Abortion delivered? : the impact of telemedicine abortion services on abortion access and care in the rural United States

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A thesis submitted for the degree of
Doctor of Philosophy

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Declaration

I declare that the work presented in this thesis is my genuine and original work.

<u>Abstract</u>

Telemedicine abortion has been lauded as a 'game changer' for women and pregnant people who live far away from an abortion clinic. By remotely prescribing and dispensing the 'abortion pills' (mifepristone and misoprostol), telemedicine abortion promises to eliminate travel distance as a barrier to abortion care by making the pills travel to the patient. However, this idea has not been sufficiently interrogated in the context of the United States where 'direct-to-patient' telemedicine abortion services were not available until 2020 in response to the COVID-19 pandemic. This research therefore asks, to what extent does telemedicine abortion reduce, eliminate, or help to reimagine geographic barriers to abortion care in the US? I focus on a case study of one of the first fully telemedicine abortion providers in the US: Just The Pill (JTP). Drawing on spatial analysis using GIS and semi-structured interviews with patients, staff, and partners of JTP, I explore geographic barriers to abortion care for rural women and consider how telemedicine abortion addresses them, in terms of abortion access and experience. I find that distance was not the primary barrier to abortion care nor the only barrier that was considered geographical. Rather, rural women imagined and encountered multiple practical, socio-cultural, and economic barriers which led them to choose telemedicine abortion. In practice, telemedicine abortion did not preclude travel; depending on state of residence and restrictions on telemedicine abortion, patients travelled by car and plane to other states to have their remote consultation and pick up the pills. Nevertheless, rural women considered it more convenient than going to an abortion clinic. Moreover, telemedicine abortion facilitated participants' control over the timing of the abortion, the space in which it took place, and the people who accompanied them during the process, which enabled more privacy, comfort, and ease. I ultimately conclude that telemedicine abortion is not a panacea for abortion access for rural women and pregnant people, because patients are still travelling across state lines—what I call 'cross-border telemedicine'. Nevertheless, telemedicine abortion advances access to and shapes new experiences of abortion care because it displaces care away from clinical spaces which participants saw as expensive, inconvenient, and potentially stigmatising.

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1 | INTRODUCTION

1.1 | Introduction

'Abortion is healthcare' has been an important and unifying rallying cry for the abortion rights movement in the United States. It has been on placards alongside slogans such as 'abortion rights are human rights', 'my body, my choice', and 'keep abortion legal', among others, which emphasise the shared understanding that abortion access is a right and that this right shall not be infringed by the government. Yet this right has been infringed repeatedly and increasingly in the nearly 50 years following the *Roe v. Wade* (1973) decision which legalised abortion at the national level. More than 1,000 state-level restrictions on abortion culminated with the US Supreme Court decision to overturn *Roe* in 2022 and subsequent abortion bans in 14 states. Yet *Roe* has never been a reality for many women and pregnant people in the US; the stark disconnect between what the 'pro-choice' movement reaffirms as a right of bodily autonomy and the experience of marginalised people whose 'choice' has been limited in a society marked by reproductive injustices begs the question of what we mean when we shout 'abortion is healthcare' and, by extension, 'healthcare is a human right'. Premised on these health and human rights arguments, calls to safeguard abortion access during the COVID-19 pandemic lauded the promise of telemedicine to fill potential gaps in abortion care. The impending overturning of *Roe* likewise drew increased attention to telemedicine and mobile clinics as potential solutions to the abortion care crisis.

Telemedicine is widely upheld as a solution to health system challenges and lack of access to health care in the US and globally. The World Health Organization (WHO, 2019) has identified digital health as having a role in health system strengthening and the achievement of universal health coverage. The WHO suggests that telemedicine can reduce unnecessary clinical visits, provide more timely care, and extend coverage to underserved communities. The underserved communities that are understood to particularly benefit from telemedicine are rural areas, which are less likely to have local health care facilities, thereby requiring residents to travel greater distances to access care. The WHO itself defines telemedicine as 'the use of digital technologies to overcome distance barriers in the delivery of health services'

(WHO, 2022b). By enacting care 'at a distance' (Pols, 2012), telemedical services should eliminate the barrier of distance without compromising on quality of care.

The same reasoning underpins telemedicine abortion services, specifically. Telemedicine has gained particular traction in global sexual and reproductive health (SRH) services, such as through the use of mHealth for sharing information (Rokicki and Fink, 2017), supporting midwives (White, Crowther and Lee, 2019), and family planning (Smith et al., 2015), especially in 'developing countries'. The WHO (2022a) officially recommended the use of telemedicine abortion for safe and effective early abortion services in 2022, after recognising the importance of telemedicine for ensuring abortion care delivery during the COVID-19 pandemic (WHO, 2021).

Like telemedicine more broadly, telemedicine abortion claims to reduce unnecessary clinical visits and provide more timely care because it is safe and effective to 'self-manage' an abortion with pills. Thus, an abortion with pills and, by extension, telemedicine abortion, represents potential macro-level cost savings for health systems (Rodgers et al., 2021). However, the introduction of remote care in the abortion care pathway may be a way in which abortion providers attempt to address increased demand resulting from clinic closures or new restrictions (Lattof et al., 2020). Moreover, in the context of the COVID-19 pandemic abortion, some abortion clinics in the US suggested patients choose medication abortion or telemedicine abortion to reduce risk of viral transmission in clinical interactions. However, given the potential for telemedicine abortion to 'reduce pressure on overburdened health systems' (Skuster, Dhillon and Li, 2021, p.1), as demonstrated during the pandemic, it is abortion seekers who may now feel the pressure to choose a telemedicine abortion over other methods (Footman, 2023).

Telemedicine abortion also claims to extend coverage to underserved communities. It is understood specifically to reduce the burden of travel distance to an abortion clinic, because it has long been established that the farther an individual lives from an abortion facility the less likely they are to have an abortion (Fuentes and Jerman, 2019; Jones and Jerman, 2013; Shelton, Brann and Schulz, 1976). Telemedicine makes the abortion pills, rather than the abortion seeker, travel across the 'large

swathes of land' (Hennessy-Fiske, 2016) without an abortion provider, thereby promising to alleviate the burden of accessing care, if not the total state refusal to provide abortion care. As such, telemedicine abortion is understood as a '*game changer* for some women who live far from an abortion provider' (Sethna, 2019, p.9, emphasis mine) and thus a 'spatial fix for a geographical problem' (Calkin, 2019b, p.27).

The notion that telemedicine abortion can improve abortion access for rural women and pregnant people has not yet been sufficiently interrogated. I set out to determine whether telemedicine abortion reduces, if not eliminates, geographic barriers to abortion care in the US—and how—and therefore more critically examine the move towards digital health interventions in SRH.

1.1.1 | Research question and aims

This research asked: to what extent does telemedicine abortion reduce, eliminate, or help to reimagine geographic barriers to abortion care in the United States? To do this, I had the following aims:

- Identify the geographic barriers to abortion care for rural women and pregnant people.
- Determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people.

This research question and its attendant aims enabled me to understand whether the promises of telemedicine have been realised and, in either case, how telemedicine has affected abortion access and abortion care, as well as the implications of telemedicine abortion more broadly.

1.1.2 | Key arguments

In this thesis, I argue that telemedicine abortion reduces geographic barriers to abortion care, in terms of accessing the abortion pills, while also reimagining geographic barriers to abortion care, in terms of experiencing an abortion with pills. My argument is based upon interviews with telemedicine abortion patients, providers, and funds and is advanced through three sub-arguments that address the aims of this project.

Firstly, I argue that the simplified and rational narrative of the travel-to-abortion burden does not sufficiently account for how women imagined and encountered barriers in making their abortion decisions and attempting to arrange care. Distance was neither the primary barrier to abortion care nor the only barrier to abortion care which could be considered geographic or spatial. Rather, participants considered multiple barriers to abortion care, including practical, socio-cultural, and economic *and* distance barriers, which affected them particularly as rural women. This combination of barriers led them to choose telemedicine abortion as opposed to an in-clinic abortion procedure.

Secondly, I argue that abortion seekers are often just as likely to cross borders for telemedicine care and therefore it cannot be assumed to be a panacea for rural health inequality. Telemedicine abortion is thus not entirely 'virtual'; like brick-and-mortar clinics, it relies on place-based infrastructure and is subject to state regulation and coercion. On the other hand, telemedicine abortion pushes abortion care into new temporal and spatial patterns which enable women to evade practical, socio-cultural, and economic barriers to abortion care. Even where telemedicine abortion maintains the burden of distance, it facilitates affordable and timely abortion care.

Thirdly, I argue that, by moving abortion care away from brick-and-mortar clinics, telemedicine abortion opens opportunities for alternative experiences of abortion care. As such, telemedicine abortion not only affects how individuals *access* care but also how they *experience* care. Away from the abortion clinic, women choose the timing of their abortion, manage their own symptoms, and create the atmosphere in which the abortion takes place, while also having medical supervision and support from providers 'at a distance'. Telemedicine abortion therefore facilitates non-judgemental, empowering, and holistic abortion care which is relational even as it is 'self-managed'.

1.2 | Context

To understand my argument that telemedicine abortion reduces and reimagines geographic barriers to abortion care, it is necessary to understand:

- what abortion is, who has them, when, and why;
- how abortion is regulated by the legal and health care systems; and
- how abortion is restricted at the state-level.

In this section, I detail each of these contextual factors in turn.

1.2.1 | Abortion 101

Abortion is a process by which a person ends a pregnancy. Anyone with the capacity to become pregnant may have an abortion. This includes not only cis gender women but also trans men, non-binary or gender non-confirming individuals who have uteruses[1]. Data collected about abortion frequency among certain populations has not sufficiently accounted for gender diversity and most statistics refer to women as a discrete category. It is estimated that one in four women will have an abortion in their lifetime (Jones and Jerman, 2017). However, the number of abortions in the US is likely an underestimate due to underreporting and methodological challenges (see for example Mueller et al., 2023).

Women and pregnant people have abortions for a wide variety of reasons. Research shows that financial reasons are the most common reason for which to terminate a pregnancy, followed by it not being the right time, partner-related reasons, and focusing on other children (Biggs, Gould and Foster, 2013). There is likely to be more than one reason (Foster, 2020), but ultimately, whether the pregnancy is wanted or unwanted, people have an abortion because they do not want to or cannot be pregnant, give birth, or raise a child. Because of abortion-related stigma, there is a perception among abortion-seekers that they should justify their reasoning (Allen, 2015; McKinney, 2019). Moreover, some laws limit the conditions under which a person can have an abortion. Researchers and activists have pointed to a 'hierarchy' of abortions whereby some abortions are deemed 'good' while others are deemed 'bad' (see for example Millar, 2017). This research has been conducted with the staunch belief that abortion should be on-demand and that justification should not be

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[1] In this thesis, I strive to use gender-inclusive language in the recognition that not only women have abortions and therefore abortion access is not just a 'cis-sue'. I generally use 'women and pregnant people' or 'abortion seekers' when speaking broadly about abortion access. I generally use 'women' when speaking about my participants specifically, because they all identified as cis women.

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provided to earn access to a necessary health procedure. We should, however, be concerned with abortion reasons insofar as they are shaped by reproductive (in)justices in society.

Most abortions occur in the first trimester of pregnancy (Jones, Witwer and Jerman, 2019) and first trimester abortion is the most available procedure in the US (Cartwright et al., 2018). Abortions after the first trimester, around 13 weeks gestation, account for around one in 10 abortions (Jones and Finer, 2012). Abortion is generally not permitted after foetal viability—the gestational age at which a foetus could potentially survive outside the womb—though exceptions may be provided for 'therapeutic' reasons, especially for foetal abnormalities incompatible with life which may not be diagnosed until later in pregnancy. Nevertheless, abortion scholars underscore the need for abortion at all gestational ages (Kimport, 2022). Gestational age determines which type of abortion procedure is available and there are two key methods: 1) procedural abortion and 2) medication abortion.

Procedural abortion is generally referred to as surgical abortion, though it is not in fact a surgery, and is performed by a medical professional. A manual vacuum aspiration (MVA) is the most common procedural abortion and is used until around 14-16 weeks gestation. It involves using suction to remove the contents of the uterus. A dilation and evacuation abortion (D&E), which uses a combination of suction and medical tools to remove the contents of uterus, is normally used after 16 weeks gestation. In the US, procedural abortions can only be accessed in a medical facility. Generally, this would be a specialised abortion clinic rather than a primary care clinic or hospital. Although the name Planned Parenthood is ubiquitous in the cultural imagination around abortion in the US, it is independent abortion clinics that provide most abortion care.

Medication abortion, which is also referred to as 'medical abortion' or 'abortion with pills', involves the use of medication to induce an abortion. Most medication abortions are done in the first trimester. The most common regimen involves the use of mifepristone to stop the pregnancy from growing and misoprostol to expel the contents of the uterus. The results of a medication abortion are indistinguishable

from a spontaneous miscarriage. Prescribed timing and dosage may vary, particularly if using just misoprostol, which is a common regimen in areas with restrictive abortion laws. In these areas, mifepristone, which is known as an abortion drug, is difficult to access, while misoprostol may be available over-the-counter as an ulcer treatment.

In the US, the drug mifepristone was not approved by the Food and Drug Administration (FDA) until 2000. Originally under FDA requirements mifepristone use was restricted to the first 49 days of pregnancy. It could only be prescribed and administered by a physician with at least two visits to the provider (Tomlinson, 2021). FDA approval of mifepristone suggested that abortion would be more widely accessible because it could be delivered by a wide range of non-specialist providers (Finer and Wei, 2009), though this has not necessarily been realised. Nevertheless, mifepristone became 'an integral part of abortion provision' in the US (Finer and Wei, 2009, p.628): the proportion of medication abortions rose from 5% in 2001 to 39% in 2017 while the overall abortion rate declined (Jones, Witwer and Jerman, 2019). Medication abortion is now the most common abortion method in the US (Jones et al., 2022). The use of the medication abortion regimen has also allowed for earlier abortions (Aiken et al., 2021b; Grindlay and Grossman, 2017; Raymond et al., 2019; Upadhyay and Grossman, 2019). The FDA regulations were updated in 2016 to allow mifepristone use in the first 70 days of pregnancy at a lower medical dose, to authorise its provision by non-physicians and to end the requirement for follow-up exams (Tomlinson, 2021).

1.2.1.1 | Telemedicine abortion
Throughout its more than 20 years of approval by the FDA, mifepristone has been treated as exceptional through overregulation. Of the 20,000 drugs regulated by the FDA in the US, mifepristone is the only one that must be dispensed in a medical office but can be self-administered at home (American Civil Liberties Union, 2020). Instituted under the guise of patient safety, these requirements are medically unwarranted and not in line with current medical standards (Henney and Gayle, 2019). As Berer explains, '[w]ith no other medication of this kind does a doctor need to watch the person put the pill into her mouth and swallow it' (2020, p.49). Sheldon

(2016) questions the degree to which the state can purport to 'control swallowing', especially where the abortion pills have been accessed online, while Calkin (2019b, 2021b, 2023b) elsewhere shows that states are ineffective in stemming the flow of these pills.

Prior to 2020, patients needed to attend at least one in-person appointment to take the mifepristone in the presence of an abortion provider in an abortion clinic. The four misoprostol pills were then dispensed to be taken at home between one and two days later. In July 2020, the FDA (2023) eliminated its requirement that mifepristone be dispensed in-person, thereby enabling 'no-touch' or 'direct-to-patient' telemedicine abortion. Without the in-person requirement for mifepristone, both pills could be sent directly to a person's home, if permitted by state law. Telemedicine abortion therefore involves the provision of abortion pills using some degree of remote care. Some or all components of abortion care can be completed remotely or in-person, including confirmation of pregnancy and gestational age, consultation and counselling, dispensing of drugs, and aftercare—Parsons and Romanis (2021) describe this as a 'telemedical continuum'.

Drawing on the case study of the telemedicine abortion provider Just The Pill (JTP) (see Chapter 2), I understand telemedicine abortion as taking place in legal settings, within the formal health care system, but at home for most or all aspects of care. Both studies of 'partial' and 'full' telemedicine medication abortion services have demonstrated that in-person visits are not necessary to terminate a pregnancy safely and effectively. A telemedicine abortion can be a self-managed abortion, but a self-managed abortion does not necessarily need to be initiated through the formal healthcare system. With global providers, online pharmacies, and 'underground' distribution networks, pregnant people can illegally obtain the abortion pills and have an abortion at home with or without 'accompaniment' from feminist networks, which are not generally considered telemedicine (Berro Pizzarossa and Nandagiri, 2021).

Building on Parsons and Romanis (2021) and drawing on my research in this thesis, here I describe five methods through which abortion pills can be accessed remotely, including through telemedicine (summarised in Figure 1.2a).

Online abortion provider: There are two key online abortion providers which serve the US: Women on Web and Aid Access. Women on Web was established in 2005 by Dr Rebecca Gomperts. Women on Web is a Canadian non-profit organisation that provides access to abortion pills for current or future use in nearly 200 countries. Individuals fill out an online consultation which is reviewed by Women on Web's medical team who then prescribe the abortion pills and have the medicines sent by mail. The cost is on a sliding scale, depending on the country, for between 70 and 90 euro. An email helpdesk is available 24/7 for support before, during or after the abortion. Aid Access is also led by Dr Gomperts and follows the same process for prescribing and dispensing the abortion pills and supporting their use but provides abortion exclusively to the 50 states of the US. While these providers might be considered telemedicine as all aspects take place remotely and there is clinician support, both are operating outside of the formal US health care system.

Online pharmacy: Websites like abortionpillrx.com and buymifeprex.com, among others, sell generic combination packs of mifepristone and misoprostol which are called mifeprex. As Calkin (2023b) extensively details, these kits are from mid-tier Indian manufacturers. While these websites might appear to be based in North America or Europe, they are likely based in India. The kits are sold without a prescription, without any clinician support, and at a significant mark up over typical retail price. They operate outside of the formal US health care system and are therefore difficult to regulate.

'Full' telemedicine abortion: In full telemedicine abortion, all aspects of abortion care take place remotely: booking an appointment, consulting with a clinician, prescribing and mailing the abortion pills, and following up after the abortion. Providers may have a brick-and-mortar clinic and also offer telemedicine, or they may exclusively offer telemedicine abortion. The latter providers were only possible after the FDA decision to allow remote dispensing of mifepristone and several were launched in 2020 and beyond. At least three of these, Hey Jane, Abortion on Demand, and Choix, are companies and frequently described as 'start ups'. While financial information is not easy to access, we know that Hey Jane is in large part

funded by venture capital, raising questions about the financialisation of health care in the US. JTP, on the other hand, is a non-profit organisation, like Women on Web and Aid Access, and therefore operates differently to these companies.

'Partial' telemedicine abortion: Partial telemedicine abortion was the only possibility in the US prior to the FDA decision. In some cases, the patient still travelled to the abortion clinic, and it was the clinician who dialed in remotely from elsewhere. This enabled patients to access abortion care at a sexual and reproductive health clinic that did not initially provide abortion. This was spearheaded by Planned Parenthood clinics in Iowa and Alaska.

Cross-border telemedicine abortion: This is an emerging pathway for 'remote' abortion care and is the subject of this thesis. In this model, patients who live in states where telemedicine abortion is not legal travel to states where it is legal to access remote care. Whereas in full telemedicine abortion the patient speaks to the provider and waits for the pills to arrive from the comfort of their home, in cross-border telemedicine abortion the patient must speak to the provider and pick up the abortion pills in a particular state. This is the situation of most of my participants and is likely being used to access care from other providers, not only JTP. JTP takes patients at their word that they are in the correct state, but in some cases patients may not have actually travelled. On the other hand, Abortion on Demand uses software to verify a person's presence in the telemedicine-providing state during their appointment and Choix requires an address for that state. Outside of the scope of this thesis are abortion seekers who use other strategies like mail forwarding or virtual mailboxes to avoid the travel, while still accessing telemedicine abortion in a different state.

Figure 1.2a | Remote provision of abortion pills in the US

Model of remote abortion pill provision	Examples	Description
Online abortion provider	Women on Web, Aid Access	Provider may be located overseas or domestically. All aspects take place remotely. Clinician support.

Online pharmacy	Abortion Rx, Get Mifeprex, Abortion Ease	Provider has no physical presence. <u>All</u> aspects take place remotely. No clinician support.
'Full' telemedicine abortion	Hey Jane, Choix, Abortion on Demand, JTP	Provider may have physical presence or not. <u>All</u> aspects take place remotely. Clinician support.
'Partial' telemedicine abortion	Planned Parenthood	Provider has a physical presence. <u>Some</u> aspects take place remotely and some in an abortion clinic. Clinician support.
Cross-border telemedicine abortion	JTP	Provider may have a physical presence or not. <u>Some or all</u> aspects take place remotely in a state where the patient is not a resident. Nothing takes place in an abortion 'clinic'. Clinician support.

1.2.2 | Abortion law and provision

Based upon the United States Constitution of 1776, the US governs under a federalist system in which federal law supersedes or pre-empts state law. The US Congress (the legislative branch), which includes the House of Representatives and the Senate, develop bills which are then signed into law by the US President and implemented by federal agencies (the executive branch). The federal court system (the judicial branch), from circuit courts to the US Supreme Court, interpret the laws. The judges in these courts are not elected but appointed by the US President and confirmed by the US Congress. Individual states also have these three branches of government—legislative, executive, judicial—but their laws cannot contravene those created at the federal level.

This basic explanation is critically important for understanding the 'patchwork of laws' (Calkin, 2019b, p.23) that constitutes the abortion landscape in the US. When I began this PhD in 2019, the legal right to abortion in the US had been national law for nearly 50 years, following the US Supreme Court decision in *Roe v. Wade* (1973). Prior to this decision, individual states could confer the right to abortion or not. After this decision, individual states *had to* confer the right to abortion, but they did not have to facilitate access to the procedure. Thus, *Roe* established a negative

right to abortion in which the 'choice' to have an abortion would be made between a woman and her doctor without state interference. It was not long after *Roe* that it became clear that this right was stratified—certain women were able to access abortion more easily than others—and 'still unsettled law' (Watson, 2018, p.211), meaning that the highest-level judicial ruling was considered incorrect and still worth fighting by anti-abortion activists and lawmakers throughout the country

Individual states governed by anti-abortion lawmakers began to pass laws that intentionally challenged *Roe*. These challenges made their way up through the court system and the US Supreme Court decided to listen to the cases or not. One landmark ruling was in *Planned Parenthood v. Casey* in 1992. Pennsylvania had passed a law in 1982 requiring a waiting period, spousal notification, and parental consent for minors—less than a decade after *Roe*. The Supreme Court re-settled *Roe* unfavourably by implementing an 'undue burden' standard by which a state abortion law would be deemed to be too burdensome for an abortion seeker to access care. This decision paved the way for individual states to implement abortion restrictions without superseding federal law, with the ultimate goal of presenting a challenge to *Roe* that would eliminate abortion, which they later accomplished with *Dobbs v. Jackson Women's Health Organization* (2022). Throughout the five decades of *Roe*, these groups have chipped away at the rather limited right to abortion through over-regulation as well as coordinated campaigns and attacks against clinics, including multiple murders of abortion providers and clinic escorts.

Individual states pushing the boundaries of *Roe* combines with the particularities of the US health care system to make abortion a right contingent upon geography and social capital. The US has a combination of a publicly funded and privately financed health care system. There are two publicly funded insurance programmes: Medicaid, based upon income, and Medicare, based upon age or disability status. Privately financed health care generally comes through an employer but can also be purchased on the market. According to the US Census, a total of 66% of Americans are on a private plan, 35.7% on a public plan (including Medicaid and Medicare), and 8.3% are uninsured (Keisler-Starkey and Bunch, 2022). It should be made clear that private insurance coverage is neither free nor comprehensive. What is particularly

relevant for abortion care, firstly, is that federal law prohibits the use of federal funds for abortion (Upadhyay et al., 2022). As such, individual states decide whether to supplement coverage for abortion in their Medicaid programmes. Secondly, abortion is an expensive procedure in both absolute and relative terms (see further Chapter 4) and is not generally covered by private insurance. Thirdly, abortion clinics may—but do not uniformly—accept private or public insurance.

For numerous regulatory and legal reasons, as well as the stigmatisation of abortion, most abortion care is provided in specialised clinics that are structured by different state and regional policies and regulations. This makes them easy targets for violence and protest. As a result of these efforts and the numerous restrictions implemented at the state-level since 1973 and particularly in the twenty-first century, abortion-providing facilities are fewer and farther between. States have implemented medically unnecessary restrictions that have forced clinic closures and made getting an abortion harder and harder—which is the very point of these laws.

The difficulties of accessing and affording an abortion have become exponentially more difficult with the 7-2 decision in *Dobbs* which overturned *Roe* and *Casey* thereby sending abortion 'back to the states'. The majority opinion asserted that because the Constitution makes no explicit mention of abortion and that abortion rights are neither 'deeply rooted' in the history and tradition of the US nor 'implicit in the concept of ordered liberty' (US Supreme Court, 2022), abortion is not a protected right by the federal government. Justice Samuel Alito, writing the majority opinion, claimed, '*Roe* was egregiously wrong from the start. Its reasoning was exceptionally weak, and the decision has had damaging consequences. And far from bringing about a national settlement of the abortion issue, *Roe* and *Casey* have enflamed debate and deepened division' (US Supreme Court, 2022). The *Dobbs* decision is the latest—albeit the most momentous—action in a long history of US federal and state governments undermining abortion access.

1.2.3 | Abortion restrictions

Abortion access has *never* been a guarantee in the US. Analysis by Nash (2021a) shows that 1,336 state-level abortion restrictions were passed between 1973 and

2021, 44% of which were enacted between 2011 and 2021. These restrictions led to a 'patchwork of laws' (Calkin, 2019b, p.23) across the country prior to *Dobbs*, when abortion was still legal at the federal level. In this section I detail and group the laws using Bentele, Sager and Aykanian's (2018) five categories of abortion restrictions, all of which are deeply geographical in nature in that they are specific to the state or municipality and they restrict the access of those seeking abortions in their areas. I add a sixth category to account for more recent restrictions on abortion pills and telemedicine abortion, which were particularly introduced in the wake of COVID-19. These categories are: 1) restrictions on providers, 2) restrictions on clients, 3) restrictions on funding, 4) efforts to discourage women, 5) symbolic restrictions, and 6) restrictions on care pathway. I detail these categories within the pre-*Dobbs* context, but note that some of these states now ban abortion completely.

Restrictions on abortion providers: According to data from the Guttmacher Institute (2022h), 23 states over-regulate abortion providers beyond what is necessary to ensure patient safety. They require licensing standards comparable to ambulatory surgical centres; room or corridors to certain specifications; as well as specified proximity to, transfer agreements with, and admitting privileges to local hospitals. These laws are most frequently referred to as 'TRAP' laws (targeted regulation of abortion providers).

Restrictions on abortion seekers: A total of 22 states have pre-viability bans on the books, prohibiting abortion from 20 to 24 weeks gestation (Donovan, 2020). According to data from the Guttmacher Institute (2022d), 36 states require some parental involvement in a minor's[2] abortion. Exceptions and specifications abound in this set of restrictions. States might require the consent, notification, or both consent and notification of one or both parents. In 11 states parents must have identification and in 4 they must have proof of parenthood, while 2 states require a minor to have identification. In some cases, another relative, guardian, or health professional can substitute for a parent. Judicial bypasses, where the state can provide consent in

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[2] In the US, a minor is generally anyone under the age of 18. It differs slightly between states and may range between anyone under the age of 14-18, depending on the law, but is most commonly 18.

cases where a minor does not want to or cannot notify their parent, are available in 35 of the 36 states requiring parental involvement. However, these are onerous to obtain. Parental involvement may be waived in a medical emergency or in cases of abuse, assault, incest or neglect.

Restrictions on abortion funding: According to data from the Guttmacher Institute (2022g), 33 states and D.C. adhere to the federal standard of providing funding for abortion in 'therapeutic' cases of threat to life, rape, and incest while 4 also provide funding in cases of foetal imapriment and an additional 4 provide funding in cases of threat to physical health. In Iowa, the governor must approve each Medicaid-funded abortion. Just 16 states require Medicaid funding for abortions whether voluntary or with a court order. The restrictions on private insurance are more complex: 11 states restrict abortion coverage in all private insurance plans, 25 states restrict abortion coverage in plans offered through health insurance exchanges, 22 states restrict abortion coverage in health insurance plans for public employees, and 20 states have a combination of these restrictions. Just 8 states require private insurance coverage of abortion, and only in cases where prenatal coverage is offered (Guttmacher Institute, 2022e).

Efforts to discourage abortion seekers: According to data from the Guttmacher Institute (2022b), 32 states require patients to receive counselling prior to their abortion. 27 of these states require a subsequent waiting period ranging from 24 to 72 hours, and 15 of the 32 require counselling to be provided in-person thereby mandating two trips to the abortion clinic and precluding telemedicine abortion. A total of 27 states regulate the provision of ultrasound by abortion providers, some mandating that the image must be shown and described to the patient (Guttmacher Institute, 2022f). Various exceptions and specifications apply to mandatory counselling, waiting period, and ultrasound laws. Further to these discouraging laws are crisis pregnancy centers (CPCs), which aim to dissuade individuals away from abortion (see Chapter 4). In the US, there were nearly 2,500 CPCs with physical locations in 2019 and an estimated additional 173 mobile CPCs in 2021 (Thomsen et al., 2022b)—vastly outnumbering the number of abortion clinics with physical, mobile or non-physical locations.

Symbolic restrictions on abortion: According to data from the Guttmacher Institute (2022a), 11 states ban sex-selective abortion, 4 states ban abortion for reasons of race, and 6 states ban abortions for reasons of foetal genetic anomaly, while 3 others instead require counselling prior to the termination for reasons of foetal genetic anomaly. There is limited evidence to suggest that sex- or race-selective abortions are occurring in the US (see for example Citro et al., 2014). Rather, these laws ensure that abortion providers question the motivations of their patients. On the other hand, abortion for foetal genetic anomalies do occur, such as for when a foetus' condition is incompatible with life, though they are not among the most common reasons for abortion.

Restrictions on abortion method: According to data from the Guttmacher Institute (2022c), 29 states require physicians to administer medication abortion and 18 states require the physical presence of the administering clinician, thereby prohibiting telemedicine abortion. As stated above, these restrictions are not medically necessary. Rather, these restrictions limit the clinical staff who can provide abortion and ensure that abortion seekers must travel to a clinic to have an abortion, often more than once.

Figure 1.2b | Requirement for physicians to dispense medication abortion, 2022[3]
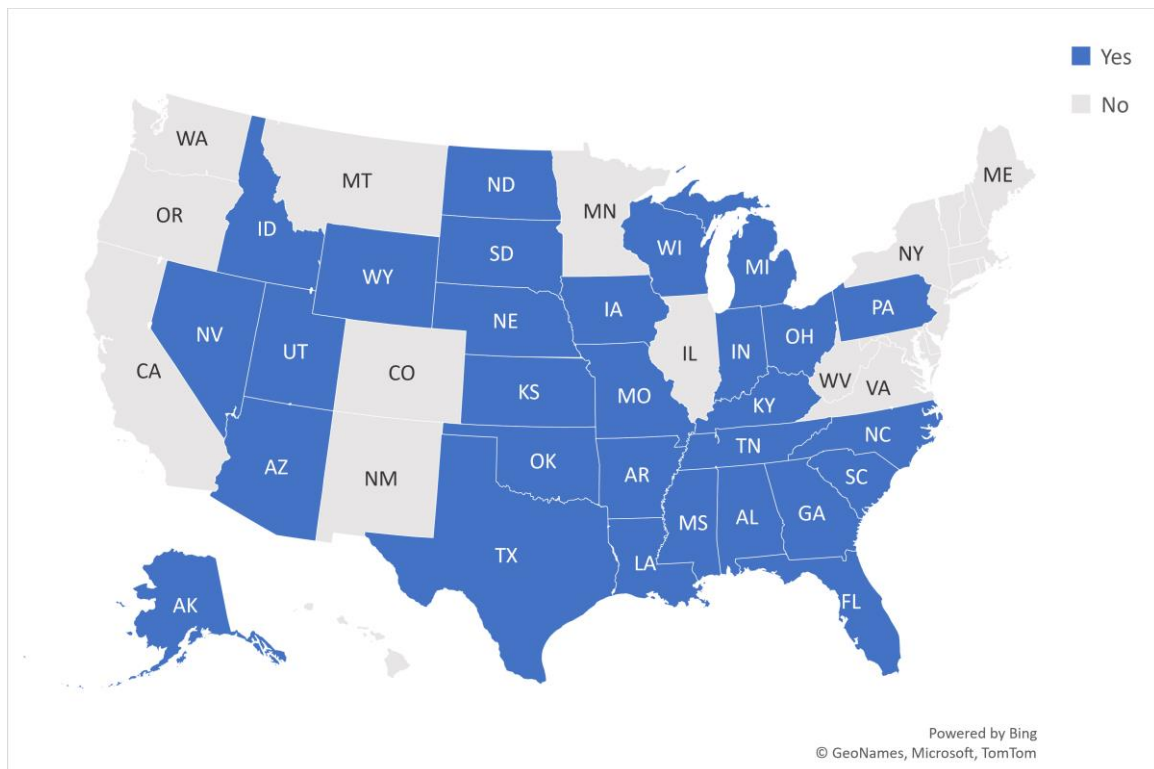
Figure 1.2c | Requirement for medication abortion-dispensing physician to be physically present, 2022

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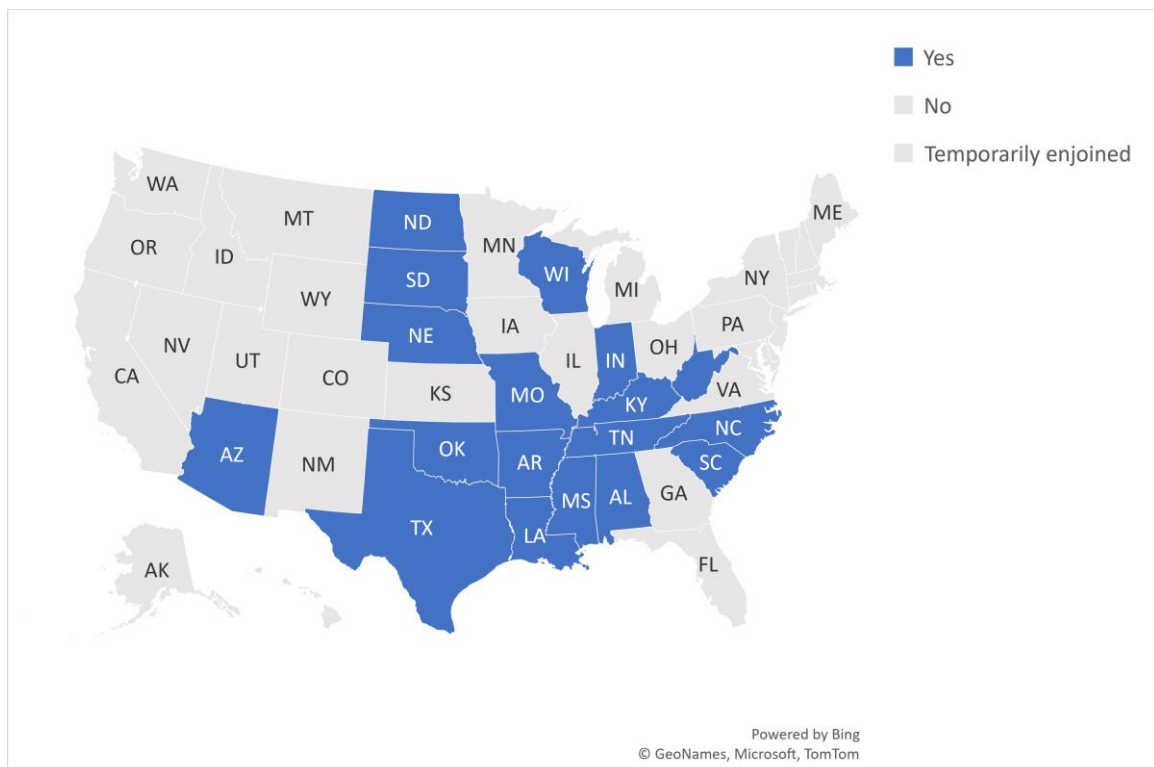
[3] I created this and the following map using on Microsoft Excel. I used a table of the 50 states and whether they had these requirements and created a 'Map Chart'.

1.3 | Overview of research

Given the 'patchwork of laws' (Calkin, 2019b, p.23) seen in these maps, I wondered how the advent of telemedicine abortion would shape access within and across state borders. Building on the health and care, reproductive, and abortion geographies literatures and drawing on 19 interviews and GIS, I argue that telemedicine reduces and reimagines geographic barriers to accessing and experiencing abortion care.

