska, K., & Yanow, S. (2018). Understandings of self-managed abortion as health inequity, harm reduction and social change. *Reproductive Health Matters*, *26*(54), 13–19.

Faúndes, A. (2010). O uso do misoprostol no Brasil. In M. Arilha, T. Lapa, & T. Pisaneschi (Eds.), *Aborto medicamentoso no Brasil* (pp. 9–22). São Paulo: Oficina Editorial.

Gerdts, C., Jayaweera, R. T., Baum, S. E., & Hudaya, I. (2018). Second-trimester medication abortion outside the clinic setting: An analysis of electronic client records from a safe abortion hotline in Indonesia. *BMJ Sexual & Reproductive Health*, *44*(4), 286–291.

Guttmacher Institute. (2018). *Induced abortion worldwide*. Retrieved from www.guttmacher.org/sites/default/files/factsheet/fb_iaw.pdf

Lorde, A. (1984). The transformation of silence into language and action. In A. Lorde (Ed.), *Sister outsider: Essays and speeches* (pp. 40–44). Berkeley, CA: Crossing Press.

Madeiro, A. P., & Diniz, D. (2016). Serviços de aborto legal no Brasil – um estudo nacional. *Ciência & Saúde Coletiva*, *21*(2), 563–572.

Mc-Reynolds-Pérez, J. (2016). Argentina's abortion activism in the age of misoprostol. *Global Dialogue*, *6*(4). Retrieved from http://globaldialogue.isa-sociology.org/argentinas-abortion-activism-in-the-age-of-misoprostol/

Mc-Reynolds-Pérez, J. (2017). No doctors required: Lay activist expertise and pharmaceutical abortion in Argentina. *Signs*, *42*(2), 349–375.

Miller, A. M., Roseman, M. E., & Rizvi, Z. (2019). Introduction. In A. M. Miller & M. J. Roseman (Eds.), *Beyond virtue and vice: Rethinking human rights and criminal law* (pp. 1–14). Philadelphia, PA: University of Pennsylvania Press.

Nelund, A. (2014). Troubling publics: A feminist analysis of public criminology. *Radical Criminology*, *4*, 67–84.

Pazello, M. (2010). Internet, restrição de informações e acesso ao misoprostol. In M. Arilha, T. Lapa, & T. Pisaneschi (Eds.), *Aborto medicamentoso no Brasil* (pp. 81–119). São Paulo: Oficina Editorial.

Ramos, S., Romero, M., & Aizenberg, L. (2014). Women´s experiences with the use of medical abortion in a legally restricted context: The case of Argentina. *Reproductive Health Matters*, *43*(supp44), 4–15.

Ruibal, A., & Fernandez Anderson, C. (2018). Legal obstacles and social change: Strategies of the abortion rights movement in Argentina. *Politics, Groups, and Identities*. Advanced online publication. doi:10.1080/21565503.2018.1541418

World Health Organization (WHO). (2018). *Medical management of abortion*. Geneva: Author.

Zamberlin, N., Romero, M., & Ramos, S. (2012). Latin American women's experiences with medical abortion in settings where abortion is legally restricted. *Reproductive Health*, *9*(1), 34.

Zurbriggen, R., Keefe-Oates, B., & Gerdts, C. (2018). Accompaniment of second-trimester abortions: The model of the feminist Socorrista network of Argentina. *Contraception*, *97*(2), 108–115.