1.3.1 | Summary of research methods

In this research, I used a mixed-methods approach to answer my research question: to what extent does telemedicine abortion reduce, eliminate, or help to reimagine geographic barriers to abortion care in the United States?

In the quantitative component of my research, I used geographic information systems (GIS) to begin to address the first aim of this research: Identify the geographic barriers to abortion care for rural women and pregnant people. As I describe in further detail in my methodology (Chapter 2), I drew on three datasets— telemedicine abortion patient location, abortion clinic location, and rural population data—to determine how far telemedicine abortion patients *would have had to* travel to access an in-clinic abortion if they had not used telemedicine and whether these distances were correlated with rurality.

The qualitative component of my research further addressed this aim through semi-structured interviews. Following my literature review (Chapter 3), the quantitative and qualitative datasets are brought together in Chapter 4. I conducted interviews with patients of telemedicine abortion provider JTP (n=11), staff of JTP (n=5), and staff of partner organisations (n=2). JTP therefore served as a case study for this research and the organisation facilitated access to interviewees. These interviews also addressed the second aim of this research: Determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people. The data from these interviews serves as the basis for my analysis in Chapters 5 and 6.

1.3.2 | Sites of research

Research interviews were conducted remotely with patients and providers located in the Midwest, South, and West of the United States. JTP is licensed to provide telemedicine abortion in the states of Colorado (CO), Minnesota (MN), Montana (MT), and Wyoming (WY), but they serve patients from neighbouring states and states further afield due to inter-state abortion travel. As such, my interviewees were not only resident in Minnesota and Montana but also North Dakota (ND), South Dakota (SD), Texas (TX), and Wisconsin (WI). Drawing on data from the US Census (2020) and the Guttmacher Institute (2022a, 2022b, 2022c, 2022d, 2022e, 2022f, 2022g, 2022h; Jones, Kirstein and Philbin, 2022), in the following figures (1.3a,b,c) I provide pertinent information about the United States and the eight states of relevance to this study, including geographical area, population, political party, abortion rate, number of abortion providers, and state-level abortion restrictions.

Figure 1.3a | Location of the primary states under study

Powered by Bing
© GeoNames, Microsoft, TomTom
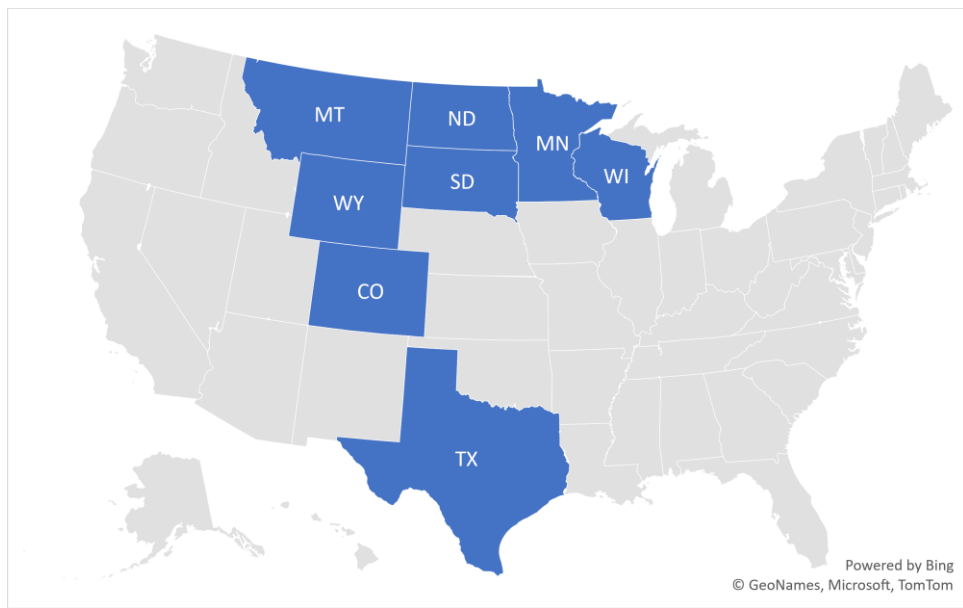
Figure 1.3b | Overview of geography, demography, and politics of US and 8 states under study

Statistic	US	CO	MN	MT	ND	SD	TX	WI	WY
Region of the US	—	West	Midwest	West	Midwest	Midwest	South	Midwest	West
Land area (miles^2)	3,533,038	103,637	79,627	145,550	63,995	75,809	261,267	54,167	97,088
State ranking by land area (miles^2)	—	8th	14th	4th	17th	16th	2nd	25th	9th
Population	331,449,281	5,773,714	5,706,494	1,084,225	779,094	886,667	29,145,505	5,893,718	576,851
Population density (number of people per mile^2)	93.7	55.7	71.7	7.4	11.3	11.7	111.6	108.8	5.9
Population – 'white alone'[4]	71%	70%	83.20%	90.90%	82.90%	80.70%	50.10%	80.40%	98.70%
Governor (2023)	D[5,6]	D	D	R	R	R	R	D	R
House (2023)	R[7]	D	D	R	R	R	R	R	R
Senate (2023)	D	D	D	R	R	R	R	R	R

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[4] This is a category on the US Census. The rest of the population identify as Black or African American, American Indian and Alaskan Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race, or Two or More Races.

[5] Democratic Party.

[6] The President of the US.

[7] Republican Party.

Figure 1.3c | Abortion information for US and 8 states under study

Statistic	US	CO	MN	MT	ND	SD	TX	WI	WY
Annual number of abortions (2020)	930,160	13,420	11,060	1,630	1,170	130	58,020	6,960	100
Rate of abortions (per 1,000 women aged 15-44) (2020)	14.4	11.2	10.2	8.2	7.8	0.8	9.5	6.4	0.9
Number of abortion providers (2020)	807	23	10	6	1	1	24	4	2
Number of abortion providers (2017)	808	18	7	5	1	1	21	3	2
Restrictions on abortion seekers (2022)	—	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Restrictions on abortion seekers (2022)	—	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Restrictions on abortion funding (2022)	—	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Efforts to discourage abortion seekers (2022)	—	No	No	No	Yes	Yes	Yes	Yes	Yes
Symbolic restrictions (2022)	—	No	Yes	No	Yes	Yes	No	No	No
Restrictions on abortion method (2022)	—	No	No	No	Yes	Yes	Yes	Yes	Yes
Abortion ban (after *Dobbs*)	—	No	No	No	Yes	Yes	Yes	Yes	No

1.3.3 | Timing of research

My research and research participants have not only been affected by the *Dobbs* decision, but several other legal and policy changes that have taken place at the federal and state levels since 2020.

In response to COVID-19, in July 2020 the FDA eliminated its requirement that mifepristone—the first of the two drugs used to terminate a pregnancy with pills—be dispensed in-person (American Civil Liberties Union, 2020). Prior to this decision, mifepristone was taken in the physical presence of an abortion provider in an abortion clinic. The four misoprostol pills were then provided to the patient to be taken at home between one and two days later. Without the in-person requirement for mifepristone, both pills could be sent directly to a person's home. This enabled a 'direct-to-patient' or 'no-touch' telemedicine model with that all aspects of the medication abortion are done remotely, including confirmation of pregnancy and gestational age, consultation and counselling, dispensing the drugs, and aftercare. This decision was reversed six months later (January 2021) and then re-instated (April 2021).

Following *Dobbs*, South Dakota and Wisconsin have implemented abortion bans (2022), Montana and North Dakota's bans have been blocked by the courts (2022), and Wyoming was the first state to introduce a ban on abortion pills which was subsequently blocked by the courts (2023). Mifepristone has also been under threat by a federal court case in Texas (2023). Not all changes since *Dobbs* have been negative ones, however: a Minnesota court instituted the right to *access*—not just 'choose'—abortion and struck down many of the state's extant abortion restrictions (2022).

During this thesis, *Roe* and *Casey* were still the law of the land. Abortion was legal albeit restricted in various ways in all the states under study. Writing this thesis in light of these changes has been a moving target. The context section was one of the last to be completed in the final draft of the thesis, because the law kept changing. The 'U-turns' on telemedicine abortion law in 2020-21 directly impacted the work of the provider and how I ultimately designed the research. My work is representative of

research into rapidly changing areas; I worried about the 'generalisability' of the research and whether it was already out-of-date by the time it was finished. However, while the research is situated within the spatial-temporal and legal context described in this chapter, it provides insight into abortion access and care more broadly—through the lens of telemedicine abortion in this particular context.

1.5 | Chapter outlines

This thesis comprises seven chapters, including this introduction. In this section I outline each of the chapters.

1.5.1 | Chapter 2: Methodology

In Chapter 2, I outline the methods I used over the course of my research. I justify my approach to the research as a feminist health geographer by drawing on methods from feminist health geographies and the field of feminist geography more broadly, including qualitative, quantitative, and mixed-methods research methods. I pay specific attention to feminist critical GIS and qualitative interviews as they are the key methods that made up my mixed-methods approach. In the latter, I briefly discuss issues related to online interviewing during the COVID-19 pandemic.

I then detail how I came into contact and managed the relationship with my research partner, JTP. I justify the use of a case study approach and then outline the research sites—eight American states—and context. I then address the quantitative and qualitative data collection and analysis processes in turn. Firstly, I provide a brief description of the spatial analysis I conducted, in advance of a lengthier description in Chapter 4. Secondly, I provide an overview of participant recruitment and interviewing and how I executed these aspects and analysed the qualitative data using a feminist health geography approach. I also consider positionality and ethical concerns.

1.5.2 | Chapter 3: Literature review

In Chapter 3, I review the key literatures that I draw upon throughout my research analysis chapters. These are, broadly: 1) health and care geographies; 2) reproductive geographies; and 3) abortion geographies. Each of these literatures

explores technology, access, and care, which are central themes in this research, and I bring these three strands of scholarship into conversation to explore how the technology of telemedicine abortion shapes the geography of abortion access and care in the US.

Within health and care geographies, I consider how we understand health inequalities from a geographical perspective, how care and caring are spatial phenomena, and how care is then configured across space. As such, this body of literature speaks to my focus on inequality of access to reproductive and abortion care in the US as well as considerations of how abortion access and care are shaped by space and place and ultimately changed by telemedicine or care 'at a distance'.

Within reproductive geographies, I explore how scholars have conceived of bodies and bodily experiences with respect to reproduction and how reproduction has been regulated within and across borders and in biomedical places. This work is foundational to my understanding of abortion access and, in turn, the experience of abortion care in the US as shaped by—but not ultimately *determined* by—state and federal law.

Within abortion geographies, I discuss abortion mobilities, spatiality and discourse to demonstrate that abortion is an inherently geographical phenomenon. Of especial relevance to this research is scholars' focus on the mobilities of abortion pills and the changing spatial configuration of abortion as a result of abortion pills.

1.5.3 | Chapter 4: Geographic barriers to abortion care

Chapter 4 is the first of three analysis chapters. It is concerned with the first of my two research aims: identify the geographic barriers to abortion care for rural women and pregnant people.

In Chapter 4, I begin by discussing the notion of barriers to health care and how abortion scholarship has conceived of distance as a barrier to care, particularly for women in rural areas of the US. I premise the chapter on an interrogation of the

primacy of distance and a consideration of whether distance represents the only 'geographic' barrier to abortion care.

I outline and present my GIS analysis which shows that the distances between JTP patients and their nearest abortion providers can be especially long for those living in rural areas and large states in the Midwest and West. While I explain that these findings are in line with previous work in public health that reveals numerous 'abortion deserts' in the US, my qualitative data challenges the primacy of distance for rural women accessing abortion.

Instead, I detail six barriers to abortion access that my participants anticipated or encountered in their abortion decision-making and arrangement of abortion care:
- crisis pregnancy centres (CPCs)
- abortion restrictions and bans
- the number, availability, and accessibility of abortion clinics
- abortion stigma
- 'sidewalk counselling' and anti-abortion protest
- cost of the abortion and related costs

This combination of socio-cultural, practical, and financial barriers coalesced to make participants choose telemedicine abortion with JTP. Although participants acknowledged that the distance to their nearest abortion clinic was a long way, they were in many cases used to travelling for health care and other needs because of living in rural areas. Distance was a factor but not the determining one, especially as several participants still had to drive considerable distances, sometimes more than once, to access telemedicine abortion with JTP, which I assess in Chapter 5. I then discuss the implications of this chapter with respect to rural health inequality and the 'choice' of telemedicine in the legal, material, and spatial context of the US. I conclude that this combination of barriers constrains access to timely, local, affordable, and patient-centred abortion care, which JTP's model of abortion care has attempted to redress.

1.5.4 | Chapter 5: Abortion access via telemedicine

Chapter 5 is the second of three analysis chapters. It is concerned with the second of my two research aims: determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people.

In Chapter 5, I begin by discussing the notion that telemedicine abortion is a 'game changer' for people who live far away from an abortion provider. I explain that mHealth has considered telemedicine as a panacea for rural health inequalities and that abortion geographers have considered remote abortion pill provision as a 'spatial fix' in restrictive settings. The underlying idea for these strands of literature is that health care is provided remotely, preventing the necessity of travel for the patient. I questioned whether this was true of legal telemedicine abortion services in the US for rural women and pregnant people.

I respond to this discussion in this chapter by detailing how my participants accessed an abortion with JTP, including

- finding and contacting the provider;
- having their remote appointment; and
- acquiring the abortion pills.

Through this pathway, I show that there is a divergence between patients who live in states with legal telemedicine abortion services (in this case, Colorado, Minnesota, Montana, Wyoming) and those that do not (in this case, North Dakota, South Dakota, Texas, Wisconsin). For the former group, the promises of telemedicine and remote abortion pill provision can be realised because the pills arrive on their doorstep. For the latter group, they must travel across state borders to have their appointment and pick up the pills, which I describe as 'cross-border telemedicine'. Here I also detail the advent of JTP's mobile abortion clinic. I demonstrate that telemedicine abortion is not eliminating the need for travel and that the burden of distance remains, but that its other benefits make it more convenient for many rural women and pregnant people as I discuss in this chapter and further in Chapter 6. I argue that cross-border telemedicine and mobile clinics serve as multi-scalar strategies for abortion access in the context of abortion restrictions and regulation.

<u>1.5.5 | Chapter 6: Abortion experience with telemedicine</u>

Chapter 6 is the third of three analysis chapters. It is concerned with the second of my two research aims: determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people.

In Chapter 6, I begin by discussing the notion that there is more focus on provision of and access to the abortion pills than there is focus on what happens *after* the abortion pills are 'put into women's hands'. I suggest that telemedicine needs to be understood not only in terms of how it affects access, but also in terms of how it affects the experience of abortion care. I explain that abortion care via telemedicine has temporal, material, and spatial dimensions and that these shape the embodied, emotional, and affective experience of abortion care.

I explore these dimensions throughout Chapter 6, roughly following the chronology of the abortion, including

- abortion timing;
- use of the abortion pills;
- symptoms of the abortion; and
- having the abortion at home.

Throughout these sections, I explore how telemedicine abortion is understood as an alternative to in-person, clinic-based care. Following from my analysis in Chapter 5, I discuss the benefits of telemedicine abortion, with respect to care, which make it more convenient for many rural women and pregnant people. However, throughout this section, I highlight that these benefits are not straightforward but are understood within the context of an anti-abortion and neoliberal health care and political system. I observe that, within this context, telemedicine abortion does not challenge prevailing ideas of biomedical or legal abortion, but nevertheless offers a respectful, person-centred approach to abortion care, outside of the abortion clinic.

<u>1.5.6 | Chapter 7: Conclusion</u>

Chapter 7 is my conclusion. I review the findings of my analysis chapters and extend their discussions to consider three prescriptive questions which arose from my research:

- who should provide abortion care?
- where and how should abortion care be provided?

I detail potential future areas of research in this area and discuss my findings in the context of *Dobbs* to conclude.

1.7| Contribution

Across these seven chapters, my thesis makes several empirical and theoretical contributions to abortion research and geography. In US abortion research, cross-border travel is an understudied aspect of abortion access and care. Telemedicine abortion is also insufficiently studied, given its recent emergence in 2020 in the US. My study extends both these areas of research. It is the first study, of which I am aware, on experiences of abortion access and care through telemedicine abortion which requires cross-border travel. I propose the concept of cross-border telemedicine abortion to account for this gap.

Drawing together abortion research and geography, my research problematises the prevailing notion that distance is the primary barrier to abortion care for rural women and pregnant people. I do this by combining a spatial analysis of distance and insights from my semi-structured interviews which demonstrate that distance was one among several geographic barriers to abortion care, including practical, social, cultural, and economic barriers which particularly affect those in rural areas. An empirical contribution within this is that the spatial analysis considers abortion patients who *would have* had to travel to their nearest abortion clinic, but ultimately chose telemedicine abortion instead.

My research makes an important contribution to geography, which has historically been silent on issues of abortion, by bringing together health and care geographies and the emerging fields of reproductive and abortion geographies, with attention to key concepts in geography such as law and space. My research extends the health

and care geographies literature which has primarily considered the provision of long-term or chronic care in the home. This work has generally not related to sexual and reproductive health. My research shows that telemedicine abortion is an acute form of care that is increasingly being emplaced in the home as care is spatialised away from the clinic.

My research extends the abortion geographies literature, which has primarily considered the extra-legal remote provision of abortion pills, to consider the legal provision of abortion pills via telemedicine in a restricted setting. Previous work has focused on how feminist networks have mobilised misoprostol to extend access in settings where abortion is prohibited or heavily restricted at the national level. My research focuses on restrictions at the state- and regional-level of the US, demonstrating that legal provision via telemedicine in part precludes the radical potential of the abortion pills, particularly with respect to abortion travel. This is an empirical contribution, in terms of studying the geographies of telemedicine abortion, and a theoretical contribution, bringing reproductive and abortion geographies literature into conversation with mHealth and telemedicine work within and beyond the discipline of geography.

Bringing these three contributions together, I ultimately advance our understanding of telemedicine more broadly and telemedicine abortion specifically within the context of the anti-abortion and neoliberal health care and political system in the US.

2 | METHODOLOGY

2.1 | Introduction

This research asks, to what extent does telemedicine eliminate, shift, or re-imagine the geographical barriers to abortion care in the United States? To address this question, I implemented a feminist mixed-methods research project that combines both quantitative and qualitative data collection and analysis. First, I used geographic information systems (GIS) to determine the geographical and spatial barriers to abortion care for rural women and pregnant people who have accessed an abortion via telemedicine. The quantitative analysis was initially conducted in 2021 and updated with new data in early 2022 to expand the scope of analysis to cover patients from October 2020 to December 2021. Second, I conducted qualitative interviews with patients (n=11), staff of Just The Pill (JTP) (n=5), and staff of partner organisations (n=2). The qualitative interviews were conducted between May and July 2022 and later in December 2022 to account for patients who had used the new mobile clinic in Colorado. With this combination of quantitative and qualitative data I seek to address the following research aims:

- Identify the geographic barriers to abortion care for rural women and pregnant people.
- Determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people.

As a researcher based in the United Kingdom conducting doctoral research about abortion geographies in the United States, I wanted to perform an in-depth case study to understand first-hand experiences of abortion 'on-the-ground' within the context of the dynamic and uneven national landscape of abortion law and access. With this feminist mixed-methods health geographies approach, as detailed below, I am able to speak to how telemedicine reduces, eliminates or, reimagines geographical barriers to abortion care. I prioritise participant interviews within my analysis in line with feminist research which seeks to give voice to women's lived experiences. This is particularly important with research on abortion in which stigma may serve to silence the voices of people who have had abortions.

2.1.1 | Structure of chapter

In this chapter, I justify my approach to this research as a feminist health geographer by drawing on methods from feminist health geographies and the field of feminist geography more broadly. Specifically, I discuss mixed-methods qualitative methods (particularly interviews), and quantitative methods (particularly GIS) within these fields. I then lay out the careful work of research partnership management within the context of eight US states amidst COVID-19 and frequently changing abortion laws. I then detail my process for quantitative data gathering and analysis, my process for qualitative data gathering and analysis, including participant recruitment, interviewing, and how I executed these aspects using a feminist health geography approach. In the qualitative research section, I address issues of positionality and ethics. Finally, I discuss my approach to data analysis to my research for this thesis.

2.2 | Mixed-methods research in feminist geographies

Within a feminist geographies approach, drawing on a wider range of literature from health, care, reproductive, and abortion geographies (Chapter 3), I chose to use both quantitative and qualitative methods to answer my research questions. Feminist geographers do not necessarily hold one research method as 'distinctly feminist' (2002a, p.647), but choose methods appropriate to the research question and data at hand. Hesse-Biber (2015) argues that not only should the research reflect on research design and methods, but also on how research design is linked to what the researcher wants to know. This requires the researcher to reflect on values and biases they may bring to the project and how they may shape questions asked – or not asked – and who the research is for. Irrespective of method chosen, McDowell (1997) explains that feminist geographers focus on the relationship between the researcher and their participants and emphasise experiential data. Although feminist research is more often associated with qualitative research, it is also highly relevant to quantitative studies (D'Ignazio and Klein, 2020; Jenkins, Narayanaswamy and Sweetman, 2019). Feminist geographers in the last two decades have particularly recognised the value of both qualitative and quantitative research methodologies and have integrated them into mixed-methods research studies.

Quantitative research has largely been understood to align with positivism insofar as there is an objective truth that can be discovered through the research process. Qualitative research, in its emergent and iterative nature, has largely rejected the notion of objectivity and contends – to varying degrees – that there are different ways of knowing and being that can be revealed through the social process of research. Poon (2004) puts it this way: quantitative geographers assume that their concepts and data *model* reality while qualitative geographers assume that their concepts and data *constitute* reality. As such, Elwood observes that the potential of mixed-methods research 'rests a bit uneasily alongside long-standing debates in geography that have sought to demarcate clear separations between quantitative and qualitative methods, or between positivist, humanist, post-structuralist, and other epistemological perspectives' (2010, p.2). Yet Elwood argues that mixed-methods research challenges the separation of these epistemological commitments because 'they insist upon the possibility of mixing ways of knowing' (2010, p.5). Feminist geographers have indeed articulated these possibilities in various ways.

Mixed-methods research offers numerous benefits to the priorities of feminist research and feminist geography, which focuses on considerations of power, reciprocity, patriarchy, and knowledge production' (Johnston and MacDougall, 2021, p.1). Across varying conceptual, theoretical, and methodological approaches, Kwan (2002a) observes that feminist geographers have a few common concerns. Firstly, feminist geographers are concerned with 'the material and discursive construction of gendered identities' and how these shape the different lived experiences of men and women (2002a, p.647). Feminist geographers are 'looking at the actions and meanings of gendered people, at their personalities, and biographies, at the meaning of places to them, at the different ways in which spaces are gendered and how this affects people's understandings of themselves as women or men' (McDowell, 1997, p.382). Secondly, feminist geographers contend that there is no transcendent objectivity in research. Rather, knowledge is situated and, in the process of collecting data, researchers are themselves situated in a subject position relative to their participants (Kwan, 2002a). Thirdly, feminist geographers are concerned with progressive social change.

Although feminist research emerged from critiques of positivism in which 'truth' was an objective reality that could be known through the empirical method, Leckenby (2007) reminds us that feminism and empiricism are not necessarily incompatible. Indeed, feminist geographers have questioned that quantitative and qualitative ways of knowing are diametrically opposed. Other researchers have used quantitative and geo-visual methods to examine the challenges of mixing approaches (Kwan, 2002a, 2002b; Pavlovskaya, 2009). Elwood concludes that mixed-methods research 'provides a tremendous opportunity to create ways of doing research that intersect contested epistemological and methodological differences, and to disrupt persistent efforts to frame different paradigms and modes of inquiry as inherently incompatible' (2010, p.2).

Feminist researchers can use mixed-methods research as an analytical tool to 'give voice to the range of women's issues at the social policy table with regard to economic and social justice initiatives' (Hesse-Biber, 2012, p.145). Qualitative methodologies are 'particularly well-suited to addressing the relationship between political praxis and knowledge production' (Johnston and MacDougall, 2021, p.1). In conjunction with qualitative research highlighting the lived experiences of women and other social groups, quantitative methods can be powerful in illustrating gender inequalities (Lawson, 1995; McLafferty, 1995, 2002). Using quantitative data, however, can raise questions around the scientific authority granted to these forms of knowledge production (Pavlovskaya, 2020; Turner, 2003). Relatedly, Hesse-Biber cautions the use of qualitative methods to 'illustrate quantitative results or to assist with the building of more robust quantitative measures' in the service of positivist-oriented quantitative-led projects and researchers (Bryman, 2006, 2007; Hesse-Biber, 2010, p.457). This leads Hesse-Biber to suggest a qualitative-driven mixed-methods research that is designed to further the goals of 'a qualitative approach to understanding social reality' (Hesse-Biber, 2010, p.457).

2.2.1 | My mixed-methods approach

I therefore designed a mixed-methods research project which used quantitative GIS and qualitative semi-structured interviews. In combining these approaches, I intended to respond to scholarship which reifies the primacy of distance as a barrier

to abortion care for rural women and pregnant people and thus the potential for telemedicine abortion services to eliminate this barrier—the central premise of this research. In particular, in line with this research, my use of GIS demonstrated that distances between rural patients and their nearest abortion clinic were indeed far. However, my qualitative research demonstrated that patients in states without legal telemedicine abortion services were still travelling the same distances to have their consultations and pick up the abortion pills as they would have done if they had gone to a brick-and-mortar clinic. Moreover, the qualitative component of this research added necessary context to the barrier of distance revealed in the GIS: patients themselves did not consider distance to be the most important barrier to care. Ultimately, by drawing on both quantitative and qualitative data in my analysis, I give ground to my participants' abortion stories and thus understand barriers to abortion care—and whether telemedicine addresses them—from their perspectives rather than through spatial analysis alone.

2.3 | Research partnership, sites, and context

2.3.1 | Research partnership

2.3.1.1 | Just The Pill (JTP)

JTP was the first fully telemedicine abortion provider in the United States certified by the National Abortion Federation (NAF), the professional association of abortion providers that includes both non- and for-profit clinics and clinicians. Whereas many independent abortion providers in the US are run as for-profit entities within the privatised health care system, JTP is registered as a 501(c)(3) not-for-profit organisation. This means that they are a public charity which makes most of its income from donations and is therefore exempt from federal income tax. JTP was the brainchild of the Executive Director, who prefers to remain anonymous, who has worked in abortion care for a long time and had become increasingly concerned about the lack of abortion clinics in rural and remote areas of the state of Minnesota. She was put in touch with Dr Julie Amaon who wanted to provide abortion care following her medical training. They started JTP in spring 2020 with the intention of fundraising for mobile clinics that could offer an array of primary care and sexual and reproductive health services in rural Minnesota. When the US Food and Drug Administration (FDA) eliminated their in-person dispensing requirement for

mifepristone in response to COVID-19, the Executive Director and Dr Amaon decided to start a fully telemedicine abortion service. Whereas before the FDA's decision abortion-seekers had to go to an abortion clinic to take mifepristone and take home the misoprostol, all aspects of the abortion care process could now take place remotely.

They are based in the Twin Cities metropolitan area of Minnesota but have no physical clinical space which patients can visit—all appointments are done remotely, and all internal organisation work is done from each staff member's home. At the start of JTP's telemedicine abortion service, they served just the state of Minnesota and had a staff of two: the Executive Director and Dr Amaon who is the Medical Director. They have since expanded to provide telemedicine abortion services to Colorado, Montana, and Wyoming and have recruited a Program Director and Clinic Director, a board, approximately six patient educators, a travel coordinator, and additional clinical staff for the mobile clinics. There are two mobile clinics in Colorado which were launched in the summer of 2022. Although the intention was for one to provide procedural abortions, at this moment both are providing only medication abortion pick-ups for both Coloradans and those coming from out-of-state.

These mobile clinics were chosen to be 'deployed' in the state of Colorado because it is geographically near to 'ban' states like Oklahoma and Texas—the latter of which has one of the largest state populations in the country, though spread across a vast area, nearly three times the size of the UK by area. They are working on opening a third mobile clinic that will be operational in a to-be-determined state. They have served travelling patients from as far west as Washington state, as far east as Pennsylvania, and as far south as Texas, but the majority of their telemedicine patients are resident in Colorado, Minnesota, Montana, and Wyoming.

2.3.1.2 | Contact, partnership, and research progress

At the beginning of October 2020 I came across a tweet by Robin Marty, the author of several recent books on the status of abortion rights and access in the US (Marty, 2019; Marty and Pieklo, 2013, 2019). She shared an article from *Bustle Magazine*, which was an interview with Dr Julie Amaon, the Medical Director of a new 'mobile

reproductive health clinic' in Minnesota called JTP (Gerson, 2020). Understanding that I wanted my research to address reproductive health advocates' strategies to reduce barriers to abortion access in the US, I immediately reached out to JTP to gauge their interest in conducting collaborative research about their organisation. I filled out their online contact form at the end of September asking whether they might have 30 minutes or less to chat about my research project, the results of which I wanted to benefit organisations like theirs.

After an initial discussion that month, where the Executive and Medical Directors expressed enthusiastic interest, and my sending of an informal research proposal outlining how the research might work collaboratively, we decided to go forward in working together. They were the only organisation I ended up contacting because they were interested in supporting the research project. At the start of our relationship, they had not yet seen any patients and did not see their first patient until late October 2020. I spoke with them on a regular basis via email and video chat. I also supported them in some fundraising activities through social media posts and organising a Just Giving page. At the time, I was still determining my research approach and was considering participatory action research, so these collaborations were just-in-case I decided to pursue that route. I also wanted to start our partnership with feminist acts of reciprocity. This support petered out as they recruited additional staff, so I was ultimately never embedded 'within' their organisation.

When they began to see patients, I had not yet applied for ethical research approval for the study because I was still solidifying my methodological approach. When JTP had to start an *ad hoc* mobile clinic from January to April 2021, I explored the idea of 'mobile methodologies' (Hein, Evans and Jones, 2008) and asked whether they would be interested in taking photos or videos or sharing journal entries from their travels around Minnesota. Initially, they expressed interest in the idea, but it did not come to fruition because of time-commitment issues and the mobile clinic stopping operation due to changing law in April 2021. Telemedicine became their primary focus in service provision, so it also became my primary focus in research. Although the mobile clinic came back in summer 2022 and I have data from both iterations of

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the mobile clinic, most of my data is about telemedicine abortion specifically and that is what I primarily focus on in this thesis.

In autumn 2021 I decided to move forward with qualitative interviews with patients of JTP who lived in rural and remote areas to begin to address this research's aim: to examine if telemedicine abortion and mobile abortion clinic services reduce or perhaps even eliminate geographic and spatial barriers to abortion care. JTP expressed approval of this approach and contacted patients on my behalf. The research partnership ultimately consisted of sporadic updates from my end on my research progress, their contacting patients and staff of partner organisations on my behalf, and their participation in research interviews. JTP has not attempted to influence my research questions or results in any way. While I portray their service favourably in this thesis, this is based upon the perspectives of their patients and is accompanied with appropriate reservations or critique.

2.3.1.3 | Justifying the case

By focusing on JTP patients and staff of JTP and partner organisations, I am able to study the wider issue of abortion access through the lens of an individual case. I am primarily concerned with the interrogating the 'game-changing' nature of the abortion pills and telemedicine abortion, which have been emphasised with respect to rural health disparities as well as in response to the COVID-19 pandemic. JTP is the first fully telemedicine abortion service in the US and the first to launch mobile abortion clinics and is therefore a strong example of both care pathways. The case provides a lens through which to study the broader issue of geographic and spatial barriers to abortion care and the potentiality of the abortion pills delivered via novel care pathways to address these barriers. By focusing specifically on telemedicine abortion and geographic and spatial barriers to care through the case of JTP, I am able to narrow the scope of this research. The narrower scope means that the research is *particularised* (Stake, 1995), but it still holds relevance. Some findings can be generalised to other contexts, and the particular insights also inform the wider issue of abortion access in the US and beyond.

2.3.2 | Research sites

JTP is licensed to provide telemedicine abortion in the states of Colorado, Minnesota, Montana, and Wyoming, but they serve patients from neighbouring states and states further afield who do not have telemedicine abortion services in their state of residence (Chapter 5). As such, my interviewees were residents of Minnesota and Montana (I did not have any participants resident in Colorado or Wyoming) as well as North Dakota, South Dakota, Texas, and Wisconsin. As I detail below, these were the not the location of interviews, which were conducted online, but rather the geographical context of the research.

2.3.3 | Research context

This research project began in earnest in autumn 2020 when I first made contact with JTP. The outbreak of the COVID-19 pandemic and the subsequent move towards remote healthcare enabled the organisation to begin providing telemedicine abortion to patients in October 2020. In 2021 I began the GIS component of the research using JTP data. I applied for and received ethical approval for patient interviews in June 2021 and later applied for and received ethical approval for 'key informant' interviews in May 2022. Patient and key informant interviews were conducted between January 2022 and June 2022, with two additional interviews in December 2022 to account for patients who had been served by the recently launched mobile clinic in Colorado. Just four of the 18 interviews were after the US Supreme Court overturned the constitutional right to abortion in June 2022. As such, nine of the 11 patients interviewed had their abortions while abortion was legal in their state. State and national laws on abortion have changed repeatedly since the inception of this research. Ultimately, this research is concerned with the period from July 2020 to June 2022, when a) full telemedicine abortion in the US was introduced and b) abortion was still legal—albeit heavily restricted—in all 50 states.

2.4 | Quantitative research: feminist critical GIS

2.4.1 | Quantitative methods in feminist health geographies

Feminist critical GIS is the quantitative component of this mixed-methods research project. Quantitative research is focused on the measurable, the generalisable, the mathematical and the logical; it seeks to 'smooth out and normalize' data (Aitken and Kwan, 2010, p.4). In geography, quantitative research aims to provide 'useful

evidence towards a better understanding of spatial processes' (Fotheringham, 2006, p.238). Although Aitken and Kwan (2010) observe that this is generally true of qualitative research in geography as well, qualitative and quantitative research have been understood to be based upon different epistemologies and ontologies even where their goals may align.

Drawing on the work of feminist science and technology scholars like Donna Haraway and Sandra Harding (see for example Haraway, 1991; Harding, 1991), feminist geographers began to criticise the masculinist gaze in cartography and geography which favours a visual observation that 'positions a geographer as a detached, disembodied, and objective scientist' (Pavlovskaya, 2020, p.30). Maps are a 'political technology' (Rose-Redwood et al., 2020, p.152) which hold scientific authority and are used to 'support hierarchies of race and gender, imperial ambition, capitalist exploitation, and pervasive surveillance' (ibid.). As Kelly and Bosse argue, maps 'cannot be separated from their makers as they present a view from somewhere that materializes and concretizes in/visible power relations' (2022, p.400).

The development of feminist GIS has required challenging the notion that GIS is inherently a positivist and masculinist tool. Kwan posits that if GIS 'cannot be used to understand difference and subjectivities, it is quite difficult to conceive any role for GIS methods in feminist geography' (Kwan, 2002a, p.647). While recognising that 'GIS is by no means a neutral tool', Schuurman and Pratt suggest moving beyond critiques of positivism, arguing that an 'understanding [of] how GIS produces truth opens opportunities to produce truth otherwise' (2002, pp.297–298). Indeed, Lawson argues that 'a technique for gathering information has been conflated with a theory of what can be known' (1995, p.451). GIS practices can be reimagined towards critical and feminist geographies (2002a, p.648). Pavlovskaya (2009) agrees, observing that geospatial technologies are no longer incompatible with non-positivist research. Instead, the meaning and use of these technologies is socially produced.

Feminist geographers began to use GIS to 'produce geographic knowledge that is critical of social oppression and supportive of geographies of justice and care'

(McLafferty, 2002; Pavlovskaya, 2020, p.29). Hanson, Kominiak and Carlin (2010), McLafferty (2002), Schuurman and Pratt (2002), and other feminist geographers argue for the use of GIS in feminist research by combining the reflexivity of feminist methodologies with the representativeness of GIS methods. Feminist geographies have made a 'profound impact on practices of cartography, GIS […] and geospatial technologies' by introducing gender as a vital dimension of geographic difference and laying the ground 'for the analysis of spatial configurations of patriarchy, race, class, national belonging, and other dimensions of social difference' (Pavlovskaya, 2020, p.29). Kwan explains that '[t]he purpose of using GIS in feminist geographic research is not to discover universal truth or law-like generalizations about the world, but to understand the gendered experience of individuals across multiple axes of difference' (2002a, p.649). Feminist GIS 'aims at illuminating those aspects of everyday life that can be *meaningfully* depicted using GIS methods' (Kwan, 2002, p.649, emphasis mine).

Feminist visualisation is one method of spatial analysis that feminist geographers have advanced. It uses in-depth datasets and incorporates qualitative data into GIS to make visible women's experiences and everyday practices (Knigge and Cope, 2006; Kwan, 2002a; Pavlovskaya, 2009). Feminist visualisation can reveal discrepancies between remote and 'on-the-ground' knowledge (Aitken and Kwan, 2010). Aitken and Kwan connect feminist visualisation to the notion of qualitative GIS: '[t]he question of what is representable (numerics, visuals, texts) and what is not representable (meanings, feelings) bears heavily on a discussion of how GIS and qualitative methods collide […] we argue that this collision may elaborate a creative tension rather than a schism' (2010, p.12). Feminist visualisation offers the potential opportunity to incorporate affective, emotional and embodied geographies that feminist geographers have called attention to.

2.4.1.1 | My approach to quantitative research

I therefore designed my quantitative methods to be used in conjunction with qualitative methods to make visible women's experiences of abortion in the rural US. I wanted to understand the gendered experience of individuals with respect to health care and abortion and present a critique of the political and social oppression that

underpins the spatial configuration of abortion care revealed through GIS. I felt that spatial analysis alone was insufficient to incorporate the affective, emotional, and embodied geographies of abortion (see Chapter 3) and therefore used mixed-methods to meaningfully explore the role of distance in determining access to and experiences of abortion care.

2.4.2 | Spatial analysis

I used the GIS programmes ArcGIS and ArcGIS Pro to critically explore and visualise the factor of distance from an individual's home to an abortion clinic. Abortion access in the United States is an acutely spatial phenomenon which relegates abortion care to a limited number of clinics which must serve greater numbers of pregnant people. Distance to these clinics has been understood as a barrier to care, particularly for those living in rural areas, and telemedicine abortion has likewise been understood as a 'spatial fix for a geographical problem' (Calkin, 2019b, p.27) because it moves abortion pills to the abortion seeker. Previous quantitative explorations of abortion travel distance have not considered the notion of distance with respect to decision-making around and experiences of telemedicine abortion. I therefore used GIS to visualise the barrier of rural distance, understood as travel time to an abortion clinic. I used three datasets in my GIS analysis:

- **A dataset provided to me by JTP listing 1,389 patients served from October 2020 to December 2021.** It provides their ZIP code, date of abortion, demographic information (age, race, education level, marital status), and reproductive health information (gestational age of pregnancy, number of previous abortions and miscarriages, and number of children). I cleaned and organised this data and then geocoded (assigned a longitudinal and latitudinal coordinate on a map based upon location [in this case, ZIP code[8]]) the data for analysis.

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[8] Zip codes are similar to the first half of a UK postcode, referring to the broader geographical area in which someone is resident, generally within a city or township. They often start with similar numbers within a state area.

- **Abortion Facility Database.** This is a database created by Advancing New Standards in Reproductive Health's (ANSIRH), which is a research group at the University of California, San Francisco. I applied for access to this database by filling out a Google Form detailing my project and how I planned to use the database. When I used the online map and database, it had last been updated in autumn 2020 and contained a list of over 700 abortion-providing facilities in the US and its overseas territories. In addition to providing the clinic name, address, and contact details, the database indicates whether the facility is currently operating and whether it provides medication abortion or surgical abortion and up to what gestational age. I added this data as a 'layer' to the JTP patient data map for analysis.

- **US Census (2010).** ESRI (the developer behind the ArcGIS software) offers access to numerous verified datasets from the US Census, including 2010 US Rural Urban Population by County. I added this data as a 'layer' to the JTP patient data map for analysis.

These datasets were assessed through spatial analyses conducted in ArcGIS. I used a proximity tool called 'find nearest' to calculate the nearest abortion facility to each patient by 'rural driving time'. This reveals how long it would take patients to travel to the closest abortion facility, if they had not accessed an abortion via telemedicine. I then used a process called 'join features' to add population information from the 2010 US Rural Urban Population by County dataset to the dataset with JTP patients and their nearest abortion clinic, which included their resident county. With this additional information, I was able to examine the relationship between distance from nearest abortion facility and rural population by county. I detail this methodology further in Chapter 4. In Chapter 4, I bring the results of this visualisation process into conversation with my interviews with JTP patients, providers, and staff of partner organisations to suggest that distance is not necessarily the most important barrier to care for rural women and pregnant people and that telemedicine abortion strategies have a limited capacity for reducing distance in certain areas.

2.5 | Qualitative research: semi-structured interviews

2.5.1 | Qualitative methods in feminist health geographies

Semi-structured interviews are the qualitative component of this mixed-methods research project. In the most basic terms, qualitative research refers to research that produces findings *not* obtained through statistics or quantitative means. Using methods such as in-depth interviews, focus groups and participant observation, qualitative research in geography emphasises people's lived experiences of socio-spatial contexts (DeLyser *et al.* (Eds), 2010; Limb and Dwyer (Eds), 2001). Kwan and Ding explain that qualitative research is 'useful for illuminating how people's experiences of particular spaces, places, and landscapes across geographic scales are shaped by their emotions, aspirations, and memories' (2008, p.447). Following feminist research priorities, qualitative research is especially useful for centring the voices and knowledge of marginalised people who have otherwise been silenced by previous research practice (Pavlovskaya, 2020). In this way, qualitative methods 'elaborate more ephemeral, perhaps deeper and more personal meanings' and are 'predisposed to individual perspectives, unique contexts and specific renderings' (Aitken and Kwan, 2010, p.4). The qualitative research process is 'emergent and iterative' and '[does] not necessarily follow a rigid plan or flow' (Kwan and Ding, 2008, p.447).

Qualitative interviews, particularly from a feminist research perspective, are concerned with understanding the lived experiences of respondents (Linabary and Hamel, 2017). Qualitative interviews are a 'very significant tool with which to understand central features of our conversational world' (Brinkmann, 2014, p.278). Brinkmann suggests that qualitative interviews are 'the most objective method of inquiry when one is interested in qualitative features of human experience, talk, and interaction because qualitative interviews are uniquely capable of grasping these features and thus of being adequate to their subject matters' (2014, p.278). Qualitative interviews can provide 'depth and detail' and 'a way into uncovering complex processes of causality' (Edwards and Holland, 2020, p.583). Particularly paired with feminist ways of knowing in which 'research relations are never simple encounters, innocent of identities and lines of power, but, rather, are always embedded in and shaped by cultural constructions of similarity, difference, and significance', feminist researchers suggest that qualitative interviews can be a powerful tool (DeVault and Gross, 2012, p.215; Gazso and Bischoping, 2018).

In feminist health geographies, researchers centre lived experiences of health and health care within various socio-spatial and temporal contexts. To do so, they adopt a range of qualitative research methods with a particular emphasis on the use of qualitative interviews. For example, Ahmed (2020) uses interviews alongside focus groups and participant observation to reveal the agency of community health and home-based workers amidst gendered expectations. Rishworth and Elliott (2022) similarly use interviews to challenge the assumption of passivity of older women by exploring issues of embodiment and temporalities in gender-age inequality. Embodiment, in its material and discursive forms, is also at the centre of interviews conducted by Clancy (2022) about the affective forces shaping eating disorders.

While interviews may be conducted with key informants (see for example Hawkins, 2011; Rishworth and Elliott, 2022), such as health care providers, the focus of qualitative interviews in feminist health geographies is the experience of health and health care, particularly for women and/or other minoritised groups. Mearns, Bonner-Thompson and Hopkins (2020), for example, use interviews to examine the spatial experiences of trans people in health settings. Shee (2023) uses interviews to explore affect and emotions in health activities, and draws attention to the lingering historical forces of racism, misogyny, and fatphobia in shaping participants' experiences. Often using interviews as a method, case studies in feminist health geographies enable research which moves away from the scale of the state to localised approaches to health and health care (Jenkins, 2008; Shattuck, 2021), as Calkin (2019b) has called for in abortion geographies, specifically.

Attention to the emotionality of lived experiences is a component of feminist research. Although qualitative interviews on 'sensitive' topics can be distressing, participants may appreciate the opportunity to share their stories (Carter et al., 2008), and may find that interviews lead to catharsis, self-acknowledgement or awareness, a sense of purpose and empowerment, promotion of healing and a greater voice (Hutchinson, Wilson and Wilson, 1994). Feminist approaches to interviewing are perceived by participants to be particularly therapeutically beneficial. Moreover, participation in qualitative research offers benefits of learning about a

topic, connecting with a broader community, advocating for a community or cause, and helping others (Wolgemuth et al., 2015). Other research demonstrates participants' desire to learn from researchers, to have their experiences validated, and to contribute to research that will make a difference (Carter et al., 2008; Clark, 2010). Feminist interviews seek to 'normalize participants' experiences' (Campbell et al., 2010, p.62). With respect to abortion, this is critically important due to the level of misinformation and stigma that persists around it. Feminist interviews that reinforce this follow the radical history of abortion storytelling have sought to normalise and destigmatise abortion (Kissling, 2018). With this, it is important to note that interviews are emotional and embodied performances and reflexivity is required on the part of the research to engage with this dimension (Ezzy, 2010), particularly as it pertains to this sensitive topic. Moreover, as Ryan-Flood and Gill note, '[o]ften the liberatory potential of research has been unproblematically assumed to be a linear move from silence to voice' (2013, p.2). In addition, while participants can choose what to say and what to not, the research process is 'unwittingly seductive' and they may 'find themselves opening up more than planned or expected' (Ryan-Flood, 2013, p.188). As such, it is important that data is treated confidentially, and research is conducted without harm.

Feminist qualitative interviews try to recognise and account for power imbalances between the researcher and the researched. Reflexivity is one way that this is done. To begin with, feminist researchers question that the positivist notion of bias is necessarily a *bad thing*. They 'reject the idea that objectivity is attainable, seeing it instead as important to develop as sophisticated a sense of their own biases as is possible' (Jenkins, Narayanaswamy and Sweetman, 2019, p.418). In this way, before conducting interviews, it is important to reflect on one's identity and how this identity has shaped their experience of and perspective on the social world. These reflections often lead to discussions of being an insider or an outsider within the researched group, which may facilitate or obstruct research (Britton, 2020). Beyond the notion of insider/outsider status, feminist researchers and feminist geographers in particular began to employ the notion of intersectionality as a reflexive practice in the late noughties (Valentine, 2007).

Articulated by Black women throughout the 19th and 20th centuries but first coined by Kimberlé Crenshaw (1989), intersectionality 'captures the way in which the particular location of black women in dominant American social relations is unique and in some sense unassimilable into the discursive paradigms of gender and race domination' (Crenshaw, 1992, p.404). Gender, race, and class, as explored by Davis (2011), as well as age, nationality, ability, sexuality, and family status all intersect to create an individual's social location, which in turn shapes their experience of and perspective on the social world. The concept of intersectionality has been particularly important to abortion research which attempts to examine abortion within a broader history of reproductive (in)justice (Johnston and MacDougall, 2021; Price, 2011; Ross, 2017).

Reciprocity is another way feminist researchers attempt to recognise and account for power imbalances. Campbell et al. (2010) explain that feminist researchers attempt to reduce the hierarchy between the interviewer and the interviewee. They might do so by giving more control to participants, such as by 'not just [asking] questions, but [answering] them as well' (Campbell et al., 2010, p.62). This reflects the shifting epistemological and ontological nature of the qualitative interview as described in the above section. Discussing reflexivity in research in postcolonial contexts, Vanner argues that researchers who 'carry a legacy of privilege must maintain vigilance in analyzing the power dynamics of their research process to avoid misrepresenting, exploiting, and endangering their participants' (2015, p.9). Epistemologically and ontologically, an 'excellent' qualitative interview is one that has an 'analytic focus' on knowledge production in addition to communicating an interviewer's questions and an interviewee's answers (Brinkmann, 2014, p.279). In Campbell et al.'s study, participants 'exposed the interview dynamic by interrupting it' through 'turning the tables' on the interviewer (2008, p.1269). In the interviews, participants also questioned their own performance, evaluated the nature of knowledge construction, and discussed knowledge construction as 'constructions of themselves, their identities, and their realities' (2008, p.1271).

Relatedly, Bengtsson and Fynbo (2018) discuss the role of silence in the power dynamics of the interview. While conceding that silence, whether from the interviewer or interviewee, may potentially be disruptive to an interview, they suggest

that these disruptions may be generative: 'they not only allow for unwanted and unexpected expressions between the interviewer and the interviewee but also sometimes lead to valuable data' (2018, p.33). Similarly, Roulston cautions against describing interviews as 'failed' in some way, as they may provide 'fruitful grounds for asking methodological questions' (2010, p.200). Carter et al. (2008) suggest that interviewers revise information sheets to better prepare participants for the actual experience of participation as well as asking participants about their experience of the interview itself. However, Ryan-Flood and Gill (2013) suggest that secrecy and silence are factors in all aspects of the research process, not only in the qualitative interview itself, on the part of both researcher and participant, but also in the interpretation and representation of data. Scharff highlights that there are no generic solutions to unequal power-relations within qualitative research, but that reflexive attention to silence and the '"unspoken" dimensions of "speaking for others"' is a crucial way to explore these complexities (2013, p.93). Likewise, there is an enormous responsibility in researching 'sensitive' topics to treat the data *sensitively* (Ryan-Flood, 2013).

2.5.1.1 | My approach to qualitative research

I therefore designed my qualitative interviews to incorporate feminist methodological principles and practices. Although using quantitative methods within a mixed-methods approach, my analysis draws primarily on my semi-structured interviews with patients. In line with feminist health geographies, I sought to centre women's lived experiences of health and health care within their spatial and temporal context. The voices of people who have had abortions are marginalised within the wider, politicised conversation around abortion morality and legality in the US and I wanted to spotlight what they thought about access to and the experience of abortion. While discussions of national and state laws were necessary to understand the spatial and temporal context in which abortion was accessed and experienced, I attempted to further reveal how patients and providers engaged in multi-scalar work to facilitate abortion care in line with feminist health geographies.

For the interviews themselves, I described my project in detail, what participation would entail, and ensured that they had no safety concerns during the interview.

Although I had a broad set of questions, the interviews were largely guided by what participants felt was most important to discuss. I found that they did not necessarily feel that abortion was a 'sensitive' topic to discuss with me, as a researcher, and that some were excited about the opportunity to share their story in the hopes that abortion access could be improved. I tried to ensure that the discussions were validating and normalising. I also conducted a demographic questionnaire to capture how these lived experiences of abortion might be shaped by race, class, and age, among other factors, and used this in my analysis. The interviews with staff of JTP and partner organisations added additional insights to these interviews and expanded the analysis to consider issues of abortion provision and activism. Overall, my approach centred lived experiences and was shaped by emotionality, reflexivity, reciprocity, and the traditions of abortion-storytelling.

2.5.1.2 | A note on online interviewing

Qualitative interviews have generally been face-to-face and in-person. However, with the outbreak of the COVID-19 pandemic and its attendant social distancing measures to prevent the spread of the virus, qualitative interviewing became only possible to conduct online. Online or 'virtual' research methods or methodologies are not new and have utility beyond their temporary necessity during the pandemic (Lobe, Morgan and Hoffman, 2022). These methods use digital technologies to facilitate 'traditional' forms of research, and may draw on video-based platforms to imitate the 'face-to-face' interview (Lobe and Morgan, 2021). Individual interviews conducted online have the same aim as those conducted in-person, but each presents their own logistical, budgetary, ethical, recruitment, and design issues (Lobe, Morgan and Hoffman, 2022). Online methods present a potential disadvantage with respect to access to and comfort with digital technologies (ibid.), implicating the 'digital divide' (Gilbert et al., 2008). In my case, interviews were conducted via mobile phone, which does not require broadband, data, or WiFi. Moreover, most patients of JTP owned a mobile phone with which they had accessed telemedical care. On the other hand, online interviewing may also have particular advantages for feminist research (Averett, 2021; Linabary and Hamel, 2017). For instance, online interviews did not require patients to be 'face-to-face' and, like telemedicine, were able to speak about a 'sensitive' topic within the privacy

of their own homes and to work the interview within their schedule. Moreover, doing interview remotely was advantageous because I could interview across a wider geographic area without the necessity or cost of travel (Lobe, Morgan and Hoffman, 2022). In my case, I interviewed 18 people in at least seven states, which would not have been feasible without being done 'online'.

2.5.2 | Positionality and ethics

Since I was studying for my undergraduate degree, I have had a passionate interest in reproductive rights and abortion rights specifically. I volunteered for Planned Parenthood, a nationwide US sexual and reproductive health care provider, and worked for politicians and political campaigns that identified as pro-choice. I fervently believe in the normality of abortion and the necessity of abortion access in the fight for reproductive and social justice. This belief was reinvigorated, so to speak, when the Donald Trump administration reinstated the Mexico City Policy, or, 'Global Gag Rule', banning federal funds from being used for abortion services overseas as a caveat in federal aid. I then chose to study the effects of US 'moral' exports in abortion policy changes in Latin America for my Master's degree and knew that I wanted to continue this line of research in a PhD.

I originally designed my research to follow on from my Master's dissertation and focus on abortion access in Colombia and Peru for Venezuelan migrants. With the travel constraints of the COVID-19 pandemic, I considered doing my research remotely on abortion accompaniment networks in Latin America. I did not sufficiently reflect on my positionality when approaching one of these networks and was rejected on the basis of 'extractivism'. This led me to choose to conduct research in my own national context of the US where I would not be employing a kind of colonial gaze.

Nevertheless, there were still a number of issues of positionality to consider in approaching and designing my research. There were two that I flagged from the beginning: 1) that I have never had an abortion and 2) that I have never lived in a rural area. This brief reflection on my positionality in the research speaks to Griffin's discussion of the 'compromised researcher', which problematises the assumption that there is a 'synonymy between what you are and what you do research on […]

and for it to be otherwise might mean, or does mean, that your research is compromised' (2012, p.337), raising a myriad of issues during and following the research process. Griffin (2012) thus raises questions about why researchers engage with particular topics and participants, both for when they are 'the same' and when they are not. Firstly, although I have not had an abortion myself and cannot understand this experience directly, I decided that this was not strictly a limitation. In line with feminist research methodologies, I aimed to amplify the voices of those who *have* had an abortion and try to do justice to their narratives. Secondly, although I have not lived in a rural area, this was not the crux of the geographical insider/outsider dynamic that unexpectedly emerged in my research. Because my call for participants indicated that I was based at a British university, several participants thought that I was British. I anticipated that having an American accent would make my identity self-evident, but others did not perceive my accent as American. As such, it was not so much that I had no lived experience of rurality, but participants tried to explain things about the US and rural US as though I was indeed a foreigner. This likely led some participants to frame their responses on a broader scale or to be more specific so that someone unfamiliar with the context could understand.

Due to the framing and content of my call for participants, I feel that participants understood that I was not a part of JTP but an independent researcher. The public call, for example, said 'our friend' was looking for participants. The direct call instructed interested persons to contact me directly. My information sheet, consent form, and introduction to the interview provided further information about my relationship with JTP. My status as an independent researcher then likely influenced the dynamics between myself and my participants. Some were really interested in the research project as a whole and several chose to be notified about future publications that result from the research. In some cases, I was the only person to whom participants chose to disclose their abortion. I believe that they felt I was a safe person to discuss it with in part because I am interested in abortion and a stranger as well as because I stated that their data would be pseudonymised.

I was also aware of my intersectional position as a researcher. While sharing the nationality of my participants, I was certain that my lived experiences of race, class, and family were going to differ from some participants—in addition to geography. I am an able-bodied white woman from a middle-class background, have no children, and am educated to the doctoral level. I approached the interviews with the understanding that rurality was not a monolith and that there was an immense amount of diversity in these places and so made space for participants to share their experiences from their own positions. Participants shared about their experiences of working underpaid jobs, having caring responsibilities, receiving benefits, and experiencing racism in their towns. The demographic questionnaire added further detail to the interviews and facilitated an analysis that considered how experiences of rurality, health care, and abortion care are shaped by wider structures of white supremacy and capitalism.

2.5.3 | Semi-structured interviews

The main component of this research project was 18 qualitative interviews with patients, staff of JTP, and staff of partner organisations from January to May 2022 and in December 2022. The qualitative interviews were designed to address the research questions around geographic barriers to abortion care and how telemedicine addresses them or not. In this section, I detail the process by which I designed and implemented my qualitative interview method, including participant recruitment and interviewing process.

2.5.3.1 | Participant inclusion criteria

For patient participants, I decided to target individuals who lived in rural areas for one key reason: telemedicine has been lauded as a ''*game changer* for some women who live far from an abortion provider' (Sethna, 2019, p.9, emphasis mine) because it is the abortion pills that travel rather than the abortion-seeker. This is in part why JTP began to provide telemedicine abortion services with the specific aim of reducing barriers to care for rural communities. But I would suggest that this idea has not been sufficiently interrogated. Firstly, Baird argues that '[n]ew means of abortion provision such as medical abortion in the form of abortion pills do not necessarily solve old inequalities' (2019, p.165). Secondly, Gomez importantly notes

that barriers such as time, money, accommodation, school, work childcare, travel, and immigration enforcement 'create an intricate series of obstacles, each entangled with the other' which may prove to be 'an insurmountable hurdle, even before the issue of travel distance or time arises' (2016, p.56). I wanted to understand how these factors shaped abortion decision-making and experiences with respect to telemedicine abortion for rural women and pregnant people.

Using the JTP patient data, I identified over 350 patients in rural areas who were then contacted directly by JTP for recruitment based on the following criteria:

- have had a telehealth appointment for an abortion with JTP
- live in Colorado, Minnesota, Montana, Wyoming or one of their surrounding states that JTP serves over-the-border (e.g. Idaho, Iowa, North Dakota, South Dakota, Wisconsin)
- be more than 18 years of age
- speak English or Spanish
- able to meet for online or telephone interview

The first two inclusion criteria are self-evident as they were already identified as JTP patients and living in states where JTP could provide them the abortion pills. The criterion that participants were over the age of 18 was to avoid ethical issues involved with researching minors' healthcare. The criterion that participants spoke English or Spanish was to ensure that communication was possible given my language abilities as well as an attempt to include individuals who might otherwise not participate due to a language barrier. Spanish is the most common language spoken in US homes after English (Dietrich and Hernandez, 2022). Although I considered issues of language choice in interviews, translation, and publication (see for example Cortazzi, Pilcher and Jin, 2011; Qun and Carey, 2023), all of my interviews were ultimately conducted in English because all participants contacted me in English. And, lastly, the interviews were to take place remotely due to the constraints of the COVID-19 pandemic as well as to account for the vast geographic spread of participants.

2.5.3.2 | Participant recruitment

JTP facilitated access to patients and staff of partner organisations by texting previous patients who met my inclusion criteria and emailing staff of partner organisations who might be interested in sharing their perspectives. For staff, I reached out directly to those who I had previously spoken with. Their facilitating role positioned JTP as a 'gatekeeper' to my participants. This meant that my recruitment was dependent on JTP staff capacity to assist, causing some delays to my planned timeline (Spacey, Harvey and Casey, 2021). However, it was ultimately beneficial because JTP has an established relationship with patients which meant that patients might see me as trustworthy as well. Moreover, JTP used my list of potential participants and call for participants and participants were directed to contact me directly if they were interested.

2.5.3.2.1 | Patients

Patient participant recruitment began on 20 January 2022. I provided the Clinic Director of JTP with a list of just under 200 patients who lived in counties with at least a 50% rural population. These patients were identified using GIS. Patients were contacted via text message by JTP (Appendix 1). Another batch of patients was contacted using the same text messages in June 2022. These patients met the same criteria but had their abortions at later dates. At the same time, the social media coordinator for JTP also posted on their various accounts about the research, which added an inclusion criterion of living in a rural area because this was an open call rather than targeted using patient data. Eight participants were recruited in the first round and one participant was recruited in the second round after seeing the Facebook post. I offered to compensate participants, which I discuss below.

Figure 2.5a | @justthepill Instagram post from 20 May 2022

In October 2022 I discussed with the Executive and Medical Directors the possibility of interviewing mobile clinic patients. I then contacted the Clinical Director who agreed, and another member of staff texted a few dozen patients from Texas who had gone to the mobile clinic in Colorado. Two participants were recruited in this round. The original text messages were altered to account for the different focus and the new ban on abortion in Texas (Appendix 1).

2.5.3.2.2 | Staff of JTP and partner organisations

I asked four JTP staff members directly via email if they would be interested in being interviewed for the research. I had spoken with everyone previously and therefore had some rapport established. All four I asked said yes and were subsequently interviewed. The fifth staff member, Susan (JTP's Board Director), was contacted during the recruitment of staff of partner organisations as we had no previous contact. She agreed to be interviewed as did the partners who were contacted. I explained to the Executive Director of JTP that I was interested in speaking with some of the staff of partner organisations, particularly those who worked for abortion funds, and she reached out to four people at the end of April 2022, including Susan. From this, I recruited Susan, Marie from Midwest Access Coalition, and Shayla from OurJustice into the study. Although the fourth person was willing to participate, we mutually agreed that her expertise might not be suitable for the research project—

her previous role was entirely non-clinical with no involvement with patients or provision.

2.5.3.3 | Number of participants

The intended sample size of this project was 15-20 patient participants. Likely due to perceived risks of prosecution, violence, and stigma, I ended up interviewing a rather small number of patient participants. Using my inclusion criteria, JTP sent a text message call for participation to more than 350 individuals across two rounds. I received text and email messages of interest from between 20 and 25 people but ended up interviewing 9 from these two rounds. Those that I did not end up interviewing did not reply after initial or later responses from me. Nobody dropped out of the process after scheduling an interview. Later, JTP sent a text message call for participation to a few dozen individuals in Texas who had gone to the Colorado mobile clinic. I received less than 10 responses and ended up interviewing two. This resulted in a total of 11 participants who were patients of JTP. I interviewed five staff of JTP and two staff of partner organisations who the Executive Director of JTP put me in touch with. This resulted in a total of 7 'key informant' participants. Altogether I interviewed 18 people across 19 interviews (I interviewed the Executive Director twice due to a power outage on her end in the middle of the first interview).

2.5.3.4 | Interview process

2.5.3.4.1 | Scheduling the interview

Participants reached out to express their interest in participating to either my Skype Mobile phone number or to my Birkbeck email address. I asked them if they had availability soon, what their time zone was, and what time would work best for them. I emailed them the information sheet and consent form through Adobe for them to digitally sign (Appendix 2). My subscription to Adobe ended prior to the final two interviews so I sent the form via email, but both participants were able to provide written signatures. Participants were asked to sign the consent form prior to the interview, although one person signed it while we were on the phone at the start of the interview.

2.5.3.4.2 | Introducing myself, the research, and the interview

At the scheduled time of interview, I called each participant on their mobile phone via Skype Mobile. After they answered, I thanked them for their participation and confirmed their consent to be recorded and then began the recording.

I introduced myself, re-emphasising information that was provided in the recruitment text message: my name, my university, and how I began to partner with JTP and why. I then introduced the research project. I explained that the overall goal is to assess the role of telemedicine abortion in addressing geographical barriers to abortion care in the United States, particularly for rural women and pregnant people. I specified that part of this research is therefore concerned with finding out what those barriers in addition to understanding abortion decision-making around telemedicine and the experience of abortion at home, especially as it relates to living in a rural area. (Later, for the two Texan participants post-*Dobbs* who flew to Colorado, I explained that most of the research was prior to *Dobbs* and that I was concerned with their experience of accessing abortion in innovative ways.) I then introduced the interview and explained that I had some broad questions but that it would be open-ended, conversational, and guided by their responses. I said that I would like to conclude with a brief demographic questionnaire. I concluded my introduction with a brief re-cap of the information sheet and ethics form, and asked whether they had any privacy or safety concerns during the interview for which they could end the interview at any time or switch to a set of fake questions unrelated to abortion.

2.5.3.4.3 | Interview guides

My primary set of interviews (n=11) was with individuals who had an abortion via telemedicine with JTP (although one participant [Beth] miscarried prior to taking the pills), most of whom lived in rural or remote areas of the midwestern or western US and two of whom lived in urban areas of Texas. The participants were all cis gender women who were mostly white, heterosexual, parents of children, and educated past high school level, but represented a wide range of ages, employment, and incomes (see 2.5.3.4.4 for further detail). Many were excited to tell their stories and ready to speak about abortion care inequalities and how great of an experience they had with JTP. This speaks to the tension between secrecy and the desire to talk in interviews

about stigmatised topics (Grenz, 2013). There appeared to be an impetus amongst some participants to share their story, which overrode or evaded potential issues of stigma or criminalisation that might have prevented others from participating in the research.

My participants in Texas (n=2) lived in urban areas so I primarily focused on their abortion decision-making and experience of accessing the abortion pills at the Colorado mobile clinic and then taking them at home. For the other patient interviews (n=9), I originally designed my guide to bring out participants' experience of living in a rural area (Appendix 4). However, I found that participants were ready from the start to discuss abortion and sexual and reproductive health in general. I would start with the first question—'[tell] me a bit about where you live'—and the conversation would move in the direction that the participants wanted. I found that the 'rural experience' was more omnipresent than explicitly discussed, unless prompted by me. Many of these questions were answered in the conversation without them being directly asked. I tried to let the participants' responses guide the conversation rather than fit their responses within my pre-conceived narrative or set of questions. Sometimes this led to tangents that may have had little to do with my research, but I attempted to embrace this. I wanted to the interviews to be about experiences of abortion care and all that this entails. By allowing participants to guide the interview and centring their perspectives, I attempted to align my research with feminist principles as discussed above.

The other set of my interviews were with 'key informants' (n=7). These were with staff of JTP (n=5) and staff of partner organisations (n=2). I had previously spoken with all but one of the JTP staff, so was able to email them directly, and was put in touch with the two staff of partner organisations. I had some general questions for each set of participants and some shared questions between them, which were about their experiences working in abortion care and their thoughts on rural abortion access and the prospect of telemedicine to address any barriers to access (Appendix 4). I asked follow-up questions based upon responses from participants.

I finished the patient interviews with a demographic questionnaire (Appendix 5). These participants were contacted because they lived in a county with more than a 50% rural population, according to data from the US Census. The inclusion criteria beyond this were that they had a telemedicine abortion appointment with JTP, and therefore lived in a state serviced by the organisation; were over the age of 18; and spoke English or Spanish (no interviews were ultimately conducted in Spanish). Beyond these eligibility criteria, there were other demographic characteristics I bore in mind throughout the study which I primarily captured through a demographic questionnaire. A demographic questionnaire both holds the research accountable to capturing a wide array of experiences but is also critically important to understanding the intersectional barriers to care beyond rurality given the stratified nature of abortion access. Participants were informed that responding was optional and that they could answer 'I don't know' or 'other' to any of the questions. Although the questions are phrased as a list and 'select all that apply', most respondents answered without requiring the list. Also, some of these questions were incidentally answered in the interview itself. The categories were as follows:

ZIP code. The patient's ZIP code confirmed their location in a rural county and allowed cross-referencing with JTP patient data. ZIP codes and town names are not identified due to privacy risks, so the data is aggregated to state level. Participants were residents of rural counties in **Minnesota (n=2), Montana (n=1), North Dakota (n=3), South Dakota (n=1),** and **Wisconsin (n=2)** and in urban areas of **Texas (n=2).**

Age. Reproductive age is generally considered 15-49 years of age, but most abortion patients are in their 20s (Jerman, Jones and Onda, 2016). Many who are denied abortion are young (Foster, 2020), and the young may travel the farthest for abortion (Sethna and Doull, 2013). Moreover, age is an important factor for minors who face additional barriers to access, such as parental involvement laws, though I do not interview anyone under the age of 18 in this study. I had participants in their **teens (n=1), 20s (n=3), 30s (n=4), 40s (n=3).**

Race and/or ethnicity. There is no race or ethnicity that is more likely to have an abortion in the US, but it is well documented that people of colour may face more barriers in accessing abortion. This barrier is contextualised by a problematic history of reproductive genocide and eugenics, including forced sterilization, for Black, Latina, and Native/indigenous women. Due to the coding of rural places as white despite the diversity of rural populations, it is important to understand how race is implicated in this study. The majority of participants were **white (n=8),** with other participants identifying as **Black and Native American (n=1), Latina/Mexican (n=1),** and **Black (n=1).**

Primary language spoken at home. Primary language spoken at home was intended to offer insight into citizenship, although this is a never clear connection (Brown et al., 2018). However, given any nation-state's immigration policies, researchers decidedly do not ask about immigration status unless it is mandatory aspect of a study. There are notable immigrant populations living in rural areas in states pertinent to this study, particularly in Minnesota and Texas, which have both taken in a significant number of refugees. The practical, logistical, and legal issues a citizen may face in accessing an abortion are exacerbated by precarious or undocumented immigrant status. Due to possible or perceived legal risk to participants, questions about immigration were not asked directly. All participants **spoke English in their homes (n=11).**

Gender. Abortions are required by cis gender women, trans gender men and those who identify as genderqueer, non-conforming or non-binary. Data has shown that approximately 1 in every 3 cis gender women will have an abortion in their lifetimes, but similar data does not exist for trans individuals. Nevertheless, JTP has seen at least one patient who identifies as a trans man. Considering the general understanding of rural areas as conservative, gender identity may be an important abortion demographic in terms of barriers to care. Furthermore, this research strives to be gender inclusive in design and language. All participants identified as a **'female' or a woman and not trans (n=11).**

Sexuality. Several reproductive justice organisations emphasise that abortions are required not just required by heterosexual or straight women and pregnant people. Like gender identity, sexuality may be an important abortion demographic in terms of barriers to care. Most participants identified as '**straight' or heterosexual (n=9)**, while other participants identified as **bisexual (n=1)** and **pansexual (n=1).**

Marital status. Marital status is also an important abortion demographic wherein most abortions are had by younger, unmarried women. However, this may be complicated in rural areas where there is a younger age of marriage; as Pruitt (2007) notes, rural women are more likely to be married and more likely to have married young compared with their urban counterparts. This may further affect an individual's circumstances around the abortion. A minority of participants were currently **married (n=3)** while others were **single (n=5), divorced (n=1),** or unmarried but **living with their partner (n=2).**

Parental status. Most abortion seekers have had at least one live birth, regardless of marital status (Jerman, Jones and Onda, 2016). Whether an individual has children may affect their abortion decision and, similarly, previous induced abortions may affect their decision to have a medication abortion versus a surgical one. Most participants had **at least one child (n=8)**, including those below and above the age of 18, while other participants had **no children (n=3).**

Socio-economic status. In 2014, when the most recent national data is available, three-quarters of abortion patients were low-income (Jerman, Jones and Onda, 2016). Often intersecting with race, socioeconomic status is a major barrier to abortion due to the cost of an abortion itself, which increases with gestational age, and related logistical costs in accessing care. Abortion may or may not be covered by private insurance and federal funds cannot be used for abortion, thereby forcing anyone on Medicaid/care or using the Indian Health Service to pay out-of-pocket unless state funds are set aside. Approximately 28% of abortion patients had no health insurance coverage in 2014, and more than half of patients paid for their abortion out-of-pocket while 24% used Medicaid (Jerman, Jones and Onda, 2016). More recent data found that abortion patients in restrictive states were more likely

than those in permissive states to pay out-of-pocket for abortion, rely on financial assistance, and indicate that it was difficult to pay for the abortion (Jones and Chiu, 2023).

Rural populations are among the poorest in the country (Pruitt and Vanegas, 2014) and finance is likely to play a role in the decision to have a medication abortion at home as it is a less expensive option. Socioeconomic status may be indicated by education level, income, or employment status. All participants had **graduated high school (n=11).** Eight of the 11 participants had higher levels of education: **some college (n=4)**, including one full-time undergraduate student, an **associate degree (n=2),** and a **master's degree (n=2).** Employment status and household income level varied considerably. Besides one full-time **student (n=1),** participants were employed **full-time (n=5),** one **part-time (n=1),** and a few were **unemployed (n=4).** Incomes ranged from **no income (n=2)** for those unemployed, **low-income (n=1)** for the student, **between $20,000 and $35,000 (n=3), between $40,000 and $50,000 (n=3),** and **over $100,000 (n=2).**

Name	State	Abortion MM/YY	Age	Race	Language	Gender	Sexuality	Marital status	No. of children	Education level	Employment	Income
Beth	MN	N/A	41	White	English	Cis woman	Hetero	Married	3	Masters	Full-time	50k
Erin	WI	07/21	20	White	English	Cis woman	Hetero	Single	0	Some college	Student	5-10k
Claire	ND	05/21	19	White	English	Cis woman	Bi	Living w/ partner	0	HS	Part-time	30k
Morgan	MN	01/21	33	Black and Native American	English	Cis woman	Pan	Married	1	Masters	Full-time	150k
Lucy	ND	09/21	24	White	English	Cis woman	Hetero	Living w/ partner	0	HS	Unemployed w/o benefits	46k
Laura	WI	11/21	39	White	English	Cis woman	Hetero	Single	3	Assoc.	Full-time	30-35k
Alice	SD	12/21	32	White	English	Cis woman	Hetero	Married	2	Some college	Full-time	120k
Helen	MT	12/21	41	White	English	Cis woman	Hetero	Single	2	Some college	Unemployed w/ benefits	20-30k
Jenny	ND	Doesn't know	28	White	English	Cis woman	Hetero	Single	2	Some college	Unemployed w/o benefits	N/A
Elena	TX	09/22	36	Latina	English	Cis woman	Hetero	Single	3	HS	Unemployed w/o benefits	N/A
Diana	TX	08/22	42	Black	English	Cis woman	Hetero	Divorced	2	Assoc.	Full-time	50k

Figure 2.5b | Demographic characteristics of patient participants (pseudonymised)

2.5.3.4.5 | Recording and transcribing

The interviews were recorded and transcribed using Otter.ai. Consent to record the interviews was sought in advance of interviews and confirmed at the start. Transcriptions were checked and corrected by me. Unfortunately, the final two recordings from interviews with the patients in Texas did not capture their side of the conversation. Thus, I have only been able to use my notes and memory rather than direct quotes.

2.5.3.4.6 | Compensation

Patient participants were offered a US$15 gift card to Wal-Mart, Amazon, or Target as compensation for their time. I received this funding from the Geography department at Birkbeck specifically for participant compensation.

Payment—which might be considered a reimbursement, compensation, or incentive—for research participants raises a number of ethical questions (Hammett and Sporton, 2012; Warnock, Taylor and Horton, 2022). Payment may represent 'some form of reciprocation between interviewer and interviewee' (McDowell, 2001, p.206). However, others suggest that paying participants may replicate the very power dynamics it attempted to address (Ansell, 2001; Anwar and Viqar, 2017). Some have also raised concerns about the financial incentive leading to deception in terms of eligibility for a study (Fernandez Lynch et al., 2019), routinisation of responses (Cook and Nunkoosing, 2008), and even commodification of knowledge (Anwar and Viqar, 2017; Hammett and Sporton, 2012). Others observe that 'the attractiveness of the offer causes participants to unreasonably discount or fail to appreciate risks related to research, which would threaten the validity of consent' (Gelinas et al., 2018, p.767).

At the same time, the notion that consent is somehow invalidated with the offer of payment makes assumptions about participants' ability to make their own decisions (see for example Hall, 2017). Likewise, we cannot assume that the quality of participation is undermined by payment (Boris and Klein, 2006). Moreover, payment does not preclude the building of rapport between the researcher and participants— in some cases, payment is required to build trust (Anwar and Viqar, 2017). With

respect to a feminist ethics of care, payment enables compensation for women's (re)productive labour (Rai, Hoskyns and Thomas, 2014). As such, Warnock, Taylor and Horton suggest payment for 'discrete, time-limited involvement in projects' (2022, p.198). Scholars suggest that payment should account for participants' time and effort (Head, 2009; Sullivan and Cain, 2004). Others suggest that payment should reflect wage rates (Gelinas et al., 2018). I chose to offer US$15 to reflect calls for a higher minimum wage by the Fight for $15 campaign. I did not offer cash but gift vouchers, which do not risk affecting benefits payments (Warnock, Taylor and Horton, 2022).

Participants who were staff of JTP or partner organisations were not offered compensation as they were participating in the capacity of their individual roles.

2.5.3.4.7 | Anonymity and confidentiality

The data of patient participants has been anonymised. Although feminist and other researchers have called into question the policy of 'anonymity by default' (Giordano et al., 2007; Gordon, 2019), I decided that it was the most appropriate approach to this research given the tangible threat of anti-abortion prosecution and violence as well as the sensitive and stigmatised nature of abortion for many people. In the case of more than one participant, I was the only person to whom they disclosed their abortion beyond JTP. Although telling their stories to me may have been empowering or a way to share their experiences for others to hear, that did not mean participants wanted their name or details publicised in any way. Given that abortion is now banned in states where five of my participants live, there is a real risk of harm should they be identified.

Anonymity is not an either/or concept but is instituted by the researcher on a continuum (Scott, 2005). As such, patient participants were initially assigned pseudonyms. Although they could have been referred to by their demographics and/or location without a name (Corden and Sainsbury, 2006), that was too impersonal from my perspective as this is highly personal research (see also Saunders, Kitzinger and Kitzinger, 2015). The method which researchers use to choose pseudonyms is not always clear and comes with particular challenges

around cultural sensitivity and choosing names that resonate with people (Allen and Wiles, 2016). As Allen and Wiles explain, 'pseudonyms have moved from being a simple way for a researcher to confer confidentiality and anonymity on research participants to a far more nuanced act of research, affected by issues of power and voice, methodological and epistemological standpoint, and considerations of the research consumers' (2016, p.153). My decision was to use the first names of cis women authors on my bookshelves while also attempting to choose names which 'reflected the cultural and ethnonational background of the participants' [actual] names' (Fazio, Hunt and Moloney, 2011, p.637).

I then chose to keep their demographic data as it was (e.g. age, race, etc.) while aggregating their location to the state-level. Some participants lived in large towns or metropolitan cities where they may not be easily identified by their demographics, while others lived in towns of just a few hundred people where there is a chance they could be identified. This decision protects their privacy and also reflects the tension between the necessity of confidentiality as well as context in researching the social determinants of health (Damianakis and Woodford, 2012). It further ensures that the data can attempt to challenge the stratified nature of abortion access in a political research project (Baez, 2002) and that the research is not '[decoupled]' from its geographically specific locations (Nespor, 2000, p.549). The understanding that the midwestern and western participants lived in rural areas, combined with their demographic data and state of residence, illustrate some of the barriers participants faced while safeguarding against potential privacy breaches.

For staff of JTP and partner organisations, in my ethics application I indicated that it would be difficult or impossible to guarantee full anonymity because this research is a case study of JTP and some of the participants are public figures. This was particularly the case for the Medical Director of JTP who has been interviewed for numerous publications and was at the time the only doctor prescribing pills at JTP. There were also the two staff of partner organisations I spoke with who are in potentially more 'activist' roles and are identified online but could have had their identities obscured. On the other hand, the Executive Director, Clinical Director, and the Patient Educator I spoke with do not have any identifying information available

online. I therefore offered anonymity and three participants opted for it. In this case I did not select pseudonyms but chose to identify participants by their position in the organisation as it was central to the perspective they shared in their interview.

2.6 | Analysis

Both quantitative and qualitative data were analysed in this research as part of the mixed-methods approach. I detail my quantitative data analysis above (2.4.3) and in Chapter 4. I detail my qualitative data analysis in this section and how I brought this analysis into conversation with the quantitative data analysis.

After completing data collection, I had semi-structured interview transcripts for 17 of 19 interviews (two recordings did not work [see 2.5.3.4.5]). I read these transcripts once through before uploading them to NVivo for coding purposes. I initially developed a set of 'top-down' or deductive codes from my literature review (Chapter 3) and context (Chapter 1). My literature review and context had numerous key themes with respect to abortion and health (care) more broadly that I wanted to scan for in the data. These included more 'obvious' mentions of rurality, abortion law, or telemedicine, for example, as well as discussions of experience which can be viewed through broad lenses like embodiment or mobilities. I found that these top-down codes were insufficient to capture some of the unexpected and more specific themes across participant interviews. For instance, blood emerged as a key theme that needed to be examined in its own right, rather than as a part of the wider theme of embodiment (see Chapter 6). In this way, I began to develop a set of 'bottom-up' or inductive codes whilst applying the 'top-down' codes and moved back to previous transcripts to ensure that I had not missed something that might be captured by a new code. In both the 'top-down' and 'bottom-up' codes, I employed a combination of descriptive codes, identifying the content, and interpretative codes, bringing out underlying meanings and patterns.

While coding, I found there was reliability in building excerpts of quotes from patients speaking to these themes. This enabled me to move from processes of familiarisation and coding to developing, reviewing, and defining themes. I made choices about what data was the most relevant and how to construct a coherent

narrative around the data. This is why data from my interviews with staff of JTP and partner organisations does not receive as much attention in my analysis as the patient interviews—I found that this data was the richest in terms of addressing my research questions. The central organising concept of women's experiences of access and care emerged at this stage of analysis (Braun et al 2015). I then ensured that my themes reflected this core idea to be used in the writing up of my analysis in Chapters 4-6.

I brought these key themes into conversation with my quantitative data analysis in Chapter 4. The quantitative data analysis was concerned with the barrier of distance, and I compare my findings with participants' perspectives on rural distance and barriers to abortion care. Across Chapters4-6, I discuss the themes both illustratively—excerpts included to demonstrate specific aspects of the narrative— and analytically—excerpts discussed to form the basis of my claims. In each chapter I explain the chapter structure, which were primarily shaped by the themes that I defined which lent themselves to chronological storytelling from abortion decision-making in light of barriers (Chapter 4), accessing the abortion pills (Chapter 5), and then taking the abortion pills (Chapter 6).

2.7 | Conclusion

In this chapter, I detailed my methodology for this research. I explained that I drew on feminist geographies and feminist health geographies to design a mixed-methods approach to this research. In this approach, I combine spatial analysis using GIS and qualitative semi-structured interviews to address my research aims and answer my research question: to what extent does telemedicine eliminate, shift, or re-imagine the geographical barriers to abortion care in the US? In the following chapter (Chapter 3), I review the key literatures that underpinned my analysis of the quantitative and qualitative data in Chapters 4, 5, and 6.

3 | LITERATURE REVIEW

3.1 | Introduction

This research seeks to understand the extent to which telemedicine abortion reduces, eliminates, or reimagines geographic barriers to abortion care. Abortion has largely been a focus of public health, sociology and gender studies, and legal studies. Public health literature has focused on the safety and effectiveness of abortion and the characteristics of people who access abortion. Sociology and gender studies have focused on issues like abortion stigma and activism, while legal studies have focused on abortion law and restrictions through analysing policies and court decisions as well as making arguments for the inclusion of abortion in human rights frameworks. Although geography has paid some attention to pregnancy in the last couple of decades, abortion has only recently become a subject in its own right. Scholars have demonstrated that abortion is inherently geographical and that geographic concepts, particularly mobilities and spatiality, are of relevance to understanding abortion access and care in a variety of contexts. To answer my research question, I not only draw on this nascent field of abortion geographies but also health and care geographies and reproductive geographies. These strands of inquiry have three common threads which are of relevance to this research— technology, access, and care—which is focused on the technology of telemedicine and its impact on abortion access and care. These broad themes are explored in different ways by each sub-field, and I seek to explore their connections and divergences in this chapter. This chapter moves from the broader field of health and care geographies and narrows first to reproductive geographies and then abortion geographies. I start with a brief overview of feminist geography and its place in the wider field of geography to lay the foundation of my review of health and care, reproductive and abortion geographies, whose insights have been made possible by the methodological and theoretical work of feminist geographers in the last three decades.

3.1.1 | The context of feminist geography

Geography has historically been and in many ways remains a 'straight white man's' discipline (Kinkaid, Parikh and Ranjbar, 2022). Historically, Oswin describes the

usual origin story of the geographical discipline as having four main phases. The first phase is the centuries of 'overtly colonial knowledge production' (Oswin, 2020, p.9) with maps of the world being produced for and by colonialists, reinforcing a particular worldview. The second phase, coinciding with the first degree awarded in Geography in the UK in the early 20th century, is the move towards a 'positivist', 'universal', or 'apolitical' approach to spatial science. The third phase is the emergence of radical/Marxist and humanistic critiques of geography in the 1960s and 1970s, but these approaches failed to understand how class intersected with other marginalised identities and 'offered limited analyses of embodiment' (Oswin, 2020, p.9). The fourth phase is the emergence in the 1990s of the reworking of cultural geographies wherein scholars 'began rethinking culture as plural, heterogeneous and shot through with power relations […] a shift away from a narrow emphasis on class-based differences and presumptions of universal subjecthood' (Oswin, 2020, p.9). The conceptual approaches within geography that have been marked by a limited worldview are manifestations of the overrepresentation of certain kinds of geographers—especially white, middle- or upper-class, 'Western', heterosexual, cisgender men—within the discipline and their attendant ontologies and epistemologies (see for example Kinkaid, Parikh and Ranjbar, 2022). This has meant that geographical knowledge production has historically been from the perceived 'centre'.

This history has continued and has contemporary ramifications for geographers from 'the margins' whose knowledge production is constructed as *marginal*. As Kinkaid, Parikh and Ranjbar explain, racism, colonialism, sexism, and cisheteronormativity are 'not new to geography' (2022, p.1557). Geography is still an overwhelmingly white discipline, which they suggest is not only a 'demographic problem' but also underpins the maintenance of 'exclusionary intellectual and institutional spaces' (ibid.) This whiteness intersects with gender and sexuality in the 'underrepresentation and undervaluation of women, queer people, and scholars of color in the field' and the attendant overrepresentation of white cisgender men with respect to knowledge production, but also the ongoing issues sexual and racist harassment in geography (Kinkaid, Parikh and Ranjbar, 2022, p.1558). Racism, colonialism, sexism, and cisheteronormativity have not only shaped who can

participate or produce knowledge in geography, but also what is considered 'legitimate scholarship' (ibid.) Tied up with the paradigm of objectivity is that researching issues 'close to the heart' is considered the 'Achilles' heel, the vulnerability of the subject which infects the object, the research' (Griffin, 2012, p.338). Nevertheless, although male geographers might have viewed feminist geography as a political project or a threat to the status quo, McDowell remarked in the 1990s that to 'realise that the feminist saying "the personal is political" could also be extended to read "and academic too" was astonishingly empowering for the early work in feminist geography' (1997, p.383).

The privileging of knowledge production by straight white men and lack of attention to the body and intersectionality is why feminist and other critical geographies' methodological approaches and theoretical perspectives have been critical to new ways of understanding our spatial world. Feminist geographies lamented the lack of 'systematic attempts to look at what constitutes geographic field research or how women's experiences and ways of knowing affect the stuff and processes of fieldwork" (Nast 1994, 56). Feminist geographies has particularly focused on issues of reflexivity, positionality and subjectivity and their impact on the research process (Hiemstra and Billo, 2017), which I discuss in Chapter 2. Feminist geography has a 'sustained interest in the origins and disruption of oppression and inequality' (Hiemstra and Billo, 2017, p.288), especially as it relates to gender. To do feminist geography 'means looking at the actions and meanings of gendered people, at their histories, personalities and biographies, at the meaning of places to them, at the different ways in which spaces are gendered and how this affects people's understandings of themselves as women or men' (McDowell, 1997, p.382). McDowell (1997) explains that this work often uses multiple scales to understand the reproduction of gendered oppression and inequalities.

Theoretical attention to embodiment, as I describe further in this chapter, was an important way through which feminist geographers began to look at gendered oppression. McDowell explains that '[w]omen's experiences of, for example, menstruation, childbirth and lactation, all represent challenges to bodily boundaries' in which the 'self is an existence centred within a complex relational nexus' (1993,

p.306). Nast and Pile further observed that bodies are 'woven together' with space in 'intricate webs of social and spatial relations that are made by, and make, embodied subjects' (2005, p.4). McDowell concluded that 'the implications of these differences for geographical concepts of spatiality, boundaries and community remain to be explored' (1993, p.306). Longhurst further questioned, 'Can focusing attention on the sexed body as a critical component in the matrix of subjectivity enable further understandings of power, knowledge and social relationships between people and environments?' (1997, p.495). The development of embodied geographies by feminist geographers is critical to the theoretical perspective of this thesis, which understands the gendered body and experiences of the gendered body as central to understanding how gender inequality is reinforced and resisted through space and time.

There was also early theoretical engagement by geographers with intersectionality—a concept developed and articulated predominantly by Black feminists in the US (Collins, 1986; Crenshaw, 1991, 1992)—which recognised instances where the discipline had 'moved beyond viewing gender, race, and class as distinct categories that operate independently in an additive fashion' and began to recognise these as 'mutually *transformative* and *intersecting*, each altering the experience of the other' (Ruddick, 1996, p.138). However, intersectionality has more recently seen a resurgence in the field of geography (Hopkins, 2018). This work in feminist geographies complements that of other critical geographers who have drawn out the problematic history of geography. They have called for 'an other geography' (Oswin, 2020) that not only recognises the contributions of queer scholars, scholars of colour and scholars from the so-called 'global South', but also draws necessary attention to how racial, class, colonial, sexual and gendered oppression and inequalities—and their intersections—are produced through space and time. As described throughout this chapter, heath, care and reproduction have been marked by injustice. The regulation of reproduction has been a mechanism through which colonial projects, past and present, have been maintained. As such, this thesis brings reproductive justice and intersectionality into conversation with political geographical perspectives to understand how abortion geographies are not just gendered but raced and classed. Overall, feminist geography has an important role to play in making visible

the history of reproduction and abortion and its contemporary implications, with respect to space, raising the voices of those affected by these issues, and aiming for a justice-oriented outcome.

3.2 | Health and care geographies

In this section, I define and review health and care geographies. The geographies of care, 'understood as the geographical complexities surrounding the provision, access to and (in)equality of health care' (Parr, 2003, p.212) have been the purview of health geographies. Atkinson et al. explain that as this field shifted from medical geographies to health, scholars 'have critiqued the unproblematic conceptualisation of care typically found within a standardised medical practice' (2011, p.565). Traditionally, care has been understood as medical intervention in medical settings (Parr, 2003), but care is not necessarily medical care which itself is not necessarily *caring* (Stone, Kokanović and Broom, 2018). Moving beyond this bounded model of care, health geographers can ask questions about 'how and where care is positioned and […] how this very positioning undermines goals of inclusion, social justice and the possibility of care as an end in itself' (ibid.). Feminist health geographers have called attention to gender inequality in health experiences, health outcomes, and access to and use of health care services at different and interrelated scales as well as the gendered nature of healthcare provision (Gideon (Ed), 2016; Wiles, 2020). They have shown how 'gender intersects with processes of economic change and powerful ideas about the roles of men and women to produce complex landscapes of gendered health outcomes and health-care provision' (Sothern and Dyck, 2009, p.232).

This section is structured around three key areas of health and care geographies which concern this research: health inequalities, caring places and spaces, and care 'at a distance'. I explore each of these areas in turn and conclude with a consideration of how they speak to issues of technology, access, and care.

3.2.1 | Health inequalities

There are persistent health inequalities within and between countries, regions, towns, and neighbourhoods. Scholars of public health and medical and health

geographers have used numerous approaches to understand the factors shaping health disparities in different contexts. The concept of access is central to understanding how health inequalities may be produced. Access is 'always defined as access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs' (Levesque, Harris and Russell, 2013, p.1). Nevertheless, access is a complex concept that has been conceptualised in different ways by scholars across disciplines (Daniels, 1982). Health access is often understood as an attribute of health services as well as the attributes of service users and the availability of health resources which affect service utilisation (see for example Andersen, 1995; Salkever, 1976). This might be articulated in terms of supply and demand (Mooney, 1983), but access is about more than availability or uptake of services (Levesque, Harris and Russell, 2013). Rather than entry into or factors influencing entry, Penchansky and Thomas offered a 'taxonomic' definition of access which described a set of dimensions describing the 'fit between the patient and the health care system' (1981, p.128), including availability, accessibility, accommodation, affordability and acceptability. Levesque, Harris and Russell (2013) rework these five dimensions into 1) approachability; 2) acceptability; 3) availability and accommodation; 4) affordability; and 5) appropriateness. They then conceptualise five corollary dimensions of population ability to interact with these dimensions, including the ability to perceive, seek, reach, pay, and engage. This conceptualisation accounts for social, cultural, financial, and physical factors at the individual, community, and health system levels. Geographically, this enables an understanding of access vis-à-vis place and local environment.

Multi-dimensional frameworks of access are related to other frameworks for understanding how health outcomes are produced unequally, such as the social determinants of health (SDH). Within SDH, there have been two main approaches: compositional and contextual (Bambra, 2018). The compositional approach argues that the characteristics of individuals determine the health outcomes of a particular place. This approach focuses on the impact of health behaviours—especially smoking, alcohol, drugs, exercise, and diet—demographic characteristics, and socio-economic status on health outcomes (Gatrell and Elliott, 2015). These individual

factors can now be explored at the molecular level with developments in epigenetics (Shantz and Elliott, 2021). The contextual approach, on the other hand, emphasises the direct and indirect effects of the economic, social, and physical environment and whether places are thus health-promoting or health-damaging (Bambra, 2018). At the scale of a particular area, health geographers use this approach to examine issues like poverty, food deserts, and pollution as causes of poor health (Breyer and Voss-Andreae, 2013; Jokela-Pansini, 2022; Senanayake, 2022). The compositional and contextual approaches are not mutually exclusive (Macintyre, Ellaway and Cummins, 2002), but together they do not sufficiently account for structural factors, resulting in 'conceptualisations that underrepresent the complex multi-scalar and interdependent processes operating at the systems level, often over many decades, to shape geographical inequalities in health' (Bambra, Smith and Pearce, 2019, p.37).

An approach that attempts to account for structural factors is the relational one. The relational approach combines the compositional and contextual approaches to suggest that 'there is a a mutually reinforcing and reciprocal relationship between people and place' (Cummins et al., 2007, p.1826). Although the relational approach has extended understandings of SDH beyond individual and local factors, Bambra, Smith and Pearce contend that it has overemphasised 'the role of lower level, localised, proximal contextual, horizontal effects, at the expense of marginalising and minimising the role played by larger scale vertical contextual influences, particularly macro political and economic factors' (2019, p.37). Other scholars have gone further in acknowledging both micro- and macro-level factors in relational approaches to health inequalities, emphasising engagements between people and the material world, otherwise known as assemblages (Brown and Di Feliciantonio, 2022; Duff, 2014; Fox, 2011; Powell et al., 2021). Fox and Powell argue that '"tiny dis/advantages" accrue from the capacities produced by everyday interactions with humans, non-human matter and places' (2023, p.239). This relational and affective approach, they suggest, 'undermines efforts toward a neat understanding of "place" as a cause, and "health" and/or "social disadvantage" as outcomes' (ibid.). Instead, they suggest that places should be 'acknowledged as complex sociomaterial assemblages' (ibid.).

Nandagiri, Coast and Strong (2020) suggest that SDH approaches have much in common with the framework of structural violence, specifically by centring structural forces and their direct impact on health outcomes and inequality. They explain that structural violence 'focuses attention on the often unnoticeable systems (legal, political, economic and sociocultural) and social relations that are part of the fabric of society and that shape individuals' experiences, including health and wellbeing' (2020, p.83). While geographers have engaged with structural violence, it has been more commonly in the realm of war and peace studies. Feminist contributions to this area have theorised 'how space and geographic imaginaries become means of structural violence, facilitate additional deployments of state violence, and become complicated sites for political mobilization' (Loyd, 2012, p.481). DeVerteuil (2015) identified the need for medical and health geographies to understand structural violence and underscored that health and violence are intertwined. Further work has considered how 'violence sits in places' and has emphasised the spatialised and embodied experiences of violence (Little, 2017). Nandagiri, Coast and Strong (2020) also make a compelling case for considering structural violence with respect to abortion research. Rosenberg argues that viewing 'violence as a public health issue and tying health geography to current economic and political crises open[s] up new directions for health geography' (2017, p.839).

Recently scholars have built upon the relational and materialist approaches to health inequalities to employ a political economy approach to health inequalities. The political economy approach is concerned with the 'social, political and economic structures and relations that may be, and often are, outside the control of the individuals or the local areas they affect' (Bambra, 2018, p.32). It is also concerned with 'the influence of the macro political and economic, structural factors shaping places and their influence on population health outcomes' (Bambra, Smith and Pearce, 2019, p.37). Ultimately, it contends that '[p]lace matters for health, but politics matters for place' (ibid.) and that health inequalities may be determined by political power and political choices. Mishori similarly calls for a 'political determinants of health' approach that recognises that 'health disparities are driven as much by policy—and politics—as by any other cause' (2019, p.491). The author

uses abortion in the US as an example of how political decisions directly impact health access. McGuinness and Montgomery (2020) also point to *'legal* determinants of health' with respect to abortion regulation, barriers, and disparities. Although the relational, materialist, and political economy approaches have advanced understandings of health inequalities as not caused by individuals or neighbourhoods but a combination of micro- and macro-level forces, they have mostly considered socio-economic status in a vacuum (Gkiouleka et al., 2018).

To address this gap, Gkiouleka et al. (2018) and Bambra (2022) call for attention to intersectionality in health inequalities research. Crenshaw first articulated the term intersectionality to 'illustrate that many of the experiences Black women face are not subsumed within the traditional boundaries of race or gender discrimination as these boundaries are currently understood, and that the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at the race or gender dimensions of those experiences separately' (Crenshaw, 1991, p.1244). In effect, intersectionality draws attention to the multiple axes of (dis)advantage which shape individual experiences and health outcomes (Bambra, 2022), such as but not limited to geography, class, race, ability, and citizenship. Much of the research around health inequalities has analysed these as discrete social categories thereby obscuring the 'multiple stratification systems that people embody simultaneously' (Bambra, 2022, p.3). An intersectional approach attempts to address this by '[allowing] us to formulate research questions about the situation of specific social groups and interrogate the institutional factors responsible for their increased vulnerability' (Gkiouleka et al., 2018, p.95). Recently health geographers have begun to employ intersectional approaches to health, such as in studies of the stigmatising experiences of Black gay men in the rural US (Scott, 2021, 2022), among others (see also Giesbrecht et al., 2018; Halliday et al., 2021).

Reproductive justice incorporates and acknowledges ideas around intersectionality and is defined as the 'complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights' (Ross, 2006, p.14). According to Ross, reproductive justice argues that 'the ability of any woman to determine her own

reproductive destiny is linked directly to the conditions in her community' (2006, p.14). Although reproductive justice specifically mentions women and girls and the right to have children, not to have children, and to raise children in health environments, it may offer a broader lens to examine 'contradictory power differentials contoured by race, gender, citizenship, ethnicity, ability, and class' (Ross, 2017, p.293). Outside of the geography discipline, reproductive justice has been applied to numerous issues of reproductive oppression and injustice (see for example Hayes, Sufrin and Perritt, 2020; McKee, 2018; Messing, Fabi and Rosen, 2020; Nixon, 2013). Its use within geography is recent and to date is mostly theoretical in nature, considering reproductive justice and issues of fertility, abortion, and surrogacy and, more recently, embodiment and environmental justice (Coddington, 2021; Engle, 2022; Gay-Antaki, 2023; Lewis, 2018b). Nash (2021b) more explicitly considers disparities in maternal health outcomes for Black women in the US with respect to reproductive justice. Her analysis offers a potential way forward employing reproductive justice alongside geographical concepts like space and place to consider health inequalities. 'In thinking about birth geographies as producing forms of obstetric violence, rather than simply the hospital as the site of obstetric harm', Nash argues that 'we can link Black maternal health and survival to spaces beyond the delivery room, to include the kinds of care required to support Black life' (2021b, p.326). In this framing, geography shows how Black women's health outcomes are shaped by space, including but not limited to the hospital, and reveal how the presence and absence of care is spatialised.

3.2.1 | Caring places and spaces

The advent of telemedicine has raised important questions about the place of care and the role of human and non-human relations in the caring process. Care and care relationships are 'located in, shaped by, and shape particular spaces and places that stretch from the local to the global' (Milligan and Wiles, 2010, p.737). Health and care geographies have introduced a number of frameworks to understand the connections between care and place. First articulated by McKie, Gregory and Bowlby, 'carescapes' and 'caringscapes' consider 'the complexity of spatial-temporal frameworks and reflect a range of activities, feelings and reflective positions in the routes people map and shape through caring and working' (2002, p.904). Atkinson et

al. suggest that this perspective 'offer[s] one route to treat different scales as mutually constituting and to connect multiple sites of care' (2011, p.567). While Ivanova, Wallenburg and Bal agree that the dual framework of carescapes/caringscapes 'offers a possibility for understanding place-shaping through resources and power', they contend that it is 'unable to make sense of the messiness "on the ground"' and therefore obscures the 'complexity and dynamics, inherent to care emplacement' (2016, p.1338). These authors integrate actor-network theory, assemblage, and place into the notion of carescapes to highlight the ongoing relationality of care as well as the specificities and ambiguities of caring places (ibid.).

Like carescapes/caringscapes, Milligan and Wiles' (2010) 'landscapes of care' framework attempts to reveal the complexities of care and care relationships, with specific attention to their spatial dimensions. This framework builds on 'landscapes of despair' (Dear and Wolch, 1987; Gleeson and Kearns, 2001) and 'therapeutic landscapes' (Gesler, 1992; Williams (Ed), 2007) to recognise the 'thoroughly spatial ways care [is] structured and practiced' (Brown, 2003: 849) . It leverages the 'loose spatial metaphor' of landscape to highlight 'its potential usefulness as a framework for unpacking the complex relationships between people, places and care' (Milligan and Wiles, 2010, p.736). Nevertheless, Ivanova, Wallenburg and Bal maintain that landscapes of care 'stays closer to spatiality in general, making less use of place' (2016, p.1338).

Bowlby and McKie later introduce the notion of care ecologies to bring together and extend their extant concepts to account for the complexities of 'informal care practices in neo-liberal austerity' (2019, p.2). They suggest that the 'metaphor of ecology' can reveal the interactions between individuals' caringscapes and their carescape context (Bowlby and McKie, 2019). Rather than viewing concepts like place as fixed, as Ivanova, Wallenburg and Bal (2016) argued, Bowlby and McKie disagree that 'the spaces of interaction are neatly nested within one another in material space' and prefer to situate this concept within the 'relational turn' in geography (2019, p.11). This ecological framework of care draws attention to the socio-economic forces shaping practices and experiences of care.

With an understanding that care is both emplaced and relational, health and care geographies consider where care takes place and who cares in those places. Care has been traditionally located and recognised within biomedical settings. Drawing on Foucault's *The Birth of the Clinic,* geographers have understood the clinic as a site of diagnosis and treatment as well as the locus of an empirical, medical 'gaze' which spatialises healthy and unhealthy bodies; this 'new biomedical epistemology not only described but constituted a certain reality, and imbued itself and the medical profession with profound epistemological authority' (Brown and Knopp, 2014, p.99; Philo, 2000). Yet the clinic, amongst other medical facilities, may not be a caring place but a historical and contemporary site of pathologisation, paternalism, or violence against vulnerable and marginalised people such as queer and trans people (Meer and Müller, 2017), disabled people (Goodley et al., 2019), or Black and Brown folks (Roberts, 2017).

Health and care geographies reveal some of these issues as well as highlight the alternative and changing space of care, including unpaid care work done in homes and neoliberal shifts towards community as the loci of care to fix crises in care provision (Dowling, 2021). Milligan and Wiles (2010) suggest that neoliberalism has shifted care towards the community and into homes, where private citizens are made responsible for care of themselves and others. Atkinson et al. (2011) add conservativism, liberalism, and working-class solidarities as reasons for this shift. They suggest that new technologies 'whether biomedical or discursive, appear to afford new possibilities for self-actualisation but must also intersect with the histories of existing material, moral and ideological landscapes' (Atkinson, Lawson and Wiles, 2011, p.564). Although the authors contend that the exclusionary nature of these landscapes may 'erode even the most limited and bounded spaces of care' (ibid.), the home is also a place where dichotomies of good/bad care and autonomy/dependency can be challenged (Danholt and Langstrup, 2012; Milligan and Wiles, 2010; Weiner and Will, 2018).

An 'infrastructures of care' approach enables an understanding of the various sites and actors involved in care—biomedical or not. Danholt and Langstrup proposed the

concept to refer to the 'more or less embedded "tracks" on which care may "run"' shaping and being shaped by actors and settings along the way' and to identify 'the way in which healthcare is materially inscribed and spatially distributed' (2012, p.515). They explain that the concept of infrastructure 'enables us to foreground the "backstage" aspects of the relations that distribute "care" across space and actors' (Danholt and Langstrup, 2012, p.518). From this perspective, we can see 'the crowdedness or emptiness of the spaces between the clinic and the home, and consider the fringes of care infrastructures, where care is inhibited or ends for someone or something' (ibid.). Their concept has been particularly extended to consider the mundane and not-so-mundane technologies and materials that facilitate care (Weiner and Will, 2018), community care provision within post-welfare and austerity contexts (Jupp, 2023; Kim, 2018; Power et al., 2022; Williams and Tait, 2022), housing (Power and Mee, 2020), and other crisis contexts (Lopes et al., 2018; Odendaal, 2021).

Looking at specific places of care, this approach reveals how spatial organisation makes care possible (Danholt and Langstrup, 2012). Langstrup advanced this idea through 'chronic care infrastructures' which she defines as the 'the often mundane and thoroughly socio-material distribution of work between the clinic and the home in chronic disease management' (2013, p.1018). These ideas have been particularly useful for understanding care in the home because of 'its attention to materials, spaces, routines, conventions and work' (Weiner and Will, 2018, p.272). In addition to chronic care in the home (see also Brownlie and Spandler, 2018), an infrastructural approach is also useful for understanding the sites, actors, and things that facilitate care in other settings such as the hospital or the clinic (Bell, 2018; Heath et al., 2018), care homes (Lovatt, 2018), and not-so-obvious sites of care, such as IT hubs which enable telemedical care (Danholt and Langstrup, 2012; Thompson, 2021) or non-medical spaces (Mangione, 2018). Latimer explains that this strand of work is concerned with how 'spaces of care are materialised in ways that produce and reproduce particular ideologies and enact strategic programmes' as well as how 'practices and materials in use make up locations of care at the same time as they enable identity-work' (2018, p.380).

Less explicit within the infrastructures of care approach is attention to social reproduction. While Buse, Martin and Nettleton briefly distinguish between paid, unpaid, and self-care, they state that these 'distinctions are often blurred in acts of caring' (2018, p.245). Yet these categories are important to understanding care work in the political economy, as Folbre's (2006, 2014) work contends. Folbre (2006, 2011) distinguishes between unpaid care work, unpaid subsistence production, informal market work, and paid employment and within these distinguishes between 'interactive' or face-to-face care and 'support' or infrastructural care. This framework enables considerations of self-care. While Folbre considers social reproduction too general a concept, it is a useful lens to understand the impacts of austerity or neoliberalism on health and social care (Hall, 2022; Power and Hall, 2018). Hall explains that 'austerity cutbacks have led to the revision of spaces and responsibilities of care, and so too informality and profit' (2022, p.304). Henry (2015), for example, argues that hospital closures represent a devaluation of social reproduction and the restructuring of the spaces and work of health care. Telemedicine has been one response to continue health care provision in the wake of these financial constraints. Dowling (2021, 2022) suggests that digital technologies seek to 'fix' the care crisis by plugging gaps in care, but ultimately displace these problems. As such, telemedicine may actually perpetuate the 'structural feature of capitalist economies to off-load the cost of care and social reproduction to unpaid realms of society' (Dowling, 2022, p.104).

3.2.3 | Care 'at a distance'

Health, medical, and care geographies have incorporated perspectives from science and technology studies (STS) to examine the role of technologies in health care practices. This work has often focused on the non-human 'things' that are involved in care and caring (Buse and Twigg, 2014; Mol, Moser and Pols, 2010) and is broadly concerned with '(ill-)health assemblages' (Fox, 2011), 'diagnostic assemblages' (Locock et al., 2016), and care assemblages (Armstrong and Day, 2017). These assemblages may include a 'range of diffuse human and non-human elements' and are 'processual, relational and dynamic, shifting across time and context' (Buse, Martin and Nettleton, 2018, p.244). Geographers suggest that there has been a prevailing focus on 'obvious health technologies' (Buse, Martin and Nettleton, 2018;

Maller, 2015), such as digital health technologies. These innovations are not new and cannot be hailed 'as the solution to all ills of the healthcare system' (Ivanova, 2020, p.1298). Ivanova proposes 'post-place care' as a lens to 'analyse interconnections and disconnections of both material and immaterial elements of caring and embrace their power to "unsettle"' (2020, p.1306). Others emphasise the need to consider materialities or material culture, including the 'obvious' (Maller, 2015) as well as the mundane (Brownlie and Spandler, 2018). Post-place care is thus a useful tool to understand how mHealth is a material health care intervention which may not solve all health issues.

mHealth refers to the active or passive 'use of wireless and mobile technologies in health and health care and includes a diverse range of activities' (Cinnamon and Ronquillo, 2018, p.279). Cinnamon and Ronquillo observe that '[o]wing to its core characteristics of mobility and portability, mHealth can expand the reach of health-care services to previously underserved populations, including those in rural and remote regions' (ibid.). However, the authors suggest that geographic concepts are frequently invoked in discussions of mHealth with underlying assumptions, like the 'trope' of 'overcoming geographical distance and barriers' (Cinnamon and Ronquillo, 2018, p.280). Previous work in geographies contrasted 'virtual' mHealth, specifically telemedicine, with 'material' or 'physical' care (Cutchin, 2002). Andrews and Kitchin likewise contend that cyberspace is 'collapsing spatial and temporal boundaries, leading to a radical space-time compression, which frees social relations from the constraints of scale' (2005, p.319). However, more recent work questions 'whether care is *really* moving into new landscapes' (Ivanova, 2020, p.1306, emphasis mine). Oudshoorn (2011, 2012) and Ivanova suggest exploring the changing space of care while also highlighting that place still matters to 'how 'good care' is imagined' and 'how power relations in health care are stabilised' (2020, p.1307). Indeed, recent work has shown that 'care at a distance' (Pols, 2012) can be 'good', affective, intimate, and relational care (Thompson, 2021; Thorpe et al., 2022; Watson, Lupton and Michael, 2021)—not something that rural society is '*made to accept* [as…] sufficient' (Cutchin, 2002, p.35, emphasis mine).

While Cutchin questions whether we should 'give up on creating material systems of care' (2002, p.35), other scholars question that telemedicine is an immaterial system of care. The idea of placeless care is 'misleading' and 'unproductive' insofar as 'place disappears, and care is abstracted' (Ivanova, 2020, p.1306). Rather, telemedicine technologies should be understood as re-distributing care responsibilities and reconfiguring who cares, how, and where (Langstrup, 2013; Oudshoorn, 2012). Telemedicine is situated within 'material and non-material relations' that are themselves emplaced (Ivanova, 2020, p.1298). Moreover, care does not necessarily require physical proximity; these new caring practices can have a 'very immediate corporeality', which should be understood as an 'embodied phenomenon […] even where care is physically distant' (Milligan and Wiles, 2010, p.742; Watson, Lupton and Michael, 2021). The material and immaterial dimensions of care are inseparable and 'reveal a precious interplay between care's practical elements and care's affective dimensions' (Dowling, 2021, p.46).

For these reasons, Ivanova proposes the concept of 'post-place' care to extend place into 'digital, affective, troubling, [and] sensory [carescapes]' (2020, p.1306). Post-place 'forces us to analyse interconnections and disconnections of both material and immaterial elements of caring and embrace their power to "unsettle"' (ibid.). While Ivanova suggests that the easy dichotomy of placeless/emplaced is conceptually appealing, 'we would do well to problematise its place as locate-able and come to terms with care places as fractured, layered and open' (2020, p.1306). While care has *moved,* it is not *placeless*. Rather, placed care is 'stretched' to include more and layered places which assemble to 'do' care (ibid.). This theoretical challenge to the placelessness of telemedicine serves to problematise how ideas about 'good' or 'ideal practices of care' (Danholt and Langstrup, 2012) are themselves placed and 'how power relations in health care are stabilised through place-making' (Ivanova, 2020, p.1307). Affective atmospheres further underscore that care is about more than proximity (Anderson, 2009). This brings the discussion back to care ecologies and infrastructures of care, which consider existing, subtle, and often invisible practices of care (Danholt and Langstrup, 2012). Telemedical technologies are simply one element of care that is *already* infrastructured through spatial, temporal, and material practices.

At the same time, there are a couple of key questions about the use of mHealth and telemedicine in health and social care which geographers and social scientists have considered. Firstly, there remains a 'digital divide' in the US, among other places, between those who have more access to ICTs—including device ownership, internet access, infrastructure, and information flows—and those who have less access. Gilbert et al. (2008) suggest reframing the digital divide not only from the perspective of those with limited access to ICTs but also from those who experience health inequalities—disparities understood to particularly affect rural areas. However, somewhat in keeping with Cutchin (2002), Roberts et al. (2017b, 2017a) and Young worry that the narrow, depoliticised framing of the digital divide normalises technological approaches to rural development while also 'responsibilizing [rural communities] for their own vulnerability' (2019, p.67).

Relatedly, the second issue is the degree to which digital health approaches are employed as a 'care fix' for ongoing crises in the health and social care systems (Dowling, 2021). With respect to ageing, for example, '[p]olicies advocating telecare as assuring independence, giving "peace of mind" and solving the "problem" of ageing' can be coercive if they 'actually enhance isolation and dependence' (Mort, Roberts and Callén, 2013, p.803). As a form of 'self-care', telemedicine 'may be interpreted as a neoliberal approach with a strong interest in the wellbeing of the individual that shies away from the overarching and custodial role of the classical welfare society' (Danholt and Langstrup, 2012, p.516). While technologies may be considered neutral by policymakers, 'like all technological innovations, they cannot be considered as "purely" technical, in that they occur within a social context and are stimulated by issues perceived within that context' (Bowes and McColgan, 2006 cited in Milligan, Roberts and Mort, 2011; Nicolini, 2006).

One of the ways that we can examine the tensions between independence and dependence with respect to care is with health technologies in the home. There is a widespread conception that the 'home is territorialised by the medical regime [of the healthcare system], the former being the weaker party' (Danholt and Langstrup, 2012, p.519). This has been explored through studies of (telecare) technologies

which encourage 'self-care' and 'care-at-home' for older people or people with chronic conditions. In this way, Milligan, Roberts and Mort suggest that 'the private space of the home becomes increasingly transformed into a site of work, inhabited by both formal and informal carers and the paraphernalia of care' (2011, p.351; Mort, Roberts and Callén, 2013). Thus, a sense of home is threatened by the emplacement of health and care technologies. However, Danholt and Langstrup point out that there are 'numerous "acts of resistance" against this supposedly all-powerful medical regime' (Danholt and Langstrup, 2012, p.519). People may engage in 'tinkering' which challenges the biomedicalisation of their care and home (Danholt and Langstrup, 2012; Mol, Moser and Pols, 2010). Overall, the 'reordering of the home into a space of care' requires contending with the home as both a caring and private place (Milligan, 2009, pp.71–72), as well as a place where care already happens.

A sense of home is not necessarily disrupted by telemedicine technologies, whether commercially or clinically acquired. In Weiner and Will's study of home blood pressure monitoring devices, the home and its inhabitants were seen as a 'resource' to embed and establish caring practices. Their participants understood the home as a shared space with symbolic importance in which care was *already* located, practically and affectively. The spatial and material dimensions of the home can enable caring practices (Buse, Martin and Nettleton, 2018; Danholt and Langstrup, 2012; Langstrup, 2013). Homes are 'more than mere locations – they are allies that help weave medication into the fabric of everyday life in the home, as both material objects and as activities' (Danholt and Langstrup, 2012, p.524). The location of technologies, like medication, can serve as a reminder to care (Weiner and Will, 2018). It is important to emphasise that medication-articulation, surveillance, emotional and informational work by individuals and caregivers maintain the care infrastructure (Cheraghi-Sohi et al., 2015). This work underscores that the home is not an entirely separate place in which 'virtual' care is done 'at a distance'. By focusing on the 'promises of telemedicine and IT-supported monitoring systems risks neglecting the complex ecology of healthcare that already facilitates self-care, and already connects the clinic and the home' (Danholt and Langstrup, 2012, p.529). Thus, 'the terrain between the home and the clinic is certainly not empty' (ibid.).

In this section, I considered three areas of health and care geographies scholarship which examine the relationship between health, care, and place. Access to care and health outcomes are in no small part shaped by place, but geographers have proposed various ways to understand this relationship, including compositional, contextual, and relational approaches. It is political economy, intersectionality, reproductive justice, and structural violence approaches that remind us that there are wider structures shaping access to and experiences of care for different groups of people. But to understand how care is structured and experienced across spaces and places, geographers have introduced numerous interrelated concepts, such as carescapes, landscapes of care, care ecologies, and infrastructures of care. These approaches recognise that care is not always located in clinical settings, that care may be provided by friends, family, or oneself, and that caring experiences are shaped by an assemblage of human and non-human 'things'. They also account for neoliberalism which has pushed care into communities and homes, placing the onus of responsibility for care onto individuals rather than the system. This consideration has relevance to the emergence of technologies which enable care 'at a distance'. While concerns have been raised about the digital divide and telemedicine as a sticking plaster over deeper health inequities, scholars have demonstrated that proximity is not strictly necessary for 'good' care. That care is provided remotely in mHealth pathways does not mean that care is placeless self-care, but rather care is still emplaced and facilitated by a network of human and non-human materials. This network is rendered invisible in the understandings of telemedicine as 'virtual', thereby obscuring the underpaid and unpaid work necessary to make care possible.

3.3 | Reproductive geographies

In this section, I define and review reproductive geographies. The reproductive geographies literature has emerged from feminist and health geographies approaches to pregnancy and birth. In geography, there has been a prevailing focus on issues like population and its implications for demography, with less attention to reproduction. Tyner suggested that population geographers move away from simple demographic questions to an approach that asks, 'Within any given place, who lives,

who dies, and who decides?' (2013, p.702). Moreover, as Fannin, Hazen and England note, reproductive justice and new reproductive technologies are raising 'important questions about the changing social and spatial dimensions of reproductive life' (2018, p.5). The research agenda on reproductive geographies, set out by Fannin, Hazen and England in their seminal collection, suggests 'new empirical, methodological and conceptual perspectives […] on analyses of reproduction, affirming how the sites, practices and experiences of fertility, pregnancy and birth are central to understanding key geographical concerns' (2018, p.7). This work is geographical in its concern with different scales, boundaries, and places, and feminist in its attention to everyday lived experiences of reproduction (ibid.). Prior to the 2020 volume edited by Fannin, Hazen and England, work in reproductive geographies focused on embodiment experiences (Longhurst, 1997, 2001, 2008); biomedicalisation (Dyck et al., 2005; Klimpel and Whitson, 2016); neoliberalism and capitalism (Cooper and Waldby, 2014; Waldby and Cooper, 2010; Waldby and Mitchell, 2006); migration (Lozanski, 2020); mobilities (Schurr, 2019; Sheller, 2020; Speier, Lozanski and Frohlick, 2020); reproductive technologies and surrogacy (Lewis, 2018b; Schurr, 2018; Speier, 2016); and biopolitics (Fannin, 2013; Freeman, 2017; Krause and De Zordo, 2012). Reproductive geographies has thus brought necessary empirical and theoretical attention to biological and non-biological reproduction across the life course.

This section is loosely structured around three key areas of reproductive geographies which concern this research and which were recently outlined by Fannin, Hazen and England (2018): bodies, places, and politics. I detail these strands and use them as a stepping off point to consider embodiment and materiality; biomedicalisation and 'intimate' technologies; bio- and geopolitics, mobilities, and reproductive justice. I conclude with a consideration of how these areas speak to issues of technology, access, and care.

3.3.1 | Embodiment and materiality
The gendered and reproductive body has been an important subject in feminist geographies, broadly, and reproductive geographies, specifically. This work considers 'how the reproductive body and bodily materials figure in wider

understandings of science, family-making and development' (Fannin, Hazen and England, 2018), without reducing the body to its biological capacity for reproduction. Although there have been a 'bewildering array' of approaches to the body (Longhurst, 1997, p.489), scholarship has particularly emphasised 'the agency of the body in social practice, showing how the materiality of the body in reproducing, sustaining and contesting dominant social assumptions and expectations becomes part of the actual production of those expectations' (Little and Leyshon, 2003, p.260). Centring the body in geographical analysis, feminist geographers have considered bodily performance, embodied experiences, and material practices of the body. With respect to bodily performance, scholars have argued that bodies are relational, territorialised, and situated within social, spatial, and temporal relations (Senanayake, 2022; White, 2022). Drawing in turn on Goffman (1959) and Butler (1990), geographers have demonstrated the centrality of space to bodily performance (Gregson and Rose, 2000; Holt, 2008; McDowell and Court, 1994). Of particular relevance to this work, Little and Leyshon show that 'the rural body is not simply acting out the dominant expectations of gender and sexual identities but is, in itself, part of the construction and reproduction of such identities' (2003, p.269).

Fannin, Hazen and England observe that 'attention to the space or scale of the body is essential to understanding reproductive processes' (2018, p.10). Recognising that reproductive experiences 'all represent challenges to bodily boundaries' (McDowell, 1993, p.306), reproductive geographies have also examined bodily interiors and the movement of bodily materials to the exterior. Recent work has considered the geographies of the uterus, following Lewis' (2018a) preeminent article on 'cyborg uterine geographies' which problematises accounts of heterosexual, 'natural', and life-affirming pregnancy and implicates the uterus within wider debates (see also Fannin, 2018; Longhurst, 2018). Importantly, Lewis asks whether uteri might help to 'expose the limits – and thus, better define the value – of the 'care' framework' (2018a, p.313). Colls and Fannin also draw attention to the relational status of bodily interiors through their work on the placenta, and suggest that '[f]or as much as work on the body posits relationality as a capacity shared between bodies, we consider the possibility that relationality can also be theorised within bodies' (2013, p.1090).

Mobilities have been a useful lens through which to understand the multi-scalar nature of reproduction within and outside of the body. Sheller suggests that reproductive mobilities start from the 'micro-scales of conception' and that 'pregnancy itself is a kind of mobilization of the body' in which potentiality, motility, formation and implantation are mobilised towards a 'potential of becoming' (2020, p.189). This work on interior reproductive mobilities has also considered, for example, artificial insemination (England, 2018) and the chemical geographies of the abortion pills (Freeman and Rodríguez, 2022)—both the facilitating and hindering of procreation. Reproductive mobilities therefore concern vital mobilities (Speier, Lozanski and Frohlick, 2020), which consider 'what needs to be moved to enable and sustain life' (Sodero, 2019, p.110). Material substances are 'entangled with bodies as well as the affects that emanate from bodies and through which movement and place is felt and sensed' (Speier, Lozanski and Frohlick, 2020, p.113).

Materiality also involves the '"stuff" that is in circulation' and 'the physical and commodified matter and objects of nodes and networks' (Speier, Lozanski and Frohlick, 2020, p.113). This work is conversation with geographies of organs and blood donation (Copeman, 2009; Davies, 2006; Sodero, 2019), which demonstrate that 'the body's interior is open to an array of medical and technological interventions through which the movement of body parts across the boundaries of the skin charts new spatial and temporal trajectories' (Colls and Fannin, 2013, p.1088). Reproductive geographers have particularly considered transnational surrogacy and assistive reproductive technologies within a broader fertility economy, which rely on the movement of bodies and bodily materials. Collard explains that '[e]ggs, sperm and embryos travel between bodies, across borders and around the world faster and more cheaply than ever before' (Collard, 2018, p.31). These reproductive networks are marked by power differentials which, for example, position some women as labourers and others as consumers (Bhattacharjee, 2018; Collard, 2022; Lewis, 2018b). But Collard also notes that biotechnologies have led to the 'respatialisation of reproduction from within to outside the body [which] has made reproduction hypermobile, but it has also rendered reproductive tissues hyper-visible at the most intimate scales of resolution' (Collard, 2018, p.32).

Despite this attention to materiality and embodiment, there has been some historical neglect by geographers of the messiness and fleshiness of bodies (Longhurst, 1995). Attention to corporeality was largely provoked by Grosz (1994) who observed that differential treatment of women was in large part due to their bodily difference from men. Longhurst pointed out the absence of corporeality in geography: '[i]gnoring the messy body is not a harmless omission, rather, it contains a political imperative that helps keep masculinism intact' (Longhurst, 2001, p.23). Reproductive geographers have emphasised Katz's (2001, p.711) point that care involves the 'messy, fleshy stuff of everyday lives' (cited in Bagelman and Gitome, 2021; Lewis, 2018a) and challenges understandings of the body which render it 'incorporeal, fleshless, fluid-less, little more than linguistic territory' (Longhurst, 2001, p.23). Longhurst's (2001, 2003) work has demonstrated that pregnant women may feel uncomfortable in public spaces because of the messy materialities of their pregnant body and their potential to leak. Scholars have also looked at interior and exterior bodily surfaces to examine the fleshiness of the body Obrador-Pons (2007) on skin; Colls (2007) on fat; Colls and Fannin (2013) on the placenta; and Longhurst (2008) on pregnancy. This work has 'lent itself easily to geographical applications of distinctly spatial concepts such as boundary, territory, and site in order to explore the nature and form of relations between bodies and spaces' (Colls and Fannin, 2013, p.1088). Lewis (2018a) brings necessary attention to the uterus as a place of gestation, menstruation and politicization, while recent work has explored the messy materialities of menstruation and menopause (Alda-Vidal and Browne, 2022; Bhakta, Reed and Fisher, 2018; Bhakta et al., 2021) and the cultural geographies of virginal blood (Militz, 2023). Attention to the corporeal experience of abortion can help us understand how in some places the use of abortion pills is considered 'menstrual regulation' or a solution for 'late periods' (Freeman, 2017; Pheterson and Azize, 2005).

3.3.2 | Biomedicalisation and 'intimate' technologies

The places and spaces of reproduction have 'strong symbolic meaning' and these meanings 'profoundly influence the lived experiences of individuals' (Fannin, Hazen and England, 2018, p.10). These places and spaces are 'never static' but rather 'fluctuate in response to a whole range of socio-economic, cultural and historical

circumstances' (Hamper and Perrotta, 2022, p.5). Reproductive geographers have particularly explored the hospital and the clinic as sites in which 'women's bodies interact with different types of technologies – both old and new, analogue, and digital – to surveil, manage, control, or enable their reproductive lives' (Schurr, Marquardt and Militz, 2023, p.13). For Perler and Schurr, the fertility clinic 'functions as a contact zone where people and processes otherwise separated by large distances and operating on different scales come into contact' (2022, p.316). It involves a multiplicity of actors whose interactions are ordered by knowledge politics (Davis and Walker, 2010; Fannin, 2003, 2013; Perler and Schurr, 2022). Thus, neither the hospital nor the clinic are neutral spaces of reproductive activity. Historically, the clinic has been a site of experimentation and oppression and clinicians have played no small part in reproductive injustices committed against women and racialised populations, in the US and its overseas territories (Briggs, 2002; Roberts, 2017; Schiebinger, 2017; Skloot, 2011). These efforts 'underscore the extent and depth of the exercise of power to preserve life, and the condensation of this power around the pregnant and birthing body' (Fannin, Hazen and England, 2018, p.10).

Understanding how this 'gynaecological gaze' (Levey and McCreary, 2022) operates within certain places and spaces is one critical aspect of reproductive geographers' engagement with biomedicalisation. In a study of birth centres as a kind of compromise between hospital and home, Hazen explains that place of birth is 'intricately interwoven with power relations between birthing mothers and medical practitioners' and that these 'place-based power relations are constructed and reinforced by medical authority, as well as broader cultural understandings of birth' (2018, p.122). Likewise, Levey and McCreary reveal the reproductive logics still underpinning approaches to contraceptive prescribing. Under the guise of 'shared decision-making', medical professionals are 'still trained to differentiate the reproductively responsible from untimely bodies […] which require the intervention of long-acting forms of contraception' (2022, p.19). They suggest that this is a colour-blind approach which 'obfuscates the ways that social inequalities continue to structure reproductive politics' (ibid.). In conversation with geographers and reproductive justice advocates, Nash suggests that a singular focus on the hospital as a site of obstetric violence and medical racism is 'not wrong' but that 'Black

maternal mortality and morbidity are entrenched social manifestations of gendered anti-Blackness that far exceed the space of the hospital' (2021b, p.302,303). This underscores Hazen's (2018) point that the dualism between hospital and home requires more nuance which considers how reproduction is emplaced across 'birth topographies' and 'birth geographies' (Nash, 2021b), 'landscapes of birth' (Fannin, 2003), or, more broadly, 'landscapes of care' (Milligan and Wiles, 2010).

As Hazen (2018) points out, there is a binary distinction between the hospital or the clinic and the home as birth sites—though we can extend this to other reproductive activities like fertility, surrogacy, and abortion. The home can represent an ideal place for reproduction *as opposed to* biomedical spaces such as the hospital or the clinic. Mamo's (2007) study of lesbian conception using sperm donors, for example, showed that insemination could be performed at home by non-medical professionals. Whitson likewise found that the homebirth was an 'explicitly spatialised resistance to biomedical norms and institutional control' (Whitson, 2018, p.142). Rather than in the hospital, homebirth allowed Whitson's participants to 'normalise birth, support their mobility and bodily autonomy during birth, permit them increased control over space during birth and re-spatialise the experience of birth' (2018, p.143). While Hazen's participants also opted out of hospital birth, they viewed the home as a comparatively risky setting and thus settled on the birth centre as a 'reasonable middle ground' (2018, p.135). Not only were these spaces seen as more secure, they enabled participants to deliver away from the 'chaos and everyday responsibilities of the home' as well as keep the home '"clean" of the mess of birth' (Hazen, 2018, p.136). These spatial and material dimensions thus shape 'affective atmospheres' and experiences of reproduction or care more broadly.

Including but not limited to the hospital and the home, reproductive geographers have considered how reproduction is spatialised. Reproductive bodies and activities are 'in place' or 'out-of-place' at different times and in different spaces (Lane, 2014; Longhurst, 2003, 2008; McNiven, 2016; Merkle, 2018). This work has particularly examined how reproductive processes are experienced in public versus private spaces and what this signifies in terms of broader understandings about gender. Bodies can be 'both privileged and Othered depending on the spaces they inhabit'

(Merkle, 2018, p.93). Merkle's participants feel out-of-place and on display on the university campus, because pregnancy is outside 'normal bodily behaviour' in these spaces (2018, p.92). Longhurst's (2003, 2008) participants likewise feel uncomfortable in public places because of the messy materialities of their pregnant bodies. These out-of-place experiences can also occur in private spaces, which are not seen as the right place to have a particular experience (McNiven, 2016). At the same time, this division between public and private can be problematic in obscuring stratified reproduction and its entanglement with capitalist modes of production. 'Private' reproductive labour remains largely invisible (Hamper and Perrotta, 2022). Perler and Schurr (2022) ultimately identify the fertility clinic as a 'noncontact' zone that is spatialised to separate reproductive labourers in the 'back stage' and prospective parents in the 'front stage'. Bhattacharjee (2018) argues that moving reproductive labour into the private sphere is essentialising and stigmatising but is also the crux of these labourers' oppression. Commercial surrogacy is thus a form of 'intimate labour, which takes shape at the intersection of the public and private spheres' (Bhattacharjee, 2018, p.118).

Surrogacy, among other reproductive activities, implicates new and emerging technologies. Schurr, Marquardt and Militz make four key points about these technologies: that they 1) are situated, 2) (re)produce or reflect existing inequalities, 3) are enmeshed in 'everyday life but increasingly also with our bodies', and 4) are intimate 'as they shape not only the way we work but also the way we reproduce, love, care, and build social relationships' (2023, p.2,3). The authors locate the use of these 'intimate technologies' in three key sites: the home, the laboratory, and the clinic (Schurr, Marquardt and Militz, 2023). Across these sites, reproductive geographers have considered issues like the mobile flows of technologies and people which facilitate reproduction through surrogacy, adoption, or fertility treatment (Payne, 2015; Perler and Schurr, 2022; Schurr, 2018; Speier, 2016, 2020; Schurr, 2019), but they have also explored the use of mobile phones and digital technologies as mediating reproductive activities with implications for telemedicine. For example, recent work by Hamper and Perrotta (2022) reveals how embryo videos moves between the site of the IVF clinic and the home, thereby shaping patient perceptions of their chances of fertility. As Hamper and Nash suggest, 'digital systems are

always embodied and constructed through the spaces and material dimensions of everyday life' (2021, p.595). Their work on pregnancy apps demonstrates that physical co-presence or proximity is not necessary for affective care or caring relationships, but that digital technologies can facilitate 'intimate spatialities' (Harker and Martin, 2012, p.770) and embodied experiences of pregnancy in couples' everyday lives (Hamper and Nash, 2021). With these potential modes of connection being mediated through apps comes with issues related to data privacy protection, as Shipp and Blasco (2020) show in their review of menstruation apps.

The affective and embodied potential and combined risks of (digital) reproductive technologies highlights that they can be 'both emancipatory and discriminatory depending on where, how, by whom, and for what purpose they are used' (Schurr, Marquardt and Militz, 2023, p.13). The historical context of reproductive injustice is made visible in the development and use of new reproductive technologies, such as assisted reproductive technologies (ARTs) (Hamper and Perrotta, 2022; Waldby and Cooper, 2010). These technologies 'have been built upon power relations where some people are empowered to reproduce, while others are not' (Bhattacharjee, 2018, p.118). This is especially clear in a global perspective on reproduction, population, and development. Long-acting reversible contraceptives (LARCs), including some with proven negative side effects, have been promoted in developing countries to 'empower' women control population growth (Bendix et al., 2020; Bhatia et al., 2020; Hendrixson et al., 2020; Sasser, 2020; Wilson, 2018). Discussing the US domestic use of LARCs in the carceral and welfare systems, Winters and McLaughlin (2020) describe LARC as a 'soft sterilization' which seeks to control the reproduction of women of colour and the poor in line with historical eugenic practices of involuntary sterilisation. Reproductive technology is thus not neutral and can (re)produce existing inequalities and perpetuate reproductive injustice.

3.3.3 | Biopolitics and beyond
Reproduction is central to the 'operation of biopolitics' (Mills, 2017) and geopolitics. Foucault defined biopolitics as 'the essential function of society or the State, or what it is that must replace the State, is to take control of life, to manage it, to compensate for its aleatory nature' (2003, p.261). Since then, reproductive geographers and

social scientists have employed biopolitics and biopower to understand 'the large-scale production and management of populations' (Morgan and Roberts, 2012, p.243). While there has been critique of Foucault from feminist theorists, such as the concern that there is no room for (feminist) resistance in his conception of power (Harstock, 1989), Morgan and Roberts (2012) suggest that his thinking on biopower, biopolitics and 'regimes of truth' alongside Fassin's (2007) 'politics of life' are useful for understanding reproductive governance. Indeed, biopolitics has 'opened new lines of historical inquiry about how state epistemologies and techniques created an object called "population"' (Dahlman, 2018, p.186) that can be produced and managed. Population geographers have particularly found value in Foucault, particularly with respect to the multi-scalar nature of biopolitics (Legg, 2005; Rutherford and Rutherford, 2013). Extending biopolitics in concepts such as 'intimate geopolitics' (Smith, 2012), the 'global intimate' (Pratt and Rosner, 2006), and 'embodied nationalism' (Mayer, 2004), reproductive geographies have drawn attention to the ways in which 'political control, violence, and security are enacted on and through reproductive bodies' (Schurr and Militz, 2020, p.438). This work highlights how reproduction is governed through 'territorial logics' (Smith, 2012), which are underpinned by a scalar link between regulation of the individual reproductive body as and population-level outcomes. Put another way, global systems are 'intimately concerned with women's bodies as reproductive and with making women's reproductive capacities the focus of national and international agendas' (Fannin, Hazen and England, 2018, p.11).

One of the main ways that these concerns are made manifest is through policies and practices which seek to promote certain women's fertility while curtailing others. Coddington offers the lens of 'anticipatory weight' to reveal how 'speculation, uncertainty and risk are deeply embedded within understandings of how fertilities are understood, or not understood, as political' at different scales (Coddington, 2021, p.1683). Attention to the multi-scalar nature of reproductive governance 'demonstrates how the individual, gendered, sexualized, racialized body can be viewed as a threat to the nation, as well as to the international order of bordered territories' (Hiemstra, 2021, p.1694). Biopolitics 'renders the problematic of population growth, fertility and ethnicity as specific expressions of territorial insecurity

amid national competition (Dahlman, 2018, p.197). Hiemstra's (2021) identification of the 'fertile figures' of the breeder, anchor baby, and bad parent are a powerful example of the multiple functions and logics of reproductive governance. Not only do these depictions 'obscure and bolster the racist, patriarchal, and heteronormative foundations undergirding U.S. political, economic, and social structures' (2021, p.1703), they also enable the state to ignore or perhaps hide its responsibility in drivers of mass migration. As 'the other' becomes a threat to the 'native' population (Dahlman, 2018), 'good' women become producers of the nation-state (Calkin, 2019b; Marchesi, 2012) and the foetus becomes a citizen in its own right (Morgan and Roberts, 2012)—thus implicating the right to abortion. Biopolitics enables an understanding of how certain groups' fertility is made problematic within a wider state agenda.

Reproductive geographers have particularly examined how immigrants constitute a threat to the nation (Hiemstra, 2021; Kaiser, 2018; Lozanski, 2020) and how population is thus produced and managed within and across borders. Restricting the reproduction of women and girls at the US-Mexico border allows for the 'reinforcement of normative identity categories and national identity, the gendered embodiment of geopolitical borders, and the maintenance of the global capitalist regime' (Hiemstra, 2021, p.1704). Likewise, Kaiser shows that negative portrayals of 'mainland maternal migrants' were 'stitched together to produce a border exteriorising mainland Chinese not only as Hong Kong's "not us", the constitutive outside, but as not properly human, as swarming locusts stripping Hong Kong bare and leaving nothing for its "native" people' (2018, p.179). Reproductive geographers have not only pointed out how these policies are implemented and what their implications are, but also their embodiment. In Bagelman and Gitome's groundbreaking approach to birthing across borders, they suggest that 'border controls and biopolitical modes of governance penetrate gendered bodies, often in intimately violent ways' (2021, p.270). Nevertheless, the women in their study navigate these constraints through the creation of informal networks of care (ibid.). This scholarship on migration and birth highlights how previous mobility, i.e., across borders, can in turn render the reproductive body immobile (Side, 2016).

While some women's fertility must be fixed through border control and restrictions on movement, others possess the ability to mobilise or navigate constellations of immobility (Gilmartin and Kennedy, 2019; Side, 2016, 2020). Reproductive geographers have thus employed the concept of mobilities to '[expose] the wider ideological issues associated with women's bodies and fertility as well as with travel and movement' (Gilmartin and Kennedy, 2019, pp.137–138). Reproductive mobilities are not just about travel or individual movement but the broader context in which these take place (Gilmartin and Kennedy, 2019; Speier, Lozanski and Frohlick, 2020). People have 'uneven powers of "motility"' that manifest in (transnational) reproductive mobilities (Lozanski, 2020; Sheller, 2018, p.20; Speier, 2020). Within reproductive mobilities, there is a 'new spatial division of labor' that privileges reproduction of certain people over others and even premises this reproduction on the reproductive labour of others (Deomampo, 2013, p.515; Sheller, 2020). The reproductive mobilities perspective 'opens up space for heterogeneous embodiments within the politics of mobility and immobility' that interrogate this stratification (Speier, Lozanski and Frohlick, 2020, p.115). Reproductive mobilities ultimately question '[w]ho or what moves, can or cannot (re)produce, can become (or not) through and during the labor(s) of reproduction' (Sheller, 2020, p.188). In other words, reproductive mobilities do not assume that everyone is equally mobile or that mobility is an inherent good, but rather examine how mobilities are implemented and regulated towards certain reproductive outcomes.

Reproductive geographies also consider how immobilities and inequalities are produced within borders, particularly for marginalised populations. Cidro, Bach and Frohlick (2020), for example, have revealed the unequal zones of waiting and immobility resulting from Canada's birth evacuation policy for Indigenous women. They are forcibly removed from their local communities and monitored until birth. This policy is contrasted with white Canadian settlers who have freedom of choice and movement in their pregnancies. The authors ask, 'Which pregnant bodies wait, where do they wait, and why?' (Cidro, Bach and Frohlick, 2020, p.179). Reproductive geographers have increasingly employed the theory and praxis of reproductive justice (Ross, 2017) and intersectionality in their work to reveal the 'the logics of domination that seek to control, surveil, police fertility across multiple contexts, often

for similar ends' (Coddington, 2021, p.1687). Lewis applies the lens of reproductive justice to the 'struggles waged on the terrain of embodied production in which that production becomes a form of care' (2018b, p.209). Though not using the term, reproductive geographers have revealed how the global fertility industry is inextricably linked to uneven geographies of capitalism, post- or neo-colonialism, and racism which have resulted in forced sterilization, sex selection, and population control through anti-natalist and pro-natalist logics (see for an overview Schurr and Militz, 2020). At the same time, Nash suggests reproductive justice itself would benefit from a 'birth geographies' perspective to reveal how 'race, gender, and space collide and collaborate to shape birth outcomes, birth inequities, and access to perinatal citizenship' (2021b, p.302).

Two other related approaches to the issues of immobility and inequalities with respect to reproduction are political ecology and political economy. These approaches are concerned with how health and wellbeing are integrated within socio-ecological, political, and economic systems and entangled with histories of racism, colonialism, and development. Rishworth and Dixon (2018) and Jokela-Pansini (2022) both explore how the environment shapes health outcomes. Rishworth and Dixon challenge assumptions that insurance coverage is sufficient to redress health inequalities and suggest consideration of how political agendas 'traverse material environments' (2018, p.216). Jokela-Pansini focused on women's embodied experiences of pollution and how the 'toxic' environment affect reproductive behaviour and expectations, thereby revealing the 'topological dimension of biopolitics' and 'the multiplicity, uneven spatiality and entanglements of women's reproductive health with material, technical and social relations across politics' (2022, p.7). This work closely aligns with reproductive justice accounts of the environment and reproduction (Gurr, 2011a, 2014). Reproduction is also embodied within capitalist production. Collard (2021, 2022), among others (Coddington, 2021; Lewis, 2018b, 2019), points to the role of bodily materials and reproductive labour within the 'bioeconomy'. Collard's study of 'abnormal', disposed embryos underscores that biomedicine and fertility are 'key sites in which social differences are biologized and, in turn, capitalized' (2021, p.116).

In this section, I considered three areas of reproductive geographies scholarship which examine the reproductive body, the place-based experiences of reproduction, and reproductive politics. Geographers have been critical to moving our understandings of the body beyond its biological capacity for reproduction to understand the reproductive body as relational, territorialised, and situated within social, spatial, and temporal relations. Attention to the body enables us to examine how the processes and materials of reproduction challenge understandings of reproduction as 'natural' and to situate the reproductive body within a wider bioeconomy. Reproductive mobilities and corporeal approaches have especially drawn attention to the materials of reproduction, within and outside of the body, and how these shape embodied experiences of space and place—whether certain bodies belong or are out-of-place. Reproductive places and spaces are imbued with symbolic meaning but have tangible effects on reproductive experience. Much work has explored the biomedicalisation of reproduction and its manifestation in clinical spaces, which are contrasted with spaces like the home along the lines of safety and care. New reproductive technologies, including digital innovations, have shaped new places and spaces of care and even re-spatialised reproduction outside of the womb, but have serious implications for marginalised populations on which technologies have historically been tested and on those who may now be considered reproductive 'labourers'. Biopolitical approaches reveal the underlying territorial logics which seek to promote some women's reproduction while curtailing others.

3.4 | Abortion geographies

In this section, I define and review abortion geographies. The abortion geographies literature has emerged from reproductive geographies and abortion research in the social sciences. In reproductive geographies, there has been a prevailing focus on issues like fertility, surrogacy, adoption, and birth with less attention to abortion (see for example England, Fannin and Hazen (Eds), 2020). Geography has been a focus for sociologists, historians, and legal scholars working on abortion (Baird, 2019; Gilmartin and White, 2011; Hill, 2021; Sethna and Doull, 2012), but abortion has far less been an area of inquiry for geographers. Despite the clear relevance of abortion to geographical scholarship, especially political geographies and issues such as

citizenship, nation-states and population (Engle, 2022)—not to mention that abortion is a common experience—the discipline has historically been silent on abortion. The absence of abortion from geography further stigmatises abortion, reinforces the idea that it is 'always contested', and suggests that it is not a respectable topic to study (Calkin, Freeman and Moore, 2022). Because abortion 'stands alone as an essential healthcare procedure that is often also a criminal act', Calkin, Freeman and Moore argue that it 'a useful lens through which we can understand the political power structures that act upon reproductive (and non-reproductive) bodies' and therefore that 'abortion should be placed at the centre of a geographical analysis to garner new perspectives on key topics of social and political enquiry' (2022, p.1415). Where geographers have engaged with abortion it has frequently been in terms of the law (Brickell and Cuomo, 2019; Brown, 2019b; Pruitt, 2007, 2008; Pruitt and Vanegas, 2014). This work has advanced geographic understanding of abortion access, even with the recognition that the notion of reproductive rights and 'choice' are insufficient to address issues of access (Engle, 2022).The abortion geographies literature has brought necessary empirical attention to abortion, a common but stigmatised procedure, while also advancing theoretical understandings of pregnancy termination within its historical, social, political, and economic contexts.

This section is loosely structured around three key strands of scholarship in this field which are relevant to this research and which were recently outlined by Calkin, Freeman and Moore (2022): mobilities, spatiality and discourse. I detail these strands and use them as a stepping off point to consider abortion travel and abortion pills; abortion beyond the clinic and beyond borders; and abortion stigma and counternarratives. I conclude with a consideration of how these areas speak to issues of technology, access, and care.

3.4.1 | Abortion travel and abortion pills

Abortion access acutely concerns mobility. As Statz and Pruitt's legal analysis finds, 'most [American] courts have assumed that women enjoy sufficient mobility to get to an abortion provider—if they want an abortion badly enough' (2019, p.1115), but the concept of abortion mobilities reveals a different picture. In a recent paper, I offer a

working definition of abortion mobilities that builds on Freeman's (2020a) definition of abortion mobilities and Schurr's (2019) concept of the 'multiple mobilities' of fertility:

> Abortion mobilities involve the movement—or lack of movement—of people, information, and things across space that facilitate or constrain abortion access at different scales. In addition to the physical fact of movement from point A to point B, abortion mobilities refer to the 'multiple mobilities' (Schurr, 2019) shaping and being shaped by this movement. This framework is concerned with who and what can travel, why, and under what circumstances; how meanings associated with abortion-related movement can instigate movement; and the ways in which different people experience movement or lack of movement (Engle, 2022, p.2).

Calkin, Freeman and Moore suggest a similar definition of abortion mobilities, stating that abortion is 'fundamentally about mobility because, across scales, from the clinic to the nation-state, bodies, pills, and knowledge are on the move in ways that reflect, reinforce, and contest power (2022, p.4). Abortion mobilities are therefore shaped by a myriad of legal, political, social, cultural, economic, and geographical factors. Due to this constellation of constraining factors, abortion mobilities must be examined in 'differential and relational ways' (Adey, 2006, p.83) that understand that '[a]bortion access is far from equal' and that 'some women are forced to travel long distances, others are not, or cannot' (Freeman, 2020a, p.897). Abortion mobilities 'encompass barriers to movement, the privilege of not moving, and technologies that facilitate (im)mobility' relations' (Calkin, Freeman and Moore, 2022, p.4).

Abortion mobilities have been frequently articulated in terms of the horizontal mobilities, the physical movement from point A to B (Schurr, 2019), involved in abortion travel. Abortion travel occurs on abortion trails, where individuals move within and across borders in search of abortion care that is not available or accessible locally. As Freeman explains, 'this mobility (or lack of it) has a clear geography; certain countries, states, cities or establishments become safe havens for women seeking abortions' (2017, p.854). It is these places that serve as destinations for abortion travel from locations that where abortion is not available or

accessible. Anti-abortion governments often seek to be 'abortion-free' and therefore 'download the procedure onto other healthcare jurisdictions' (Gilmartin and Kennedy, 2019; Sethna, 2019, p.11). The outsourcing of abortion care constitutes an 'exclusion/expulsion' that criminalises abortion, enforces mobility, and absolves states 'from the responsibility for the act of abortion' (Kelly and Tuszynski, 2016; Mecinska, James and Mukungu, 2020, p.401). Lawmakers are 'happy to put women on the move' (Mecinska, James and Mukungu, 2020, p.395).

While some abortion seekers have the privilege not to move (Calkin, Freeman and Moore, 2022), others are forced to travel and have varying abilities to do so while others still cannot travel at all. This underscores the importance of accounting for both horizontal and vertical mobilities, which refer to the unequal distribution of the mobility as a resource and form of social capital (Schurr, 2019). Scholars thus understand both mobility and immobility as 'intimately' connected with abortion access (Side, 2020, p.16). Abortion immobilities have largely developed as a 'cipher for assemblages of blocked, stuck, and transitional movement' (Khan, 2016, p.93). It is 'not only an absence of movement, but the constraining of movement in particular ways – both corporeally and emotionally' that take place within a 'complex landscape' (Murray and Khan, 2020, p.163). The movement of rural abortion seekers, for example, is the result of a 'calculus of disadvantage, injustice, and suffering' (Baird, 2019, p.163). As Kelly argues, 'travel remains a key means by which class and geography define abortion access' (Kelly, 2016, p.31).

Just as some people are able to move or not, different bodies 'actually affectively experience mobile practices and moments of immobility very differently according to their particular position in the global (bio-)economy' (Schurr, 2019, p.108). Engaging with embodiment involves asking 'how it *feels* to move, to be on the move, to be moved, whether it is comfortable or painful, forced, or free' (Schurr, 2019, p.107, emphasis mine). For example, scholars have considered the embodied experience of waiting and immobility (Heller et al., 2016; Murray and Khan, 2020) in which people have 'different capacities to escape, shorten, or make their times of waiting more comfortable' (Schurr, 2019, p.114). They have also considered embodied experiences of abortion travel. Freeman argues that viapolitics can help us to

understand the 'embodied and emotional aspects of the abortion journey', such as the experiences of bleeding and fear (2020a, p.898). Whether in private or public transportation, there may be 'visceral intensities of blood, tears, stigma and shame' (Murray and Khan, 2020, p.165). Describing the abortion ferry from Ireland to England, O'Malley uses the notion of queasiness to describe both 'nauseous bodily responses' and 'an uneasy recognition' or 'unsettling apprehension that comes when bodies cease to feel at home in the world' (2019, p.23).

With respect to fear, Freeman argues that it is 'clearly present even when traveling for a legal abortion' (Freeman, 2020a, p.901). Indeed, abortion journeys are often fraught with negative feelings (Murray and Khan, 2020). Although most women and pregnant people do not regret their abortions (Rocca et al., 2020), the conditions in which abortion is accessed, particularly when it requires travel, can evoke feelings of shame and isolation because of being an 'overwhelmingly solitary and covert act' (Calkin and Freeman, 2019, p.1327).. As Kelly and Tuszynski explain, women and pregnant people 'are reminded at each step of their journey that they are undeserving of medical care at home' (2016, p.26). Calkin and Freeman suggest that a 'focus on emotion might better centre the individual and embodied experiences of pregnant people undertaking abortion journeys', enabling an understanding of 'how pregnant people interpret and make sense of their own abortion travel' (2019, p.1327). They emphasise that emotion centres the individual's embodied experiences while a focus on affect 'helps us to understand how bodies come together with other actors on the trail' (ibid.).

Although much of the work to date on abortion mobilities has focused on the horizontal movement of abortion seekers to access care and its attendant burdens, recent scholarship has considered mobility activism and the mobilities of non-human actors. For individuals, abortion travel may at once be 'burdensome' and 'an act of social, political and emotional resistance' (Murray and Khan, 2020, p.167). Emancipatory abortion travel may be through the enaction of mobility rights to access abortion (Side, 2016) or the telling of abortion stories centring travel (Murray and Khan, 2020). At a larger scale, feminist activists have enabled abortion travel with funding and practical support (Haksgaard, 2020) and mobilised information and

technology in support of abortion. In particular they provide abortion pills or directions on how to get them and share safe abortion practices and how to protect oneself against prosecution in the process of self-managed abortion. By mobilising the abortion pill within and across borders, these organisations 'highlight the fictive nature of state control over reproduction' and, arguably, mobility itself (Calkin and Freeman, 2019, p.1329). Calkin and Freeman (2019) argue that these activist abortion mobilities have resulted in a spatial transformation of abortion access. Medication abortion itself is recognised as changing the spatiality of abortion access (Calkin, 2019b), and is a key emerging component of the abortion geographies scholarship. However, mobilities are not always emancipatory or a form of resistance. Thomsen et al. (2022b) point to the weaponisation of mobilities by mobile crisis pregnancy centers (CPCs), which are 'unruly, unmappable, and ungovernable' (Thomsen et al., 2022b) and seek to reduce access to abortion across the US. These anti-abortion activist mobilities are important to consider alongside pro-abortion activist mobilities.

3.4.2 | Abortion beyond the clinic and beyond borders

The mobility of abortion pills has brought about a huge transformation in the spatial configuration and regulation of abortion care. In the US, for example, the legalisation of abortion moved the procedure out of the 'backstreet' and its attendant unsafety, but did so 'by placing it in the clinic and vesting decision-making power over abortion in the hands of medical professionals and by extension the government' (Calkin, Freeman and Moore, 2022, p.1420). Thus, abortion has been largely governed by a 'spatial logic of medical supervision and criminalization that restricts access in practice' (Calkin, 2019b, p.28). Within this reproductive governance, legal and safe abortion care must take place in a biomedical space with the permission and supervision of a medical professional to satisfy the conditions under these professionals consider abortion to be legally allowed. It is important to remember that health care is not always caring and the requirement that women and pregnant people access abortion care in medicalised settings may be stigmatising or traumatising, especially for minoritised groups who have suffered reproductive injustices (Smith-Oka, 2015; Stone, Kokanović and Broom, 2018). Medical professionals may also be complicit in the restriction and criminalisation of abortion

through conscientious objection, chilling effects, and in the worst cases, turning patients suspected of abortion into the police for prosecution (Mecinska, James and Mukungu, 2020; Undurraga and Sadler, 2019). The clinic and the womb become contested spaces wherein pregnant women's bodies are policed and politicised (Brown, 2013; Goodwin, 2020; Paltrow and Flavin, 2013).

Abortion is thus a fundamentally spatial phenomenon which is configured and regulated at different scales and in different places: the body, the home, the clinic or hospital, the state, the country. Calkin, Freeman and Moore explain that these spaces 'speak to wider gendered norms and structures of governance that regulate women's lives', but that the 'private politics of abortion remain poorly understood' (2022, p.4). The extra-legal mobility of abortion pills, which geographers have particularly addressed (Calkin, 2019b, 2021b; Calkin and Freeman, 2019), has enabled abortion care to occur outside of the formal health care system and therefore away from the institutions charged with enforcing reproductive governance. The abortion pills, by travelling across and within borders, offer an 'alternative spatial arrangement that moves access beyond clinic space' in which abortion care can be self-managed at home (Calkin, 2019b, p.24). When pills rather than women are put on the move, individuals may be able to circumvent barriers associated with facility-based care (Calkin and Freeman, 2019; Doran and Hornibrook, 2016; Engle, 2022; Side, 2016). In this emerging spatial configuration of abortion care, abortion access is 'less connected to physical clinic spaces and, by extension, less tethered to national legal frameworks' (Calkin, 2019b, p.23).

As such, Calkin suggests thinking beyond legal frameworks and abortion travel to conceptualise 'the mobility of abortion pills, information, and delivery technologies in new ways' (2019b, p.24). Yet, in the case of legal telemedicine abortion services, which attempt to address the burden of distance to an abortion clinic, there remains a need to think about both legal frameworks and abortion travel. Medication abortion accounts for more than half of all legal abortions in the US (Jones et al., 2022)—a statistic which does not account for abortions accessed outside the formal health care system. The laws governing medication and telemedicine abortion dictate behaviour within 'spatial containers' wherein rights imbued in the law may be

irrelevant, inaccessible, or absent, such as rural areas (Pruitt, 2008, p.388; Statz and Pruitt, 2019). Moreover, with the range of telemedicine pathways available (Parsons and Romanis, 2021), abortion travel is still occurring. The prevalence of abortion travel across state borders raises important questions about the spatiality of state power to control abortion. Countries have attempted to control the flow of illegal abortion pills through customs enforcement but have largely failed to do so (Calkin, 2019b, 2023b; Sheldon, 2016). Nevertheless, individual states in the US which now ban abortion are attempting to prevent abortion through other spatial means. For example, Idaho prohibited out-of-state travel for abortion which it has termed as 'abortion trafficking' (Bendix, 2023). The border itself may not move, but there will be a 'mobile set of bordering practices that are articulated into a distinct and singular spatial strategy' of abortion criminalisation (Cobarrubias, 2020, p.9).

Enforced mobility and mobility restrictions have also been used within the space of the 'abortion-free' state to address 'problematic fertility' (Gilmartin and Kennedy, 2019, p.127). As I discuss elsewhere (Engle, 2022), restrictive abortion policies are shaped by conservative discourses (Bloomer, Pierson and Estrada-Claudio, 2020) and 'territorial logics' (Smith, 2012) of pro-natalism which seek to reproduce the national population. In these cases, women's bodies are 'both subjects of this governance and spaces for governmental action' (Calkin, Freeman and Moore, 2022, p.1420). These forms of reproductive governance are 'designed to increase surveillance, regulation, and prosecution' of certain reproductive bodies towards an 'ideal political imaginary' (Morgan and Roberts, 2012, pp.250–251). For example, pro-natalism in many contexts cannot be separated from the white supremacist and racist ideologies which promote white women's fertility while seeking to curtail the fertility of others, such as immigrants (Dos Santos, 2015), incarcerated women (Hayes, Sufrin and Perritt, 2020; Sufrin, 2018), indigenous women (Carranza Ko, 2019; Cidro, Bach and Frohlick, 2020), poor women (Wilson, 2018), and more. Reproductive justice further calls attention to the intersections between historical and contemporary eugenicist policies and practices and the territories in which they are enacted (Coddington, 2021; Ross, 2017)—issues which are especially pertinent with the resurgence of overpopulation narratives (Hendrixson et al., 2020).

3.4.3 | Abortion stigma and counternarratives

As Calkin, Freeman and Moore explain, a discursive approach to abortion 'opens up key analytic space that prevents the bracketing of the issue as a private, women's matter which artificially narrows the relevance of abortion to wider social and political issues' (2022, p.1416). Discursive analysis reveals the socio-cultural ideas and norms underpinning our understanding of abortion as well as how abortion storytellers make sense of their lived experience, thereby prioritising a focus on both representation and narration (ibid.). Scholars, particularly sociologists, have frequently understood abortion representation in terms of stigma. Drawing on Goffman (1963) and Kumar, Hessini and Mitchell (2009), scholars have categorised three types of abortion stigma: 1) internalised, which is an acceptance of negative representations of abortion); 2) felt or anticipated, which is a perception of how others may react to the abortion; and 3) enacted, which is the experience of prejudicial actions because of abortion (Cockrill and Nack, 2013; Cowan, 2017; Hanschmidt et al., 2016; O'Donnell, O'Carroll and Toole, 2018). However, this classification of abortion stigma reinforces the individual as the inevitable recipient of stigma (Beynon-Jones, 2017; Millar, 2020). This framing does not capture the multi-dimensional, variable and complex nature of stigma and '[erases] the forms of inequality that position us differently in relation to reproductive choices and outcomes' (Millar, 2020, p.6). Viewing abortion stigma instead as a socio-cultural process, we can see that it functions to make abortion practically, emotionally, and socially difficult to access by instituting barriers to care, defining 'acceptable' abortion narratives, and shaming and silencing those who have abortions.

Women who choose not to be mothers are considered transgressive in societies like the US which place an inherent value on women who fulfil their 'natural' (Jackson, 2020, p.3) procreative and maternal roles. These ideas have tremendous social weight; 'to out oneself as not desiring motherhood is to risk social exclusion' (Wilkinson, 2020, p.668). Abortion advocates may also contribute to the reification of motherhood as inevitable by framing abortions as beneficial for a woman's current or future children and '[realigning] the figure of the aborting woman with normative femininity' (Millar, 2017, p.90). Abortions are more likely to be perceived as accepted if the pregnancy was otherwise wanted, constructing abortion as 'a temporary

setback on [a woman's] journey towards motherhood' (Millar, 2017, p.135). Abortion ultimately challenges the notion that female sexuality is solely for procreation (Jackson, 2020; Kumar, Hessini and Mitchell, 2009). This idea leads to assumptions that an abortion seeker is promiscuous and irresponsible with respect to sexual relationships and family planning. Abortion is framed as a 'convenience' that 'cleans up' after sex and allows 'sex without consequences' (Millar, 2017; Watson, 2018, p.67). By positioning motherhood as the only acceptable outcome, women's sexual and reproductive behaviour becomes the purview of public interest and the boundaries between the private and public spheres become blurred (Brown, 2013). Abortion then 'manifests as an agonising and heart-breaking choice for women to make' (Millar, 2017, p.91).

This idea underscores representations of abortion as a 'difficult' or 'regrettable' decision. In these discursive framings, abortion seekers 'must at least pay a penalty of emotional distress' to access abortion (Watson, 2018, p.50). Some suggest that this affective experience may be produced within clinical settings wherein physicians may assert that 'moral instruction, or even redemption, of the clinical intervention would be lost on women if they did not have to pay anything, whether in terms of a monetary fee or through physical and moral suffering' (Krauss, 2018, p.698). This prospect of multiple abortions, or 'repeat' abortion (Hoggart, Newton and Bury, 2017), has even led some health care professionals to suggest abortion 'recidivists' should contribute to the cost of a repeat abortion as a 'deterrent' (De Zordo, 2018). This discursive production of irresponsible and criminal abortion exists within classed and racialised reproductive health care systems that deem certain groups 'undeserving' of care (Dos Santos, 2015). Geographers have pointed to discursive framings of women as naïve and in need of protection—or as criminals—as underpinning logics of medical surveillance and population control (Calkin, 2021b; Calkin, Freeman and Moore, 2022; Wainwright, 2003).

Following the abortion there is a prevailing idea that women regret their abortions, particularly due to their attachment to the foetus (Kimport, 2012). The foetus and its potential life are privileged in 'imaginings of pregnancy' thereby 'erasing the subject position of the unwillingly pregnant woman' (Millar, 2017, p.97). This focus on the

foetus renders the woman a 'passive spectator in her own pregnancy' while anthropomorphising the foetus (Petchesky, 1987, p.277), thereby positioning 'aborting women' as 'murderers' who 'kill' the foetus. Following from above, geography and scientific and technology studies have considered the development of ultrasound as according the foetus 'new forms of rights as a consequence of its increasing "visibility" and thus "localizability"' (Schurr, Marquardt and Militz, 2023, p.12). The disembodied womb thus became the site of pregnancy (Morgan and Michaels (Eds), 1999), and the foetus the subject of maternity wards (Fannin, 2003).

Both the difficult decision and abortion regret narratives undermine reproductive decision-making and stigmatises individuals who do not have the prescribed response as less morally serious (Watson, 2018). Nevertheless, evidence demonstrates most women consider their abortion to be the right decision (Rocca et al., 2020). Watson (2018) also reminds us that there is a critical distinction between decision regret, which the evidence contests, and situational regret, which may be one of the wide range of emotional responses to abortion. Nevertheless, abortion is not always difficult and, if it is, regret may not be the source (Kimport, 2012). The notion that abortions should be difficult or regretted is a powerful one and while some scholars find that this narrative results in internalised stigma (O'Donnell, O'Carroll and Toole, 2018), Beynon-Jones (2017) and Hoggart (2017) suggest that individuals navigate and resist this discourse.

Abortion storytelling is the countermovement to abortion stigma. Kissling argues that 'silence lets abortion opponents write the story' (2018, p.172). As Watson explains, if people who have abortions do not talk about it, it 'creates a storytelling vacuum, which others fill' thereby creating normative representations of abortion that are 'opinion masquerading as abortion experience' (2018, p.78). This 'opinion by default' (Fegan and Rebouche, 2003) leads women to 'protect themselves from judgement' while also being 'frustrated that they are not able to convey the complexity of their situations' (Jackson, 2020, p.6). In this context of stigmatisation and silencing, disclosing abortion, especially in public, 'has become a vital mechanism of stigma busting in the twenty-first century' (Kissling, 2018, p.46). Recent initiatives like Shout Your Abortion build upon the feminist tradition of consciousness-raising to build

'counter-narratives' (Baird and Millar, 2019) which challenge abortion stigma and its manifestation in regulatory control over reproductive decision-making.

However, just as individuals have been pressured to conform to the 'difficult decision' and 'abortion regret' narratives to ensure that their abortion was a 'sympathetic' one (Brown, 2019a; Watson, 2018), scholars have pointed to the requirement for narratives to represent abortion as empowering or unapologetic, thereby limiting emotional response or reinforcing women as neoliberal autonomous subjects (Allen, 2015; Baird and Millar, 2019). These narratives come into conflict with 'pro-choice' activism which has made discursive and practical compromises with abortion opponents (Brown, 2019a; Kelly, 2016; O'Shaughnessy, 2022), as well as with ongoing anti-abortion activism which increasingly employs geographical strategies to reduce abortion and maintain control over women's reproductive futures (Thomsen et al., 2022a, 2022b). An important development in abortion counternarratives is the challenge to the 'safe, legal and rare' discourse. Scholars have observed representations of unsafe abortion outside of clinical settings, which align with the historical emotive framing of the 'back street abortion' (Engle and Freeman, 2022; Herold and Sisson, 2019). But this idea is outdated; abortion can be safely managed at home, regardless of (il)legality.

3.4.4 | Summary

In this section I considered three areas of abortion geographies scholarship which examine the relationship between abortion, mobilities, spatiality, and discourse. Access to abortion implicates the movement of people, information, and abortion pills. This movement has always been stratified: women with resources can travel to access an abortion, while others cannot. But there is also a privilege in *not moving* for abortion. For abortion seekers who are 'put on the move', emotional and embodied responses vary. The medical technology of the abortion pills has enabled feminist networks to reduce travel burdens by mobilising the medication and 'how to' information, rather than the person themselves. This activism has thus used multi-scalar strategies to facilitate abortion access in restricted settings. By demonstrating that abortion can be safe outside of clinical settings, the abortion pills have shaped the spatial configuration of abortion care. The difficulty through which a person

accesses abortion has in turn been affected by prevailing negative attitudes about abortion, in the US and elsewhere. Pregnancy termination challenges women's 'natural' and 'happy' roles as mothers and therefore must be a 'difficult decision' or subsequently regretted. In reality, women do not regret their abortions but may feel they have to justify the decision and make their abortion more 'sympathetic'. At the same time, abortion stigma-busting movements are encouraging more empowering narratives, but these may not account for everyone's experiences. In the post-*Dobbs* context, a critical counter-narrative is challenging the notion that abortion should be 'safe, legal and rare'. Rather, abortion activists are demonstrating, like they have in other countries, that a self-managed abortion with pills can be both illegal and safe.

3.5 | Conclusion

In this chapter, I reviewed relevant literature in health and care, reproductive, and abortion geographies. Moving from the broader area of health and care to the specific area of abortion, I detailed three common threads—attention to technology, access, and care—which underpin my analysis in Chapters 4, 5, and 6:

- **Technology.** Health and care geographies call into question to what degree telemedicine is entirely 'virtual', how it is emplaced into people's homes and lives, whether it is a sticking plaster for a wider care crisis, and whether it is possible to have a caring experience 'at a distance'. Reproductive and abortion geographies both consider how technology, including but not limited to telemedicine, has re-spatialised care, within and outside of the body. Abortion geographers especially suggest that the proliferation of the abortion pills and information about their use has contributed to a new spatial configuration of abortion care and facilitated access through multi-scalar strategies. This research speaks to this discussion by asking whether and how telemedicine abortion with pills addresses barriers to care.

- **Access.** Health and care geographies offer a wide variety of perspectives for understand inequality of access to health care. Abortion scholars' use of intersectionality, reproductive justice, and structural violence have enabled analyses of health care inequalities to consider structural forces and how these particularly shape sexual and reproductive health. Reproductive and abortion geographers, especially through the lens of mobilities, both highlight

the stratified nature of reproduction and access to care. Reproduction and reproductive care access are shaped by national imperatives around population and by social norms around motherhood, sexuality, and pregnancy. Both strands of literature show how technology can be utilised towards improving access, while also reinforcing reproduction stratification in some cases.

- **Care.** Health and care geographies explore how care is shaped by different places and spaces, such as in traditional clinical settings versus at home. Multiple frameworks reveal how care is configured and made possible, including by human and non-human things, across and within these spaces. Care may be mechanised virtually, but this strand of literature emphasises that it is always emplaced. This work is carried forward in both reproductive and abortion geographies, especially considering the 'clinic' versus the home and how technology affects the space of care. Place affects not only where care is accessed but how it is experienced.

In the following chapters (Chapters 4, 5, and 6), I draw on these literatures to analyse the quantitative and qualitative data I collected, to address my two research aims, and answer my research question.

4 | GEOGRAPHIC BARRIERS TO ABORTION CARE

4.1 | Introduction

Telemedicine services are understood to reduce geographic barriers to health care. In the case of abortion, telemedicine is understood specifically to reduce the burden of travel distance to an abortion clinic, because it has long been established that the farther an individual lives from an abortion facility the less likely they are to have an abortion (Fuentes and Jerman, 2019; Jones and Jerman, 2013; Shelton, Brann and Schulz, 1976). Most research on abortion travel has focused on 'the linear movement from A to B to access a service […] the basic driver or producer of mobility' (Schurr, 2019, p.107), and has quantified travel distance or duration from point A (an individual's home) to point B (an abortion clinic) (Barr-Walker et al., 2019). This travel-to-abortion burden framework has particularly been an endeavour for measuring the burden of travel distance to an abortion clinic for rural women and pregnant people (Gerdts et al., 2016; Heller et al., 2016; Sethna and Doull, 2013). Jones and Jerman, for example, highlight that the correlation between distance and abortion service utilisation, demonstrated in several studies (Bearak, Burke and Jones, 2017; Gerdts et al., 2016; Shelton, Brann and Schulz, 1976), has a disproportionate impact on rural women and pregnant people. Researchers have reduced mobility and access to the actual, physical fact of movement from one place to another (Schurr, 2019), and reaffirmed barriers to care as constraints on this movement.

Barriers to health care are not well-defined in the geographical or public health literature. The Dictionary of Human Geography (Gregory *et al.* (Eds), 2009) does not contain a separate entry for 'barrier', but it is included under 'accessibility'. Accessibility is defined as 'the ease with which people can reach desired activity sites', such as medical care, and '[g]aining access often entails overcoming barriers' (Gregory *et al.* (Eds), 2009, pp.2–3). Indeed, much of the work in health geographies has framed barriers as an issue of access to health care services (Rosenberg, 2014). Barriers are presented as 'frictions' that constrain mobility and access, such as time, place, and socio-economic circumstances, thereby contributing to health inequalities (Darlington-Pollock and Peters, 2021). However, as discussed in

Chapter 3, access is a multi-dimensional concept which public health scholars understand as 'the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled' (Levesque, Harris and Russell, 2013, p.8). Access is thus central to understandings of what constitutes a barrier to care. My analysis in this chapter builds on multi-dimensional understandings of access to to demonstrate that barriers are not just about *access to* care but also the *experience of* care. Moreover, barriers might be imagined and anticipated and therefore evaded through health care decision-making or they might be encountered on the way to care and in pursuit of a caring experience. As such, my understanding of geographic barriers to abortion care is something that can or does constrain access to 1) affordable, timely, and local abortion care and/or 2) the experience of non-judgmental, empowering, or holistic abortion care—with implications for geography.

In this chapter I address the first research aim of this project: to identify the geographic barriers to abortion care for rural women and pregnant people. I explore 'who and what is able to travel (or not) under which circumstances, what meanings are attached to these movements and how they are experienced by (non)human actors themselves' (Schurr, 2019, p.107). I do this by first examining distance as a barrier to abortion care using geographic information systems (GIS) and then drawing on interviews to understand these maps from the perspective of abortion seekers and providers.

Findings from my research demonstrate that the prevailing focus on travel distance as a quantifiable barrier to abortion care has had two key effects: Firstly, it has reified the inevitability and primacy of travel distance as a barrier to abortion care for rural women and pregnant people. Secondly, it has pigeonholed our understanding of geographic barriers as time-space phenomena that somehow cannot be surpassed. Together, these have elided our understandings of how rural women and pregnant people understand and contend with the notion of 'distance' and how other barriers to abortion care interact with geography and arise 'even before the issue of travel distance or time' (2016, p.56).

In my GIS analysis, I determine the distances patients might have travelled had they not used telemedicine, whether this would have involved inter-state travel, and the correlation between distance and rurality. I consider these quantitative results in conjunction with the qualitative experiences of my participants, how they understand their location within the spatial configuration of abortion care. Moreover, I demonstrate that it was not only the number of abortion clinics and participants' distance from them which acted as a barrier to care, which some expected, but also and perhaps more significantly the availability and accessibility of a given abortion clinic. I consider not only 'the length of the journey' (Sethna and Doull, 2007, p.645), but also the practical, social, cultural, and economic issues which implicate geography and create an 'intricate series of obstacles, each entangled with the other' (Gomez, 2016, p.56). I contribute to the literature by detailing the barriers that participants imagined and encountered in making their abortion decisions and attempting to arrange care that exceed the simplified narrative of the travel burden alone or even primarily.

4.1.1 | Structure of chapter

This chapter is structured around seven barriers to abortion care which emerged in my analysis. In interviews with patients and staff of Just The Pill (JTP) and partner organisations, I asked about barriers to abortion care as they relate to rurality. I was concerned with understanding whether distance was a significant factor in accessing abortion, or not, given the emphasis on telemedicine abortion as a 'game changer' for abortion-seekers in rural areas. Although distance was mentioned, I found that patients understood distance as a barrier to all healthcare and that a combination of practical, social, cultural, and economic barriers, in conjunction with distance, made accessing an *abortion* difficult. These barriers are present in the literature on abortion access (see especially Jerman et al., 2017), but not given as much attention as distance with respect to *rural* abortion access. An exception to this is a new study revealing how rural women in Australia contended with their unintended pregnancies (Noonan et al., 2023), though the authors do not exclusively focus on abortion or telemedicine. I address the seven practical, socio-cultural, and financial barriers in turn in this chapter and culminate this discussion with a critical re-consideration of 'rural distance' as a barrier to health care.

In section 4.2, I present my GIS analysis. I determine the distances patients would have had to travel to access an abortion had they not used telemedicine and examine how these distances intersect with state-of-residence and rural population. I demonstrate that the nearest abortion clinic to most patients of JTP was under an hour away in one direction, but many would have had to travel longer distances—particularly those in rural or remote areas. I follow up on these maps in section 4.3, where I define and discuss the nationwide presence of crisis pregnancy centers (CPCs), which contrasts with the relative absence of abortion clinics. I demonstrate how these anti-abortion institutions work to confuse abortion-seekers and ultimately delay care.

Then I turn to rural participants' stories about barriers to abortion care and how these reflect and do not reflect the literature's primary focus on distance as the greatest barrier to an abortion for rural women and pregnant people. In section 4.4, I consider the effect of abortion restrictions and bans on accessing abortion care. I demonstrate that although patients understood their states and country more broadly to be hostile to abortion rights, they were not deterred. In section 4.5, I expand on the discussions in sections 4.3 and 4.4 to consider the number, availability and accessibility of the abortion clinics that are present despite abortion restrictions. I demonstrate that, although the limited number of clinics was discouraging, patients' ability to access care was more commonly determined by the circumstances of individual clinics, particularly wait times for an appointment, in conjunction with how far away they were.

What are the other barriers to access that are as important as distance to my participants then? In section 4.6, I explore the role of stigma in abortion access. I demonstrate that rurality is a broader construct than its spatial isolation, with respect to abortion access, insofar as anti-abortion attitudes shaped abortion decision-making by patients. In section 4.7, I extend the discussion in section 4.6 to discuss the anti-abortion strategy of 'sidewalk counselling' outside of abortion clinics. I demonstrate that 'sidewalk counselling' serves as a visual, aural, and spatial barrier to abortion care, which patients have and would have endured but makes getting an

abortion a difficult experience. In section 4.8, I detail what an abortion costs and how people afford it (or not). I demonstrate that cost is one of the primary barriers to abortion care and one that weighs significantly in decisions about where and how to access care. In section 4.9, I discuss how participants understood rurality and the notion of distance as a geographic barrier to care. In this section, I demonstrate that participants expect to drive long distances to access abortion care because of both the spatial isolation of rural communities and the general lack of abortion clinics in the region. In section 4.10, I discuss the implications of this chapter with respect to rural health inequality and the prospect of 'choice' given the barriers to health care that participants faced. These sections form the basis of my argument in this chapter that it is not only distance, but a combination of practical, socio-cultural, and financial barriers that constrain access to and experiences of abortion care.

4.2 | Distance to abortion clinics as a barrier to care

In this section, I present my GIS analysis. I determine the distances patients would have had to travel to access an abortion had they not used telemedicine and examine how these distances intersect with state-of-residence and rural population. Distance has been a key measure of abortion access in the United States because there are so few abortion clinics. The number of abortion clinics varies greatly between the states under study here. Prior to the *Dobbs* decision, North Dakota and South Dakota had 1 clinic each, Wyoming: 2, Wisconsin: 4, Montana: 6, Minnesota: 10, Colorado: 23, and Texas: 24. It is common for clinics to be counted by state or by county, which paints a stark picture of inaccessibility but one that does not account for population or inter-state abortion travel. Likewise, definitions of 'abortion deserts' vary: they may refer to the 'large swathes of land' (Hennessy-Fiske, 2016) or cities of 100,000 people without an abortion clinic (Cartwright et al., 2018). In this section, I explore the challenges of effectively measuring abortion access vis-à-vis the number of clinics using GIS. I offer three key insights which demonstrate that distance is a barrier to abortion care which particularly affects women and pregnant people in rural and remote areas:

1) Most patients live under an hour away from their nearest abortion clinic (59%), but this is for one incidence of one-way travel.

2) Longer travel times to nearest abortion clinic were associated with state of residence, particularly for residents of North Dakota and South Dakota.

3) The nearest abortion clinic might be in a different state, which was the case for the majority of patients in Wisconsin and Wyoming.

4) There is a correlation between distance to nearest abortion clinic and percentage of rural population in a county.

4.2.1 | Methods

In this quantitative analysis, I used data from JTP patients served between 19 October 2020 and 22 December 2021 (n=1389) which were provided by the Program Director of JTP. Idaho (ID, n=17), Iowa (IA, n=21), Michigan (MI, n=1), Minnesota (MN, n=985), Missouri (MO, n=1), Montana (MT, n=133), Nebraska (NE, n=1), North Dakota (ND, n=65), Pennsylvania (PA, n=1), South Dakota (SD, n=52), Texas (TX, n=2), Utah (UT, n=3), Washington (WA, n=1), Wisconsin (WI, n=85), Wyoming (WY, n=17).

Figure 4.2a | Number of JTP patients by state, October 2020-December 2021
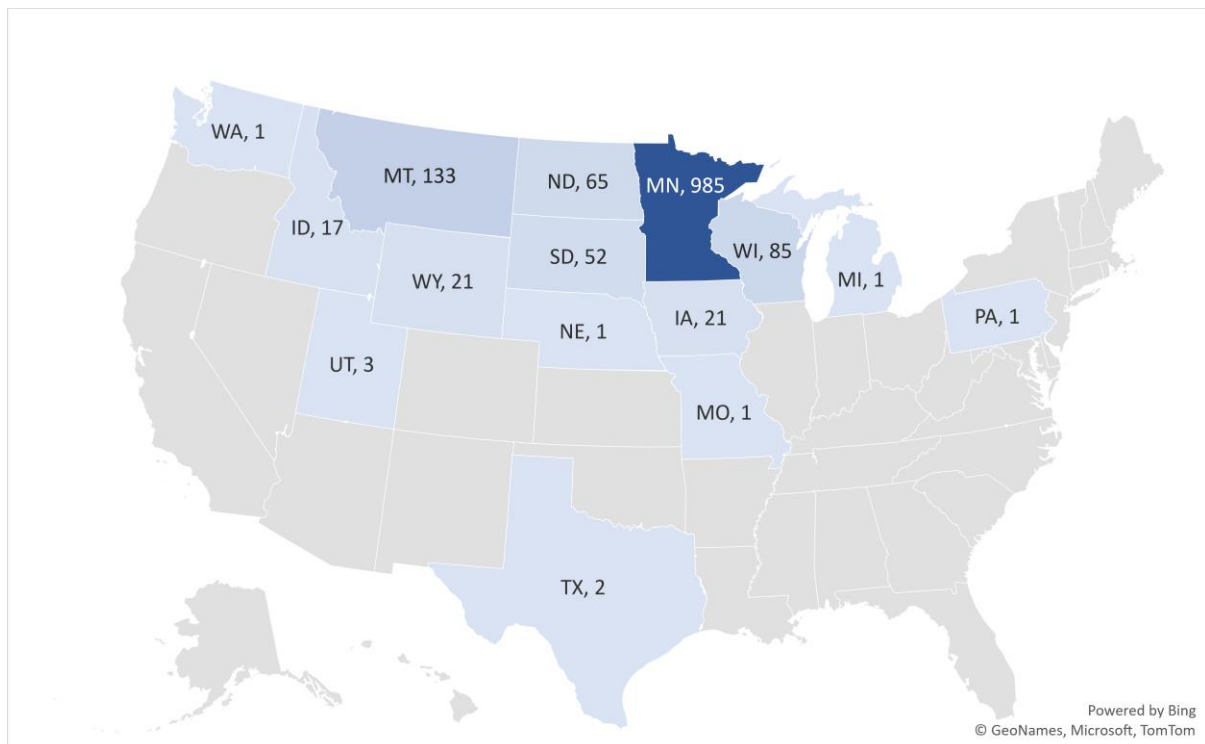
Though spread across 15 states, the 1389 patients were served in just three: Minnesota, Montana, and Wyoming (they were not yet registered to provide abortion

in Colorado). As such, 82% (1139/1389) of JTP patients were served in their own state, while 18% (250/1389) had to travel. As detailed below, my participants overrepresented those living outside of Minnesota, Montana, and Wyoming and who therefore travelled to access care (8/11), North Dakota=3, South Dakota=1, Texas=2, Wisconsin=2). I also used data from ANSIRH's Abortion Facility Database (AFD) for 2020, which I requested and received access to. The AFD listed all abortion-providing facilities in the US and its overseas territories.

Figure 4.2b | Distribution of abortion-providing facilities in the continental United States, 2020
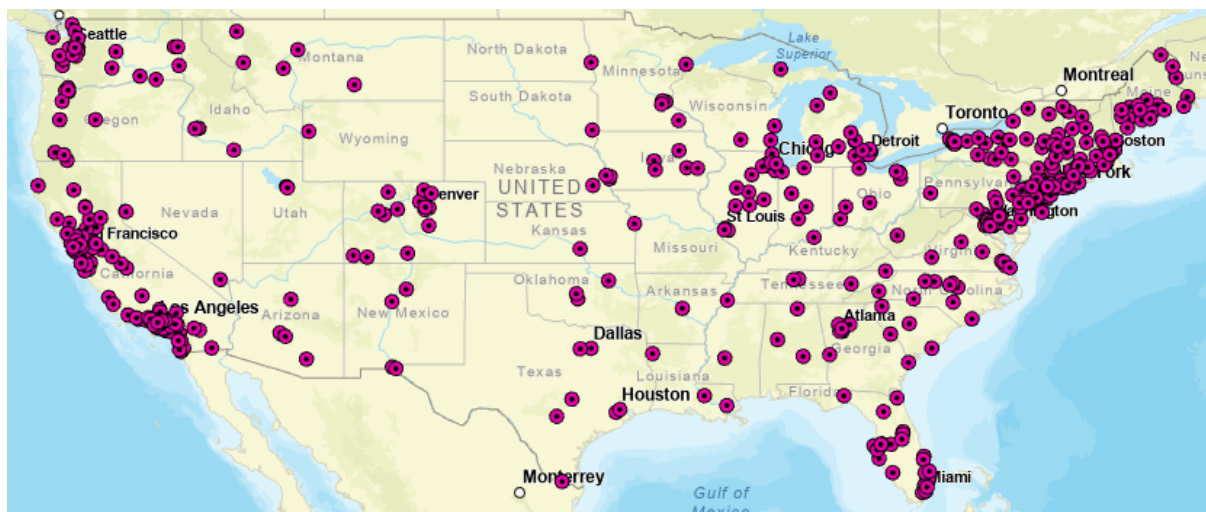
To calculate patients' distance to nearest abortion clinic, I used ArcGIS Pro to geocode the ZIP codes of patients and addresses of the abortion-providing facilities. Geocoding, in short, is a process in GIS to find the longitude and latitude for a text-based description of a map location to then identify its location on the Earth's surface. This is a necessary step for many analyses in GIS, and certainly for those exploring distance and proximity measures. I ran two basic analyses in ArcGIS Pro:

- I first used a tool called 'Find nearest' which uses either line distance (i.e. Euclidean distance or 'as the crow flies') or travel mode ('driving distance' or 'rural driving distance') to measure the distance between an 'input feature' and a 'near feature'. In this case, I used rural driving distance to measure the distance between each patients' location and their nearest abortion-providing facility, which could be across state lines. The resulting 'find nearest' analysis table details which patients are closest to which facilities, by driving time and driving distance. I then did a 'Join feature' which adds information from one

table to another based upon a common characteristic. In this case, I added patient demographic information to the 'find nearest' analysis table. I then exported this table to Microsoft Excel and used the 'COUNTIFS' function to determine how many patients lived within X travel time (minutes) to their nearest abortion clinic (Figure 4.2c). I then divided the counts by the total number of patients to determine the percentage of total.

- I then used the 'COUNTIFS' function to determine how many patients lived within X travel time (minutes) to their nearest abortion provider by their state of residence (Figure 4.2d).

- I then used the 'COUNTIFS' function to determine how many patients' nearest abortion provider was in their state of residence (Figure 4.2e).

- I returned to ArcGIS Pro to add the 'feature layer' of US Urban/Rural County Population (2010 Census) provided by the developer Esri, which includes total population, total urban population, total rural population, and percent rural population. I did a 'join feature' to add this information to the 'find nearest' analysis table, joined by patients' county of residence. I then used the Microsoft Excel 'COUNTIFS' function to determine how many patients lived within X travel time (minutes) to their nearest abortion provider by the percent rural population of their county (Figure 4.2f). This approach is similar to analyses by Gerdts et al. (2016) and Myers et al. (2019), for example, but I geo-coded data from patients who had ultimately decided to use telemedicine instead of accessing a clinic-based abortion.

4.2.2 | Distance

The average distance to a patient's nearest abortion clinic was just under one hour (μ=58.1 [minutes]). It is important to note that this is for one-way travel. In reality, for a surgical abortion a patient would be required to make one return trip—an average of 116.2 minutes total—and for a medication abortion they might be required to make up to two return trips—an average of 232.4 minutes total. Most patients lived under an hour away from their nearest abortion clinic (59%, 825/1389) or between one and two hours (384/1389, 28%). A total of 180 patients lived farther than two hours: 99 (7%) between two and three hours, 33 (2%) between three and four hours, 46 (3%) between four and five hours, and two (0.1%) between five and five and a half hours.

The smaller number of patients living at greater distances explain why the average distance measured in time remains at about an hour, with nearly 60% of patients living between 0 and 59 minutes from their nearest clinic. As such, this data set has a large standard deviation (σ=64.5).

Figure 4.2c | Travel time from patient's residence to nearest abortion clinic (2020-21)

Travel time (minutes)	Number of patients	Percentage of total
0-29	657	47%
30-59	168	12%
60-89	226	16%
90-119	158	11%
120-149	78	6%
150-179	21	2%
180-209	15	1%
210-239	18	1%
240-269	21	2%
270-299	25	2%
300-329	2	0.1%

4.2.3 | State of residence and abortion clinic location

Longer travel times are associated with state of residence. With respect to state of residence, just five states accounted for all of the travel times of three hours or more (180-329 minutes): Minnesota (11%, 9/81), Montana (20%, 16/81), North Dakota (36%, 29/81), South Dakota (28%, 23/81), and Wyoming (5%, 4/81). Given the vast size of North Dakota and South Dakota and the fact that just one abortion-providing facility existed in each state prior to *Dobbs*, their representation in these categories is sensical. Minnesota is also a large state with all of its abortion providing facilities concentrated on the eastern side of the state. I am surprised that Wyoming does not have a higher representation at these distances given its size, but one must consider both the low population of the state and that it borders Oregon and Colorado which have a larger amount of abortion clinics. What is interesting is that Montana is represented both at these longer travel times and at shorter ones—it is the only state which had patients from each of the travel time categories from less than half an hour to upwards of five and a half hours to nearest abortion-providing facility.

Montana has several abortion clinics throughout the state, which JTP patients appear to live in proximity to, but it is also a large, rural state nicknamed 'Big Sky Country'.

Figure 4.2d | Travel time from patient's residence to nearest abortion clinic, by state of residence (2020-21)

		Travel time (minutes)										
	State	0-29	30-59	60-89	90-119	120-149	150-179	180-209	210-239	240-269	270-299	300-329
Number of patients	ID	2	1	2	10	1	1	0	0	0	0	0
	IA	4	2	8	5	2	0	0	0	0	0	0
	MI	0	1	0	0	0	0	0	0	0	0	0
	MN	541	144	140	88	57	6	4	5	0	0	0
	MO	0	0	0	1	0	0	0	0	0	0	0
	MT	52	6	18	35	4	2	6	6	1	1	2
	NE	0	0	0	1	0	0	0	0	0	0	0
	ND	23	0	6	0	2	5	0	6	10	13	0
	PA	0	1	0	0	0	0	0	0	0	0	0
	SD	16	2	7	4	0	0	1	1	10	11	0
	TX	2	0	0	0	0	0	0	0	0	0	0
	UT	2	1	0	0	0	0	0	0	0	0	0
	WA	1	0	0	0	0	0	0	0	0	0	0
	WI	13	7	43	8	10	4	0	0	0	0	0
	WY	1	3	2	6	2	3	4	0	0	0	0

It is important to note that the nearest abortion clinic may not be in a patient's state of residence. That is why statistics such as percentage of state counties with or without an abortion provider are not particularly useful for providing a picture of access. Women and pregnant people traverse state borders to access care for a variety of reasons, including, but not limited to, distance. For 80% (1114/1389) of JTP patients, their closest clinic was in their state of residence, while for 20% (275/1389), it was in a neighbouring state.

Figure 4.2e | Number of patients with their closest abortion clinic in- or out-of-state, by state of residence (2020-21)

State	Total number of patients	Closest clinic in same state		Closest clinic out-of-state	
		Number of patients	Percentage of total	Number of patients	Percentage of total
ID	17	3	18%	14	82%
IA	21	12	57%	9	43%
MI	1	1	100%	0	0%
MN	985	851	86%	134	14%
MO	1	0	0%	1	100%
MT	133	132	99%	1	1%
NE	1	0	0%	1	100%
ND	65	51	78%	14	22%
PA	1	1	100%	0	0%
SD	52	40	77%	12	23%
TX	2	2	100%	0	0%
UT	3	3	100%	0	0%
WA	1	1	100%	0	0%
WI	85	13	15%	72	85%
WY	21	4	19%	17	81%

To return to the five states representing the largest travel times—Minnesota, Montana, North Dakota, South Dakota, and Wyoming—we get a more detailed picture that highlights the sheer size of these states. For the 16 patients in Montana whose nearest abortion clinic was over three hours away, that clinic was still located in Montana (Billings, MT). In fact, all but one patient in Montana had their nearest abortion clinic in state (99%, 132/133). For the 9 patients in Minnesota whose nearest abortion clinic was over three hours away, the closest clinic was in Fargo, ND (4/9) or Duluth, MN (5/9). Most patients in Minnesota (86%, 851/985) had their nearest abortion clinic in the state.

For the 29 patients in North Dakota whose nearest abortion clinic was over three hours away, the closest clinic was in Fargo, ND (15/29) or Billings, MT (14/29). For the 23 in South Dakota, the closest clinic was in Sioux Falls, SD (13/23), Billings, MT

(8/23), or Fort Collins, CO (2/23). For both North Dakota and South Dakota, however, just over three-quarters of all patients had their nearest abortion clinic in-state. And, lastly, for the 4 patients in Wyoming whose nearest abortion clinic was over three hours away, the closest clinics were over state lines in Fort Collins, CO (3/4) or Billings, MT (1/4).

It is also worth looking a bit further at Idaho, Wisconsin, and Wyoming. The majority of patients in these states had their closest abortion clinic across state lines. Prior to *Dobbs*, Idaho had four abortion providing facilities but was bordered by states with significantly more. Patients were closest to clinics in Montana, Washington, and even Wyoming. Also prior to *Dobbs*, Wisconsin's abortion clinics were concentrated to the eastern side of the state and therefore far away for many in the eastern and northern parts of the state. Of the 72 patients whose nearest abortion clinic was out-of-state, the closest clinic was in Minnesota (70/72) or in Marquette, MI (2/72), in the Upper Peninsula of Michigan, which borders Wisconsin to the southwest. Wyoming's sole abortion provider[9], which provides only medication abortion, is located in the west of the state near the Idaho border. As such, for those living in the southern, northern, and eastern parts of the state, the closest abortion clinic is over state lines in Salt Lake City, UT (4/17), Fort Collins, CO (6/17), and Billings, MT (7/17).

4.2.4 | Rurality

Longer travel times are associated with rurality. Defining rurality or rural in real terms is challenging. The US government has numerous definitions of rural that operate simultaneously. Some agencies classify a place as rural if it is non-urban or non-metropolitan, while other agencies define a place as rural by a lower level of population density. Places might be designated rural at multiple scales: the neighbourhood, census block, congressional district, county, or the state-level. In this analysis I use the county rural population estimates from the US Census.

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[9] A new clinic, which would offer both medication and procedural abortion, was set to open in Casper, WY in 2022 but was the target of an arson attack whose perpetrator is still at-large.

Although most of these states are among the most rural in the US (see Chapter 1), patients are not necessarily living in rural areas. Three-quarters of JTP patients (76%, 1061/1388) lived in counties that were less than 50% rural, according to the US Census, while one-quarter (24%, 327/1388) lived in counties that were between 50 and 100% rural.

Rurality is not a perfect explanation for how far someone lives from their nearest abortion clinic, but there is a moderate to strong correlation between the two. The correlation coefficient[10] for distance to nearest abortion clinic and county rural population is 0.56, meaning that there is a somewhat strong positive relationship between these two variables. In other words, in many cases, the more rural, the farther away the nearest abortion clinic.

Figure 4.2f | Travel time from patient's residence to nearest abortion clinic, by county rural population (2020-21)

Travel time (minutes)	County rural population (percentage of total)			
	0-25	25-50	50-75	75-100
0-29	586	44	26	1
30-59	23	84	50	11
60-89	44	118	25	39
90-119	9	78	39	32
120-149	1	12	37	27
150-179	4	4	5	8
180-209	2	5	0	8
210-239	0	8	5	5
240-269	4	15	1	1
270-299	6	14	2	3
300-329	0	0	0	2

In this section, I demonstrated that the nearest abortion clinic to most patients of JTP was under an hour away in one direction, but many would have had to travel longer distances—particularly those in rural or remote areas. These results are in line with

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[10] A statistical measure of the strength of a linear relationship between two variables.

previous spatial analyses of abortion access that show the tremendous distances people must travel to access care, but my analysis differs in two key ways. Firstly, previous work has used population data or information from patients in a clinic to highlight the travel-to-abortion burden (e.g. Bearak, Burke and Jones, 2017; Gerdts et al., 2016). In my study, patients at 'point A' did not access care at their nearest clinic at 'point B', but through telemedicine instead. As such, I can consider to what extent distance to a brick-and-mortar clinic weighed into the decision to have an abortion via telemedicine instead. Secondly, previous work has tended to rely on quantitative approaches which focus on distance alone (e.g. Cartwright et al., 2018; Jones and Jerman, 2013). In my study, I combine GIS with qualitative data throughout this chapter to show how telemedicine abortion patients understand, make sense of, and navigate distance *in conjunction with* other barriers to abortion. Distance is one of several imbricated barriers to abortion care for rural women and pregnant people.

4.3 | Crisis pregnancy centers as a barrier to care

In this section, I define and discuss the nationwide presence of crisis pregnancy centers (CPCs), which contrasts with the relative absence of abortion clinics. CPCs are a spatial—and increasingly mobile—strategy aimed at discouraging abortion and putting abortion clinics out of business. A central part of the anti-abortion movement (Munson, 2008), CPCs use deceptive tactics to get people through the door, such as imitating the appearance of and setting up near an abortion clinic or implying that they are a medical provider (of abortions) (Borrero, Frietsche and Dehlendorf, 2019; Bryant et al., 2014). As Thomsen et al. explain, 'their framing of themselves as a resource is simply a mechanism for obscuring their unethical approaches to attempting to convince people out of obtaining abortions' (Thomsen et al., 2022a, p.2). CPCs provide false and misleading information about abortion and even estimate a lower gestational age to delay care past the legal limit (Montoya, Judge-Golden and Swartz, 2022). These efforts are legally sanctioned—and even funded—by conservative state governments (Kissling et al., 2022)[11].

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[11] Recent reporting shows that the National Health Service in the UK has also promoted the services of CPCs for antenatal, carer, and mental health support (Smith Galer, 2023).

CPCs vastly outnumber abortion-providing facilities: 2,640 CPCs versus 738 abortion facilities prior to *Dobbs*. Nearly one-third (30.6%) of the US population lives closer to a CPC than an abortion clinic—primarily in 'non-metropolitan' areas—which is projected increase to 57.1% after the overturning of *Roe* wherein CPCs will remain permitted in states that ban abortions (Thomsen et al., 2022a). Studies find that CPCs specifically target Black and Latinx people and those living in rural areas (Kelly and Gochanour, 2018; Thomsen et al., 2022b). Just as abortion is no longer tied to brick-and-mortar facilities (Calkin, 2023b), CPCs are increasingly on the move and manipulating geography against reproductive justice. Thomsen et al. (2022b) reveal that there are at least 170 mobile CPCs in the US, which are unregulated, unruly and ultimately unmappable. The *presence* of CPCs, whether in situ or on-the-road, they argue, is just as important as the *absence* of abortion clinics (Thomsen et al., 2022a). CPCs have also engaged in 'mobile geofencing', or location-based marketing, to target 'abortion minded' women while they are physically at an abortion clinic to discourage them from abortion (Coutts, 2016).

CPCs have physical, mobile, and online presence designed to interfere with abortion access. According to research by the Center for Countering Digital Hate (2022), in the 13 states with 'trigger' laws for overturning *Roe*, one in 10 Google search results for 'abortion clinic near me' and 'abortion pill' led to websites for CPCs. More than one-third (37%) of Google Maps results presented CPCs as though they were brick-and-mortar abortion clinics, and approximately 28% of Google Ads at the top of search results for CPCs rather than abortion clinics (ibid.)[12]. Recent analysis by Bloomberg News similarly finds that in 33 states, CPCs account for at least one of the top 10—and up to nine—search results for 'abortion clinic' on Google (Alba and Gillum, 2022).

With 'fake' and 'real' abortion clinics being conflated in Google search results, abortion seekers, particularly first-time abortion seekers, are not unlikely to be misled

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[12] Recent reporting shows a similar trend permitted by Google in the UK (Das, 2023).

in their search for abortion care. Two of my participants, Erin and Lucy, encountered problems in their searches for abortion care:

> It really was just, popped up on the internet for me, like, as I was researching, I think I must have just put the right phrase in or something for it to work. But it was after like three or four tries and I was a little skeptical about the whole like just the state of Minnesota and mailing it and... uhm […] After talking to like all the clinics and stuff, I was like, 'Is this somebody that's just trying to take my $375 still make me have a baby like!? 'Yeah, it did seem like a scam kind of. [Erin]

> **Olivia:** So when you were in this kind of rabbit hole, were you lead in, like the wrong direction as well like going to, you know, websites that you know, are billed as women's health but you know, clearly didn't…?
> **Lucy:** Oh, man, that happened so many times, I I think, I think four or five and I just I was clicking on links and thinking, 'Maybe this will work' and it just it sent me to, uhm, abortion prevention. Like, it was like do adoption, do, you know, XYZ, and it was very very frustrating at first.

Both Erin and Lucy conducted arduous and frustrating research in their attempt to access abortion care. While Alice and Morgan both knew about the 'birth right centers of the religious Planned Parenthood' [Morgan] and were therefore able to navigate their searches more precisely, neither Erin nor Lucy had previous knowledge of CPCs and thus had to parse out the legitimate providers themselves. Although Erin said she did not encounter a CPC specifically, after hearing my description she said, 'it sounds like they could have been it was kind of I didn't talk to them long enough… But definitely, I was just taken aback that they were like offering support to women, but not in this way' [Erin]. Indeed, she mentioned that '[t]he women's health clinics that I called in Minneapolis they didn't even offer [abortion]' [Erin], which might suggest that she had spoken to a CPC which would likely not have described itself in those terms.

In reference to the difficulties that patients like Erin and Lucy experienced when researching their abortion options, the Medical Director of JTP, Dr Julie Amaon, explains that they are trying to 'up our presence on the web as much as possible so you can find us and don't find crisis pregnancy centers first, which is a huge issue as we know' [Dr Amaon]. While Democratic lawmakers have recognised misleading search results as a problem, 17 Republic state attorneys general have urged Google to keep CPCs in search results (Reuters, 2022). However, under pressure from pro-choice forces, both Google and Yelp have made steps to address this issue. Both companies disabled the ability to leave reviews on CPCs, and Google is working to delete search histories for those accessing abortion clinics as well as using verified labels under potential abortion clinics: 'provides abortions' and 'might not provide abortions' (Ingram, 2022).

While they will not provide abortions, CPCs might provide free pregnancy tests and ultrasounds. The provision of resources is generally understood as one tactic employed by CPCs to unduly influence reproductive decision-making away from abortion (Rosen, 2012). Hutchens (2021) suggests that CPCs use free ultrasounds as a form of 'religious biopower' to reinforce foetal personhood and spread medical misinformation. The woman's body 'becomes the site of implicit religious surveillance that shifts the embodiment of pregnancy to reflect evangelical understandings of fetal personhood and motherhood' (Hutchens, 2021, p.6), thereby using individual pregnancies as a mechanism for delivering macro-level population outcomes which align with conservative religious ideas. This is why it came as a surprise when Laura told me that she went to a local women's health clinic—which I later identified online as a CPC—for a free pregnancy test and tells me that she received support for her decision to have an abortion:

> **Laura:** And it came out positive and I fell apart and told her I can't do this. And that's when I decided I have to have an abortion. I can't do it.
> **Olivia:** How did they respond?
> **Laura:** She said I am 100% on your side. Whatever you decide to do. You need someone to talk to you can always reach out to me.

For Laura to have had a kind of pro-choice experience at this organisation is very unusual. The CPC she refers to explicitly states on their website that they are concerned with protecting the sanctity of life and want to give women the opportunity to keep their babies. They are in the business of reproductive coercion—not options or true choice. Following Dr Amaon, a partner of JTP mentioned the predatory nature of CPCs. Marie at reproductive justice and practical support organisation Midwest Access Coalition (MAC) prefers to call CPCs 'fake clinics' because 'that name [crisis pregnancy center] suggests a particular thing […] I mean even if there is a crisis, we don't need a fucking church to tell someone'. She did not mince words about the very real threat to abortion access that these fake clinics pose, especially in rural and religious areas of the Midwest:

> [I]t's it's really scary too, because in the Midwest, there's states that require a prior ultrasound by your abortion provider, and this like waiting period and all these things to get care and some of these fake clinics are really they're really deceitful and they'll be like get your ultrasound here so like we had folks reach out to us and they'll be like, 'I got my ultrasound' […] but that appointment you went to is not going to count. It doesn't count for the state for your abortion provider. [Marie, MAC]

Marie [MAC] points to the deceitful practices she has observed in her region which she suggests are intentional efforts by CPCs to delay or discourage abortion care. Most scholarship agrees about this, arguing that CPCs pose a public health risk (Borrero, Frietsche and Dehlendorf, 2019; Cartwright, Tumlinson and Upadhyay, 2021). However, some recent work has expressed an understanding that CPCs might be providing material resources which the state is not and therefore filling a gap in care, particularly for low-income women (Hutchens, 2021; Kimport, 2020; Kissling et al., 2022). At the same time, because these resources are limited and contingent (Borrero, Frietsche and Dehlendorf, 2019), these scholars emphasise that they cannot meaningfully be relied upon (Kimport, 2020). Indeed, as Marie [MAC] pointed out, free ultrasounds at CPCs do not count as a mandatory ultrasound required by the state prior to an abortion, and they would have to do it again with an actual abortion provider. What is evident is that Laura did not go to the CPC for

abortion, and that any encounters with CPCs by other participants did not result in them changing their mind about their abortion (Kimport, Kriz and Roberts, 2018). However, the presence of CPCs in Google search results about abortion care was confusing for participants and made the process of researching and arranging care more difficult and time-consuming.

In this section, I demonstrated how these anti-abortion institutions work to confuse abortion-seekers and ultimately delay care. CPCs are the most important form of activism in the anti-abortion movement. These institutions have physical and mobile locations which provide resources to pregnant women, such as free pregnant tests and ultrasounds, with the aim of discouraging them from seeking an abortion. CPCs are largely unregulated and are neither required to disclose that they are not a medical facility nor to provide medically accurate information about abortion or pregnancy. Most research on CPCs has focused on their deceptive tactics which serve to coerce women away from abortion and delay abortion care; they are widely considered by scholars and abortion activists to pose a public health risk. On the other hand, some scholars have pointed out that they are meeting some needs of low-income women in the context of a state which does not adequately resource reproduction. Moreover, despite the stated aims of protecting life, CPCs are not especially effective at discouraging abortion: most women who visit a CPC were already going to carry the pregnancy to term or do not change their minds. My research in part confirmed the double-edged sword of CPCs by showing an example of where a CPC provided care—but not abortion care—as well as where CPCs slowed down the process of obtaining an abortion through their online presence in and amongst *real* abortion providers. By not providing, not facilitating, and actively discouraging abortion as well as outnumbering abortion clinics in rural areas, CPCs present both a tangible and an intangible barrier to abortion care for rural women and pregnant people.

4.4 | Abortion restrictions and bans as barriers to care

In this section I consider the effect of abortion restrictions and bans on accessing abortion care. In the US, state laws have long attempted to control where, when, and how women and pregnant people can have an abortion and who can provide it.

Analysis by Nash (2021a) shows that 1,336 state-level abortion restrictions were passed following the *Roe v. Wade* (1973) decision. These are medically unnecessary laws that exceptionalise abortion with the aim of making abortion difficult or impossible to obtain. At an individual scale, abortion travel is 'one of the ways that women navigate, resist, and sometimes succumb to restrictive abortion laws and policies' (Kelly and Tuszynski, 2016, p.2). Many women and pregnant people are able to find ways to get an abortion in spite of legal or extra-legal barriers to care (Baird, 2019; Bloomer and O'Dowd, 2014). These individuals 'attempt to find spatial solutions to an unwanted pregnancy' by crossing borders to access abortion services (Sethna and Doull, 2013, p.53), while abortion providers seek 'to exploit reproductive mobility for positive political change' (Gilmartin and Kennedy, 2019, p.130). Abortion restrictions or bans do not prevent people from seeking or providing abortion care but do make it more difficult.

The decades-long effort by the anti-abortion movement to restrict abortion at the state-level has led to a collective understanding in the US that abortion is difficult to obtain. In the American public's imagination, abortion is 'controversial' and 'politicised' (Bloomer, Pierson and Estrada-Claudio, 2020), democrats (blue, liberal) are 'pro-choice', and Republicans (red, conservative) are 'pro-life' (Ziegler, 2013). Participants likewise understood that Republicans were altogether hostile to abortion and that this manifested in state laws. They attributed the lack of abortion clinics to their states being 'conservative' [Claire] (read: anti-abortion). Erin, in Wisconsin, where abortion is now banned, elaborated:

> Because it's, it's like, that, the accessibility in Wisconsin, it's like you're not going to […] You will not find access in our clinic, like a primary […] care clinic clinic in the state of Wisconsin. That's like, not that it's a long shot, that it shouldn't happen, I do believe it should happen. I think everybody should have access to it. But I was just was kind of naïve going into it, I guess with how, yeah, how not easy it is. [Erin]

Erin suggests that she thought finding access in Wisconsin was going to be easier—and that it should be easier—but that it is difficult in the state *as a whole*. Likewise, Claire in North Dakota, where abortion is banned as of 2023, said:

> It was a little... annoying, I would say because oh, why can't my state have the proper buildings for women to have these procedures and then, you know, gotta also remember my state's Republican, we're conservative. It's a lot of a lot of white old people. People who are just not okay with that kind of stuff. We just can't be progressive in, you know, these times. Mm, we just, so we didn't didn't have a building to go do stuff. So having to go across the border, you know, it having it be the next best option. I was totally okay with doing it. [Claire]

Claire, like Erin, described the lack of abortion access as a state-wide problem. She blamed this on the conservative attitude towards abortion wherein they 'just can't be progressive' [Claire]. Just as Republican was understood to be hostile, Democratic was understood to be more progressive towards abortion. For example, Morgan recognised that Minnesota was potentially a better place to live in terms of the abortion landscape because it 'remains a little more blue than red' and has 'a little more support' [Morgan]. On the complete opposite side of this, in South Dakota, where abortion is banned as of 2022, Alice provides an especially horrifying example of how state legislators dehumanise women and pregnant people in a kind of rural parody:

> I had one legislator describe to another legislator an abortion procedure, in terms of you know, what happens with a cow. Because they were ranchers. Oh, my uhm, so, literally comparing pregnant people, to cows. If that gives you any indication of, yep, who is making laws. [Alice]

Alice points to the absurdity of anti-abortion laws which are designed to restrict reproductive autonomy. Although restrictions have mostly been implemented at the state-level, national laws enable their severity as we have seen with the *Dobbs* decision which led to abortion bans in several states. Jenny was the first of three

patients I interviewed following the *Dobbs* decision in June 2022. She therefore spoke about both the state and federal governments: 'Like, you, why are you taking this whole state or this whole country and just like without any reasoning, you're just gonna like make a ban?!' [Jenny]. This served in part for her motivation to speak with me, to highlight the option of JTP given these dire circumstances:

> I was like no matter what the reason like that, this is hard enough. And it was so easy, but at the same time like like if this is hard enough, but it was easy and then all the other people with like 10 times more obstacles. And they just... I don't know, more people just need to know about this. [Jenny]

Jenny highlights that abortion is already difficult to access for many people even without an outright ban. Participants expressed discontent with anti-abortion attitudes and laws, which they described as unfair and suggested that 'ideally, [there] would be no law restricting it' [Alice]. However, when participants were confronted with the need to access an abortion, they had to make decisions within the existing legal, material, and spatial context rather than an ideal one. As such, it was the practicalities *within* the legally restricted context that really shaped their experience in accessing care. Most patients did not mention the law, legality, or criminalisation beyond describing the context of abortion care in their state. In fact, for the two Texas patients who had their abortions in a 'ban' state, they were not really concerned about criminalisation [Elena, Diana]. They knew they needed an abortion and that they would try to get one irrespective of its legality, and so focused on where and how they would get an abortion and how they would pay for it.

This points to a contradiction inherent in our focus on legal barriers to abortion care. On the one hand, with the overturning of *Roe*, the Director of JTP's Board Susan talked about states doing 'different wacky things'—some good and some bad—and '[p]atients are going to be the ones that are going to suffer from it' [Susan]. On the other hand, we know that *Roe* has never been a reality for people accessing abortions due to the multi-scalar efforts to restrict access. There is a fundamental difference between rights and access. Abortion providers and activists, particularly those working in reproductive justice, have long pointed out that without real access

there can be no 'choice' (see for reference Ross, 2006, 2017). For them, *Dobbs* does not signify the beginning of the 'post-*Roe*' context—many of the people they serve have already been living in a world without *Roe* [Shayla, Our Justice]. This is something that Marie [MAC] particularly emphasised: 'there's [a] difference between, like, what is access, like Roe, Roe, just legalizing something, I mean, that's bullshit'. This points to the need to challenge the 'suffering' frame (Herrick, 2017), in the wake of *Dobbs*, by recognising that there have been and will continue to be differential impacts of abortion law on particular places, but that these places can be sites of both oppression and resistance.

In this section, I demonstrated that although patients understood their states and country more broadly to be hostile to abortion rights, they were not deterred. The *Roe* decision in 1973 mandated states to legalise abortion until foetal viability but did not confer a right to *access* abortion. Later constitutional decisions made it easier for states to undermine access through restrictions on providers and patients. These restrictions have served to make abortion difficult to access, particularly for the most marginalised. The latest constitutional decision in *Dobbs* has enabled the banning of abortion in several states, thus making abortion even more difficult to access. However, as feminist geographers have shown, abortion travel is one way in which women and pregnant people can challenge abortion restrictions and bans. My analysis shows that rural women and pregnant people recognise the challenges resulting from anti-abortion laws in their states and largely blame conservative governments for how difficult accessing abortion is. They suggest these laws are unnecessarily punitive but, outside the resulting socio-spatial context in which they sought care, abortion restrictions did not affect their abortion decision-making. Participants understood and ultimately worked through the unjust context they were living in because they needed an abortion now—not after lobbying the state legislature. Abortion restrictions and bans shape the who, what, where, when, why, and how of abortion care and therefore present numerous barriers to care, but the law itself did not matter to patients when deciding whether to have an abortion and in what manner.

4.5 | Number, availability, and accessibility of abortion clinics as a barrier to care

In this section, I expand on the discussions in sections 4.3 and 4.4 to consider the number, availability, and accessibility of the abortion clinics. The limited number of abortion clinics is frequently attributed to individual states which are considered hostile to abortion, and which pass laws that restrict the ability of existing abortion clinics to operate there. Several participants had an imagined geography of abortion inaccessibility in their state given their government's hostility to abortion as represented in the number of abortion clinics. Claire and Lucy in North Dakota and Alice in South Dakota knew 'that the logistics were going to be challenging' [Alice] because of the state she lives in. Even Morgan recognised the challenges of the South Dakotan abortion landscape while living in Minnesota: 'I think Sioux Falls has a Planned Parenthood but possibly all their laws are so… I won't even go there, you know? [laughs]' [Morgan]. Alice considered taking an appointment in Des Moines, IA, but that was too far, another in Sioux City, IA, but their first available appointment was in February (she was calling in December), and ultimately took one in the Twin Cities, MN which was a four-hour drive but with an available appointment in late January [Alice].

Alice's experience, among other participants, highlights that abortion infrastructure cannot solely be measured by the number of abortion clinics in a state or county. Rather, we need to account for the porosity of state borders which allows patients to have a regional view of access as well as the availability and accessibility of each abortion clinic, which is shaped in large part by the population-provider ratio. The Executive Director of JTP highlights this:

> Planned Parenthood in St. Paul, the other abortion provider here is like backed up. They don't have appointments for two weeks. And in Chicago Planned Parenthood doesn't have appointments for four weeks. And so it's like, so then you have to kind of negotiate: Okay, well, where are Wisc- in Wisconsin it's there's always been a delay because there aren't enough providers, so, where do Wisconsinites go? And where do the people in

Minnesota go, now that they cannot go to the other providers who are so backed up? [Executive Director]

The Executive Director points out that the limited number of abortion clinics leads patients and providers to take a regional perspective of access. Within this, patients are struggling to get a timely appointment because of issues with supply and demand. Like Alice, Helen struggled to get an appointment locally and timely despite the presence of several clinics in Montana:

It was like- or maybe there wasn't any available. No, that's right, there wasn't any any time available in [the city] one so I would have to drive, like further away, like to [another town in] Montana or something like that? That's what it was. But it was like a couple weeks out and it was a couple hundred miles away. And then I just happened to find the JTP thing in the meantime, but uhm, and so I just went with that… [Helen]

This quote from Helen highlights that distance is just one aspect of the calculus undertaken by abortion seekers—getting timely abortion care was perhaps more important. Time was a factor in terms of the law, the cost, and the individual simply no longer wanting to be pregnant. Gestational age is implicated in abortion methods, individual clinical practice, and restrictions on when someone can have an abortion. For example, many women and pregnant people prefer medication abortion but quickly fell outside the limit of 9-11 weeks for the method after facing financial, travel-related, or legal delays (Baum et al., 2016). Jenny felt an especial time crunch when she had her first abortion with JTP, because she wanted to have the abortion with pills instead of 'when you go in and they extract it' and she found out that 'this one you can do up to this, you know, after this time, and this one you can do up to this time' [Jenny]. When the pills are acquired, there is then the question of whether the abortion will be 'done in time' and 'be fully effective' [Lucy].

If someone cannot access an abortion within the time frame for medication abortion or earlier aspiration procedures, they will pay more: abortion at later gestational ages is costlier and, depending on how much later, is offered at a handful of speciality

clinics. On top of the legal and financial implications, most women prefer to have their abortion sooner rather than later (Baum et al., 2016; Finer et al., 2006; Foster et al., 2008). The women in my study were thus aware that getting an abortion is a time crunch. You 'only have so much time' [Jenny] to get an abortion. Lucy outlines the limited timeframe and extenuating circumstances in which women and pregnant people must seek care:

> Yep, between that and, you know, most women don't even find out until six, seven weeks, and then you've got three weeks to deal with it. And a week of that could be shipping or it could be, you know, the clinic availability or transportation problems. There's there's any number of things… or funding! [Lucy]

As Lucy highlights, there are numerous practical and financial issues that could jeopardise timely care. Each woman in my study weighed the different options that might be available depending on gestational age, clinic availability, their location, and even the weather, which can affect rural transportation options. Morgan, explains these temporalities in the following quote:

> I could make an appointment, sure, to go to the Twin Cities on let's say February 13, but I have no idea what the weather's gonna be like February 13 and so if I can't make that appointment then I have to reschedule that appointment and it'll be a couple weeks out after that. Well then now what I thought was going to be, I would be at five weeks now I'd be at eight weeks or maybe I'll be at 12 weeks and then they playing that game of well now I can't do this now I'll have to go with this. Or, oh nope, you're in South Dakota so now you can't do anything. [Morgan]

Due to the number, availability, and accessibility of abortion clinics in the region, Morgan and other participants had to do logistical acrobatics to find and arrange timely abortion care. Alice, who lives in South Dakota, which had just one abortion clinic similarly anticipated 'that the logistics were going to be challenging' because of the 'timeframe that I would have to work within' [Alice]. Although Alice caught the

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pregnancy 'really early', the Planned Parenthood in Sioux Falls was not able to schedule her for another month or so, which was 'then cutting it really close' [Alice]. Another clinic could get her in a bit earlier but was a four-hour drive. For Beth, the lack of local and timely care may have posed an insurmountable barrier to abortion care had she not discovered JTP or eventually miscarried:

> Oh, yeah. Yeah, I think that had that not been an option, I don't know what I would have done. Yeah, I have no idea. There'd be a level of panic there for sure. […] Well, I mean, I own my own business. So yeah, I would have figured out the work thing. […] The kids you know, I would just had to lie. You know, I mean, like, oh, I you know, where are you at today? Oh, well. You know, I would either pretended I was at work or I would have made an excuse to why I have to drive to Sioux City to see you know, I would have said oh I have to meet you know with another agent or I have to meet with another client or I would have just done that. Uhm, I do think that it may have pushed me to to keep it. [Beth]

Beth's story underscores the consequences of inaccessible abortion care. The Turnaway Study, a longitudinal study examining the effects of being denied an unwanted abortion, estimated that in 2008 alone, more than 4,000 women carried unwanted pregnancies to term due to providers' gestational age limits (Upadhyay et al., 2014). Among those turned away due to gestational age, 21.6% considered having an abortion elsewhere but did not obtain one, primarily due to procedure and travel costs (ibid.). Indeed, other problems that participants encountered was the need to pay larger sums of money up-front and out-of-pocket for both medication and aspiration abortions in brick-and-mortar clinics.

Another issue was the clinical requirement that you must have an 'abortion buddy' following an aspiration procedure, which requires disclosure to at least one person who must be available to accompany you, but that you cannot bring children with you. This was an issue for Jenny, in particular:

I live in western North Dakota. And I think the reason I went to JTP is because... I know it was a money issue. And then... I know it was something to do with clinics and they wanted payment up front, and... There were a couple of factors that played into it. And then my kids, 'cause I don't have daycare for them right now. And they were like, well, […] you got to find someone. [Jenny]

There were a 'couple of factors' [Jenny] that played into Jenny's and other participants' abortion decision-making—not just distance or the number of abortion clinics. Laura and Erin added that going to abortion clinics was significantly more time-consuming and stressful. Laura had previously had a medication abortion and discussed the absolute hassle that this entailed at length:

So I had to physically go down to Planned Parenthood and I was there for like, seven hours. Like, you know, you go they check you in, you sit there, then you know, you talk, they want to make sure this is what you want to do. Then you go into the waiting room, then they go and talk to somebody else. And you sit and talk blah blah blah, and then you go sit in the waiting room […] they need to do a phone conversation with the doctor, or 15-20 minute conversation. But you still got to do all that. I'm just thinking, 'Okay, why is this taking so long? I just want to go home.' […] So they have me take the one pill, and then they make you sit in the lobby room for about 30 minutes. And then they call me back. And then they give you the second pill, and, you know, all the side effects and blah, blah, blah. They send you on your way. [Laura]

For Laura, going to the abortion clinic and having her appointment was a time-consuming ordeal and one that she was not eager to repeat. Erin, who had not previously had an abortion, anticipated that having an abortion at Planned Parenthood would have been arduous: 'I had to go to like multiple appointments for like Planned Parenthood. And they made sure that like, you know, it was just a lot more of a stressful experience' [Erin]. Later she said, 'it was just going to be a lot more of a difficult experience, which, yeah, I feel like maybe that's their goal' [Erin].

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She clarified that when she referred to 'they' and 'their', she meant the Wisconsin government.

In this section, I demonstrated that, although the limited number of clinics was discouraging, patients' ability to access care was more commonly determined by the circumstances of individual clinics, particularly wait times for an appointment, in conjunction with how far away they were. Participants understood abortion as difficult to access because of the limited number of abortion clinics which has resulted from state-level restrictions on abortion—not necessarily because of those laws themselves. There was an understanding amongst participants that certain states were better for abortion access than others, primarily because of anti-abortion legislators who have passed laws restricting abortion. As women in rural areas in states with limited numbers of clinics, patients understood that they would be driving significant distances to access care. What they perhaps did not realise initially was that the limited number of clinics also meant limited availability. Waiting times, combined with the particularities of each clinic—how long you had to be there, on how many occasions, and who you could and could not bring with you—made the practicality and necessity of timely and local care an important factor when making their decisions. The number of abortion clinics vis-à-vis the number of potential abortion-seekers largely shaped clinic availability and accessibility, which in turn presented barriers to abortion care for rural women and pregnant people seeking local, timely, and affordable abortion care.

4.6 | Abortion stigma as a barrier to care

In this section, I explore the role of stigma in abortion access. Abortion stigma is a 'socio-cultural process tied to the categories of difference upon which power relations are produced and legitimated' (Millar, 2020, p.6). Abortion stigma is a 'process embedded in social relations of power and privilege', which 'intersects with and is produced in relation to other forms of reproductive stigma' whose effects are 'distributed unevenly, according to multiple vectors of identity and structures of inequality' (ibid.). This definition decentres the individual as the source and location of abortion stigma and recentres macro-level structures and forces that produce stigmatising categories. That abortion stigma exists is not necessarily disputed, but

whether and to what extent individuals internalise, perceive or experience abortion stigma is contested. This is especially pertinent in rural areas of the US where residents are more likely to be oppose abortion than their non-rural counterparts (Dillon and Savage, 2006; Pruitt, 2007).

Due in part to population, isolation, infrastructure, and socio-economic conditions, participants identified 'old, recycled mentalities' [Lucy] in some rural areas, particularly with respect to gender and sexual and reproductive health. Lucy expanded upon this idea:

> It's, uhm it's it pretty much consists of like some old buildings, a post office, a hotel and like a gas station. Uhm, and there's… not- not to bring politics and everything but it is very much like a deeply deeply old school Republican community and that's not even in terms of just the town and it's the whole state. All of North Dakota is very much like that. Uhm, and the majority of the people in the area there are you know, your your old school, you know, women women take the role of, you know, basically like secretary or nurse and the the men go and work in the factories or till the fields and stuff like that. [Lucy]

Lucy's discussion of the prevalence of gendered ideas about women and men's roles in society in their area was echoed by other participants. Others highlighted issues of xenophobia and racism, which Morgan experienced directly as a woman of colour. While several participants identified their areas as conservative, red, or Republican in some way, Morgan made sure to point out that not all rural towns hold these attitudes, but it is nevertheless challenging for her and her family when they do: 'Part of the problem with living in rural – I mean, and I'd go as far as to say America – but I'll just say with certainty rural Minnesota is the like polarization politically. And so me and my husband are an interracial couple and that is taxing' [Morgan].

In this context, most participants internalised, perceived, or experienced abortion stigma to varying degrees. The women in my study experienced a wide range of

emotions, from indifference to grief, alongside a feeling that they made the right decision to have an abortion, in line with the research in this area (Rocca et al., 2020). They nevertheless felt the weight of anti-abortion attitudes:

> Why do I have any right to say anything about it? So then when it happens to you, you're kind of like, why am I doing this well, like I kind of like started to think like a protester, but like, I was like [pause] I had never thought like I would get one [yeah] but I was never like 'if I get pregnant, I would never get one' but, but like, I never thought about myself having one. [Jenny]

> I'd say it was like you said like the deep rooted conservativeness like within myself too, not even not I am, but going to the high school and I felt guilty I felt like just Yeah, it was really hard. I had a lot of emotion behind it. I felt like I was kind of doing something dirty, something wrong. When I really knew I wasn't like I I like if it weren't me, you know, I would be in like 100% of support of anybody who needed it. It just felt like for me I was like, I messed up and now I'm dealing with the consequences. And so that was kind of my experience. […] I like I thought about [the abortion] long and hard because of like the guilt I was dealing and the like, just backlash I was receiving and stuff. I was like, Fine, maybe I should just have this child and but no […] Like I really. I made the right decision for sure. For myself. [Erin]

Both Jenny and Erin supported abortion and abortion-seekers but internalised abortion stigma when they had to make that decision themselves. These experiences in part highlight the 'visceral intensities of blood, tears, stigma and shame' to which Murray and Khan refer in their study of abortion mobilities (2020, p.165). For Erin, these feelings of guilt and 'doing something dirty, something wrong' [Erin] and her related inability to share them with people around her were a large part of her motivation for speaking with me:

> You know, I'm like looking at my situation and I've like reflected on it. It was hard like, but it was I still had so many resources like I still was just pretty lucky. In that sense, like I there's just so many people that don't have even

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close to what I have […] And people shouldn't have to go through so much backlash just to keep their life on the track that they want to. So I guess that's like my biggest, like lessons that I've learned and just I want to bring more awareness to this issue and like, I struggle with being somewhere where I want to talk about my experience and so people can kind of get a better idea on like how difficult it is and like just yeah, but I also don't talk about it really ever. I don't even like to like, talk about it with my roommates or the people that I brought it up to like there's [sic] just so emotional for me. I just like felt like it was just such a big decision. And now looking back at it, it's just like, it like also wasn't like I knew from the beginning like what I needed to do and I don't know I just like wish people wouldn't feel like this huge sense of guilt or something that they did something wrong. It's just like it's so common or it's so just so easy, kind of. Yeah, I guess. [Erin]

Erin mentions that she would like people to understand her abortion experience, but that she does not talk about it 'really ever' [Erin]. For the most part, due to the perceived stigma associated with abortion that Erin's story highlights, participants worried about potential backlash within their community. Claire tells a humorous anecdote about encountering a friend at the grocery store when purchasing her pregnancy test:

> [The pregnancy test], it was so hard to get it. Because I have a friend who works at the grocery store, but I didn't want her to know 'because she's Christian too! […] I was hiding the pregnancy test behind a bottle of ranch [Olivia laughs] and then she came up to me and I was like freaking out, sweating bullets. [Claire]

This quote from Claire highlights one of the difficulties in navigating abortion stigma in rural areas: proximity to other people. Participants knew just about everyone in their small town, and everyone in their small town knew them. As Herron and Skinner explain, 'the proximity of rural people to one another often makes it difficult to keep sensitive health issues (e.g., mental health) private, and this has implications for people's willingness to seek certain types of help' (2018, p.269). There is a lack

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of anonymity in rural spaces, which had major repercussions for participants navigating this stigmatised health care process. Abortion stigma 'incentivizes concealment' (Cockrill and Nack, 2013, p.987), and my participants largely kept their abortion a secret from their community, their families, or even their sexual partners. Morgan and Claire both discussed how they would not want anyone in their area to know about their abortion:

> You know it's no different from why I don't like why I wouldn't just openly tell people. Like it's not, it doesn't matter how I feel about it. What are the repercussions for my actions? How is that going to socially affect me in a town where everyone knows everyone and last names are important and. Basically it's like your future. [Morgan]

> **Claire:** When I did get pregnant, I didn't tell anybody, because I knew what I was going to do. So I didn't want anybody in the town to know, because I didn't want them to hate me for, you know, my own decision.
> **Olivia:** Why? Why would? Why would they hate you?
> **Claire:** Oh, because with like religion stuff: [mockingly] 'Oh, you can't have an abortion! nehnehneh'.

Both Morgan and Claire felt that sharing their abortion would have negative repercussions for them. Although rural areas of the US are heterogenous, anti-abortion attitudes are correlated to Republican political affiliation and religious service attendance (Smith et al., 2022) which are in turn correlated with rurality (Gimpel et al., 2020; PRRI and ACP, 2022). The feeling that there would be social consequences for having their abortion be public knowledge was also shared by participants in Noonan et al.'s (2023) study in rural Australia.

However, with respect to anti-abortion attitudes, it was not just people in the community who participants did not want to disclose to but their families as well. Overall, these women told very few people about their abortion: 'Like I just knew it was not something that I could ever like, talk about, or people could know or anything I had to choose my support group very wisely' [Erin]. Some involved their

male partners and told a couple friends or family members, but only a select few were brought into the fold. In part, this was due to an awareness that certain people in their lives were Christian or Catholic and therefore would not approve of them terminating a pregnancy:

> His family is also very deep Christian. We have a very similar family background. So, you know, we, we've been pretty isolated from most of our families about it, uhm. I know his his mom is aware of it, but not, not in terms of abortion. We kind of had to sugarcoat it to make it known. [Lucy]

> I didn't- I didn't tell- I told one of my sisters who had also had abortions. She had an abortion prior and so I felt safe telling her what's actually pretty terrible is it I just learned about a month ago that she went ahead and told my entire Catholic family that I had an abortion so I just, yeah, huge betrayal. And it's really situation that I've just been avoiding for a while now. [Alice]

While Lucy was able to 'sugarcoat' [Lucy] the abortion, Alice faced the backlash and experienced the stigma that many participants feared with disclosing their abortion. Like Alice, some of the women disclosed their abortion to family members who did not end up being supportive. For example, Jenny had to disclose her abortion decision to her sister to solicit financial support which was then denied due to anti-abortion attitudes. Erin's mother became anti-abortion after getting involved with the political conspiracy theory and movement QAnon, which made Erin feel unable to share the abortion with her. Claire likewise received a negative reaction from her mother who she was forced to disclose to at a later date:

> **Claire:** Uhm, well at first she was mad that I didn't tell her.
> **Olivia:** That you didn't tell her? Not necessarily because of what it was?
> **Claire:** Well yeah, I didn't I didn't want her to tell him my grandparents because my grandparents are Christian. [annunciating each word] And. They. Would. Hate. Me. They are very Christian. My grandpa used to be a pastor, they like read the Bible every morning, they have sticky notes in them, I don't know, they're kind of crazy. I love them. Anyways. Uhm, I don't

think my mom told them because they never mentioned it since. And my
mom never mentioned it since that day.

Although Claire's mother later asked Claire if she was OK, her mother 'never
mentioned it' [Claire] again, reinforcing that abortion is something taboo that is not to
be spoken about. Abortion stigma, whether internalised, perceived, or experienced,
is not an exclusively rural phenomenon, but was something that most of the rural
women in this study discussed as shaping their abortion experience.

Despite the spectre or tangible presence of anti-abortion attitudes, these women
challenged the notion that abortion was something to feel bad about or something
that should be difficult to access. Millar reminds us that stigma 'is not a set of static
beliefs, values or attributes but a dynamic process that is always contested' (2020,
p.6). Abortion 'does not stigmatise individuals equally even within specific
geographical locations, and stigmatising discourses and subject positions appear
alongside those that are normalising and non-stigmatising' (Millar, 2020, p.6).

In this section, I demonstrated that rurality is a broader construct than its spatial
isolation, with respect to abortion access, insofar as anti-abortion attitudes shaped
abortion decision-making by patients. Living in rural areas not only situated people at
generally greater distances to traditional in-clinic abortion care, but also exposed
participants to anti-abortion attitudes in the community, particularly among
Christians, Catholics, and those on the right. They had strong perceptions that these
attitudes were common where they lived. As such, some participants internalised
stigma throughout the process despite simultaneous feelings of relief and decision-
rightness. Participants anticipated potential negative reactions to their abortion and
therefore disclosed their abortion to nobody or to a limited number of people. In
some cases, these anticipated reactions came to fruition with family members
expressing discomfort with their abortion. However, my participants' experiences of
abortion were not entirely defined by the anti-abortion attitudes in their community:
they disclosed their abortion to a few people who they could trust and had support
networks that accompanied them throughout their abortion. Where stigma was
internalised, perceived, or experienced, participants contested the validity and power

of this stigma—in part through their participation in this research project. Abortion stigma presented barriers to holistic and truly *caring* abortion care by making patients fearful of who they could tell or not.

4.7 | 'Sidewalk counselling' as a barrier to care

In this section, I extend the discussion set out in section 4.6 to discuss the anti-abortion strategy of 'sidewalk counselling' outside of abortion clinics. After the *Roe v. Wade* (1973) legalised abortion, anti-abortion activists turned their attention from national policy to state policy and individual clinics in their quest to eliminate abortion, and so-called 'sidewalk counselling' emerged as a key for anti-abortion activists. Under the guise of protecting women and children, this practice involves showing women and pregnant people grotesque and medically inaccurate signs and brochures as well as yelling a wide range of insults and aggrandising statements at them as they attempt to enter an abortion-providing facility, whether they are there for an abortion or not. While 'sidewalk counselling' falls under protected speech when it occurs on public property, protestors are not permitted physically block people from entering a clinic.

The term sidewalk counselling 'belies the cruelty of the practice' (Rankin, 2022, p.125), which is ultimately a public shaming. Clinic escorts, who usher patients into the clinic, help to protect women and pregnant people from the negative psychological effects of these protests (Cozzarelli and Major, 1994; Rankin, 2022). Although higher amounts of exposure to protestors may lead to negative emotion at the clinic, qualitative interviews with women encountering protestors reveal that it does not affect how individuals feel following the abortion (Foster, 2020). The presence of protestors at abortion clinics has become normalised and women and pregnant people must endure their presence to access care.

'Sidewalk counselling' constitutes a form of 'sonic patriarchy', which Lentjes (2018) defines as 'the domination of a sound world in gendered ways' in which the hearer is subject to non-consensual listening, such as in the case of mansplaining or catcalling (Lentjes, Alterman and Arey, 2020). The practice has shaped our imagination of abortion access in traditional clinical settings. The Patient Educator from JTP I spoke

with explained that 'in our current world going to clinic in person can be really, I think, traumatizing, like, protestors outside like hassling you […] just feeling the stigma in the clinic' [Patient Educator]. The abortion clinic is a site of active shaming by anti-abortion protestors and by anti-abortion restrictions that shape the clinical interaction, through mandatory counselling and ultrasounds. Participants understood that going to an abortion clinic would in some way *make them feel bad*. For Jenny and Helen, this anxious anticipation of the abortion clinic was based upon what they understood to be true, rather than prior experience:

> I think... not that I would have had a problem going to a clinic. I think the email they send you about the protesters and people being there to escort you in, like that kind of like, oh my gosh, like what am I getting into? So that was kind of like uh, like, I didn't have to worry about that kind of stuff. But... I don't know, like if someone were to call me and be like, Hey, can you walk me in? Like I'd go do it. Like, you know, I'm not... I don't know. I I know it would have bothered me like a little bit at least in the moment, but I think... I don't know, it was just, it's not their business, not their body like whether they agree with me or don't or whatever, you know, they're pro or against or whatever it is like, every person is different, every everything is always different. Like nothing is the same. [Jenny]

> Uhm, well it was better than going to a clinic. Just 'cause I didn't have to like deal with everybody's like remarks or like, everyone's making me, you know, just make you feel like shit. So I got to avoid all that. Not they would or that they do but that I I was, I was worried about that. [Helen]

While Helen worried about potential judgment from health care workers, Jenny specifically worried about protestors. She rationalised that it was 'not their business' and 'not their body' but that it would probably bother her 'a little bit at least in the moment' [Jenny]. Laura was certainly bothered by protestors when she previously went for an abortion:

Oh, yeah, you know, they're all over the place, but they're not allowed to so many feet in front of you. Because if they are, you just have to tell the, the front desk and they send out guards and stuff so that they're still there. And they're yelling, you know, and it was really nice that they saw had the windows cracked, you know, I had a friend go with me because I was like, I can't do this on my own. I'm scared. And, you know, she's like, just roll the windows up. Just, you know, as they put, they can still hear she knows you're doing what's best for you and your family. Let it go. But yeah, they're still there. And they're yelling and saying, you know, you're killing your baby, you're a piece of shit, like, and I'm just like, I'm just gonna plug my ears and close my eyes because she was driving. [Laura]

Laura needed a friend to accompany her to this abortion because she was afraid of the protestors. The fear of these protestors and the emotional and physical threats of harm are palpable for any person needing an abortion. Lucy's experience with previously seeking an in-clinic abortion starkly illustrates this:

But with those situations, you face hordes of protesters. I went through an abortion in Minnesota and it was horrific, not not in terms of the procedure, but just in the sheer amount of protesters and the amount of slander and obscenity that gets thrown at you, regardless of whether you're getting an actual abortion or not there are people that go to these clinics just to get the pill, so why, why did they hurl insults at everyone that goes through that door? […] It's it's gotten so bad in some areas that my significant other actually had a couple of the armed members of his family escort me there, because it's, it's so frightening. It is so unpredictable and even though, you know, legal action can be taken if they cross one step onto that property, it doesn't take away that feeling of fear. […] That angry mob is right outside the door, and you don't know what they're gonna do. They banged on the windows of my truck when I drove away. […] They can be violent. They can be just downright mean. They say things that hit you in places that you don't expect. They're holding signs that are offensive and demeaning and and

screaming over fences. I don't need to hear you hollering Bible scripture at me, sir. I don't need that. Put your bullhorn away. [Lucy]

Both Laura and Lucy knew that the protestors could not cross certain lines, but that it does not take away the fear, uncertainty, or the potential psychological impact of insults. Lucy points to the extreme discomfort that she experienced in facing these protestors and how those effects lingered after the visual and aural stimulation was removed. She is now a member of a Facebook group where people share their experiences of abortion for those seeking to learn more about the procedure and arranging care. Lucy mentioned the shock people experience when encountering protestors, just like she did previously:

> They're absolutely stunned, because they think it's gonna be you know, normal and safe and just like going to any other doctor appointment and then they're faced with this massive group of people and there's, you know, there's escorts that have to walk them into the building and it's, it's frightening. It can scare people away. [Lucy]

Laura, Lucy, and the experience of people Lucy has come into contact with demonstrate just how widespread the practice of 'sidewalk counselling' is in the US. Their experiences are not extreme, but emblematic of the normalised presence of and lack of accountability for these protestors at abortion clinics in the US and, increasingly, abroad. Because the presence of protestors is so normalised and largely unchallenged by government, Lucy thought that being harassed was 'just, you know, *the price you had to pay*' [Lucy, emphasis mine] to access abortion care.

In this section, I demonstrated that 'sidewalk counselling' serves as a physical, visual, and aural barrier to abortion care, which patients have and would have endured but makes getting an abortion a difficult experience. Like CPCs, 'sidewalk counselling' is a key spatial strategy of the anti-abortion movement. Also like CPCs, these protests receive tacit acceptance by most municipal, county, and state governments which do not limit their activities on the basis of free speech. That clinic escorts have arisen in response to these protests is a boon for patient safety and

security, but also signals their normalisation. 'Sidewalk counselling' is an everyday practice that has been accepted as par-for-the-course in accessing abortion care. It is widely known that protestors are outside of abortion clinics and participants feared the effect that they might have even when assured of and determined to carry out their decision. This fear was not unfounded, as demonstrated through the stories of participants who had endured these throngs of protestors previously. The presence of protestors was questioned but expected as an emotional toll to pay to access care. 'Sidewalk counselling' is a spatial strategy that poses a literal barrier to abortion care as well as a visual and aural barrier that seeks to shame women for their reproductive autonomy and decision-making.

4.8 | Cost of abortion and related costs as barriers to care

In this section, I detail what an abortion costs in monetary terms and how people afford it (or not). Abortion is expensive and unaffordable for many who need it. Evidence from a national survey of abortion patients shows that three-quarters of are low-income and nearly 50% earn incomes below the federal poverty level (Jerman, Jones and Onda, 2016). Most patients report having an abortion because they cannot afford a child or to have another child (Foster, 2020), but to prevent that future cost of children they must pay for an abortion up-front and out-of-pocket. In 2020, the median out-of-pocket charge adjusted for inflation was US$537 for a medication abortion (ranging from US$490 and to US$730), US$515 for a first-trimester procedural abortion (ranging from US$492 to US$755), and US$1,014 for a second-trimester procedural abortion (ranging from US$725 to US$1,500) (Upadhyay et al., 2022).

The cost of an abortion can be considered a 'catastrophic health expenditure' in 39 of 50 states, meaning that the out-of-pocket cost for abortion is above 40% of median monthly household income, according to analysis by Zuniga, Thompson and Blanchard (2020). The cost of the procedure exceeds or even doubles household non-subsistence income in 18 of those states. In the Turnaway Study, out-of-pocket costs for an abortion were one-third of monthly income for more than a third of women in the first trimester of pregnancy and more than half of women in the second trimester (Foster, 2020). The cost of procedure must also be considered alongside

logistical costs, such as travel, accommodation, and childcare, which are often ignored in estimates of out-of-pocket expenditure for health care (PAHO, 2021).

Rural and poor women suffer the most 'without the economic resources that would permit them to traverse the very substantial distances—sometimes hundreds of miles—to reach an abortion provider' (Pruitt and Vanegas, 2014, p.80). Rural women earn less than rural men, are less likely to own a car, and are less likely to be in stable housing (Pruitt, 2007). Their status as one of the poorest populations in the US 'magnifies their physical insecurity and denies them credibility and resources' (Pruitt, 2007, p.439). Needing to raise money for abortion and related costs significantly delays care which can in turn increase the costs required (Upadhyay et al., 2014). Due to anti-abortion restrictions, there is limited government support or insurance coverage to reduce the financial impact of accessing abortion care and, in 2020, just 80% of clinics accepted some form of insurance (Upadhyay et al., 2022).

Multiple participants confirmed that abortion was expensive, and that the cost of the abortion was a significant factor in deciding where to access abortion care. Although still costing a few hundred dollars out-of-pocket, JTP was 'the cheapest option' [Claire]:

> Pretty much JTP and Planned Parenthood were my two options and for like a medical abortion pill for Planned Parenthood, it was like $600-$800 and I was just like, with JTP that goes $350 $375 which is like doable, but like the $600 wasn't, and that was what was like, for me like I just didn't have that money at the time. [Erin]

Erin could not afford an abortion at Planned Parenthood, which cost upwards of US$800 out-of-pocket. There is little time to raise money if you do not have it because you need the abortion now. As such, women and pregnant people will go to extremes to afford their abortions. If they are low-income or do not have access to private insurance that covers abortion—which is not common and may even be prohibited by state law—they will forgo basic necessities, delay or miss paying bills, use credit cards, take out payday or private loans, and pawn personal belongings to

self-fund their abortions (Dennis and Blanchard, 2013; Dennis, Manski and Blanchard, 2014; Jones, Upadhyay and Weitz, 2013; Nickerson, Manski and Dennis, 2014). Lucy, for example, forewent bills to pay for the procedure:

> **Lucy:** Even even for me, I was lucky enough to be able to afford it at the time, but there I mean, I definitely had to forego other bills just to do it. […] Uhm, and, you know, just even even though there are, you know, resources out there, like the National Abortion Fund [sic][13] and and stuff like that, that takes a long time and that's if you're qualified.
> **Olivia:** Yeah. Yeah, I imagine some people don't quite qualify.
> **Lucy:** And that is frustrating. If somebody wants an abortion, it shouldn't it shouldn't be so many hoops to jump through, because it's not this, it's not this big, demonized process that everybody thinks. It's not. The life isn't viable yet. It doesn't, it doesn't count.

Lucy considers herself lucky to have been able to afford the abortion, even though it risked her financial security. Alice, likewise, was grateful to be able to afford the abortion out-of-pocket, but reflects on a time in her life when she would not have been able to:

> And, uh, the low to no cost [of the telemedicine abortion] too. I'm lucky, I'm I'm fortunate that, you know, I'm in a place in my life now that I could-, I could easily afford it, uhm, but, you know, I went through a really nasty divorce a few years ago, and I was really, really poor. And I mean, you know, I mean, I didn't have furniture, I could barely afford my apartment. I was working two jobs. […] And I don't know, I don't know what what I would have been able to do or I certainly could not have asked my family for money to help out with that. So, uhm, ideally, it would be low or no cost and available to everybody. [Alice]

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[13] Lucy is likely referring to the National Abortion Federation's Hotline Fund, which provides limited needs-based financial support to abortion seekers. I discuss abortion funds further on in this section.

Both Alice and Lucy reflect on the near impossibility of affording abortion if you are low-income. This is compounded by the additional costs of travel, including food, lodging, lost wages, and childcare which can incur with in-person abortion care. For example, Jones et al. (2013) found that more than two-thirds of their sample of 600 patients incurred transportation expenses averaging US$44, one-quarter reported almost US$200 in lost wages, and a small proportion spent an average of US$57 for childcare and US$140 on hotels or related costs.

Facing these costs, many ask for financial support from others to help pay for it. For example, in the Turnaway Study, approximately 32% of patients had financial assistance from the man involved in the pregnancy, 11% from family member(s), and 3% from friend(s) (Jones, Upadhyay and Weitz, 2013). However, it may not be possible to ask for financial support from friends and family if they are anti-abortion. Jenny, who is low-income, asked for help in paying for the abortion from her sister but she withdrew her support after learning what it was for:

> I don't know, like my, it's not like a conversation, any kind of even like any conversation like I've ever had with my parents, so they don't even know about it. And my sister, I had to borrow, I was gonna borrow some money from her before I found out the financial aid or help or whatever. So she was gonna give me some money for it, and then [pause] Somehow I think I got a text reminder about something about JTP. She was like, Is this what this is for? I didn't want to say no, but I didn't want to say yeah. I was like, I was just kinda quiet. And she was like, well I'm- I don't support that. I'm not giving you money. And then, like that was a whole deal. [Jenny]

Jenny's story underscores that the barrier of cost can result in forced or unwanted disclosure. Seeking external assistance may require unwanted disclosure, as '[i]t can be difficult to protect your privacy when you have to beg for money' (Foster, 2020, p.70). Unwanted disclosure not only implicates privacy but the safety and security of women and pregnant people in situations of violence or abuse (Woo, Fine and Goetzl, 2005).

It is important to share this aspect of abortion cost to highlight the critically important role abortion funds play in facilitating abortion care through the no-strings attached, non-judgemental provision of direct funding. JTP works with regional and national abortion funds and practical support organisations to support patients in affording the procedure and any related travel costs. Most abortion funds are funded by individual donor contributions in the community and they allocate their limited funding to abortion seekers based upon income. It is not just the cost of the procedure but all associated costs that can be particularly burdensome, including travel, accommodation, food, lost wages, childcare, etc. Abortion funds and practical support organisations therefore try to meet the tremendous financial need for abortion (Ely et al., 2017), which is rapidly increasing after the *Dobbs* decision.

Four patients of JTP received financial support from abortion funds, which covered part or all of the cost of the abortion pills: Helen, Jenny, Diana, and Elena. Helen, Jenny, and Elena were unemployed, Helen on benefits and Jenny and Elena without benefits, and therefore could not afford the cost of an abortion. Diana and Elena not only faced the cost of the procedure but also the cost of a return domestic flight from Texas to Colorado. Round-trip flights cost around US$150 on a low-cost airline at the lower end, which is a huge expense for people on lower incomes. The necessity and cost of air travel underscores the airport as an important site of oppression and contestation vis-à-vis abortion restrictions (Calkin, 2019a; Freeman, 2020b) as well as the potential for abortion to be a catastrophic health expenditure (Zuniga, Thompson and Blanchard, 2020).

In this section, I demonstrated that cost is one of the primary barriers to abortion care and one that weighs significantly in decisions about where and how to access care. Abortion is an expensive medical procedure whose costs vary depending on method, gestational age, and clinic. In many states, neither public insurance (Medicaid) nor private insurance can pay for abortion, leaving few options for those on low incomes as the abortion must be paid for up-front and in full. The cost of the abortion is compounded by travel and related costs, which increase for those living at greater distances to an abortion clinic and disproportionately impact rural women and pregnant people. Participants were on varying levels of income which facilitated

and constrained their ability to pay for an abortion and therefore shaped their decision-making around which provider and which method. Some participants were able to pay for the abortion in full due to higher incomes, while those on lower incomes had to forgo bills or borrow money to pay for the procedure. Participants on the lowest incomes received financial support through an abortion fund which paid for the procedure in part or in full. The cost of an abortion and the time it takes to raise the money present significant barriers to care.

4.9 | 'Rural distance' as a barrier to care

In this section, I discuss how participants understood rurality and the notion of distance as a geographic barrier to care. Throughout this chapter, I have addressed a range of barriers to abortion care. These barriers are present in health geographies in different ways. While barriers like stigma and cost emerge especially for marginalised populations (Collins et al., 2016; Scott, 2022) and barriers like CPCs and 'sidewalk counselling' are particular to abortion care in the US (Hutchens, 2021; Lentjes, Alterman and Arey, 2020; Thomsen et al., 2022b, 2022a), distance is widely represented as a barrier to care for rural people and is even a 'trope' in discussions of mHealth (Cinnamon and Ronquillo, 2018). In abortion scholarship specifically, rurality is infrequently mentioned when discussing multiple barriers to care, or rurality is conflated with the geographic barrier of distance (for exceptions see Pruitt, 2007, 2008; Pruitt and Vanegas, 2014; Statz and Pruitt, 2019). Yet, as this chapter has demonstrated, distance is just one of several barriers imagined and anticipated by abortion-seekers in rural areas. Rural people are already isolated from a variety of services, including health care, and often drive long distances to access them. Travelling may in fact be preferable to accessing local care due to perceptions of quality and privacy. So, what then is distance to a rural person when it comes to abortion care?

For many rural women and pregnant people, that they must travel to access care is unsurprising. Because rural areas are generally more isolated, rural distance is a 'normal part of rural life' (Statz and Evers, 2020, p.5)—even a 'hallmark of rural life' (Pruitt, 2007, p.477). Distance, both in its material and immaterial forms, is 'deeply implicated in rural living' (Pruitt, 2008, p.365). Attention to distance across 'empty' or

vast landscapes '[become] a legal framing of its traversal, powerfully imbued with significance' (Statz and Pruitt, 2019, p.1120). However, rural distance is not a 'singular or inevitable spatial barrier' but a 'multifaceted dimension of accessing health care' (Statz and Evers, 2020, p.3). Indeed, rather than view rural distance as a tyrannical or 'inevitable component of health care deserts and a broader barrier to rural health care', distance is conceived by feminist legal geographers as a 'particularly dynamic lens through which view both the topological and relational workings of law' (Statz and Evers, 2020, p.2; Statz and Pruitt, 2019, p.1108).

'Rural' represents a diverse range of locations; while some respondents lived in towns of just a few hundred people, others lived in large towns at the centre of rural counties. Some had a degree of proximity to urban areas while others were 'in the middle of nowhere' [Morgan]. In line with research on gender and rurality, interviews revealed that rurality is not a monolith and that there are 'degrees of rural' [Morgan] within each state or within the US as a whole. However, despite the differences between where participants lived, there were common definitions of rurality. The first major commonality was distance to bigger towns and what their town has or does not have with respect to infrastructure and amenities:

> Well, I mean, like, there's no traffic, so, you know, there. I mean, like we have Wal-Mart, but we don't have anything else. Like there's no Target there's no malls of any sort. You know, there's just there isn't a lot of stuff right? There's no hockey rink, or concert venues or football teams or baseball teams or anything. There's nothing. [you have to] drive an hour and a half and like Sioux Falls is the closest town like big town to us. So I mean, that's an hour and a half pretty easily. [Beth]

> Two gas stations, a small little grocery store we lived at this uh cheap apartment. It wasn't terrible, but it wasn't my favorite place to live. […] I've mostly just lived in I don't know what I mean, the city I live in now is 20,000 people. I wouldn't call that very big. But it's a better sized than 2,000. [Claire]

So when I say rural, I mean like, literally there's nothing here. Like we joke like the kind of small town life where you don't have a gas station in town. You know you just have like bars and churches that's kind of where I live. The closest big town is 45 minutes away. And that that would be just I would quantify that as a big town. That is closest like real true urban area like the Twin Cities Minneapolis St. Paul is three and a half hours away. [Morgan]

So [town] has a population of about I think it's close to 45,000. Last I checked, but there's… There's still not a whole lot here. It's very, very residential. There's something that around here they call it a mall, but really, it's this strip of small businesses and like there's tax offices, a Walmart and some some factories littered around, but it's still not much. It's still very much that you feel like you're in the outskirts, even when you're in the heart of town. [Lucy]

Yeah, it's like a small town with. You don't really have anything but a grocery store and a lot of bars. And I'm not a drinker. So it's kind of like, I do my own thing. My own business. Yeah, there's a lot of hiking trails and a waterfall. Kind of nice. [Laura]

Participants understood where they lived—and rurality more broadly—as a place that is spatially isolated, sparsely populated, and lacking services, shops, or things to do. In terms of abortion access, however, rurality may not only signify these aspects but the 'large swathes of land' (Hennessy-Fiske, 2016) without an abortion clinic. This is how Susan, the Director of JTP's Board, defines rurality in the Midwest:

I am using the term rural too sometimes it really broadly because because of the way abortion services are provided. So, in there's there's clinics in Minnesota in Minneapolis, but and there's one small clinic in Duluth, but really, you know, anybody who's outside the Twin Cities is far more and most of Northwestern Wisconsin are really considered rural, even though they're not rural areas, you know what I mean? Because they have no access. And

so, in many ways we call those areas where all cities have 50,000 people were not really rural, but they just didn't have any access. [Susan]

Susan therefore defines rurality in terms of relative remoteness from an abortion clinic. She points out that most of Minnesota and most of Wisconsin are without access because of the concentration of abortion clinics in the eastern regions of both states. Both states are 'really big', and the clinics are 'so far away from the rest of the state' [Susan].

Participants discussed both the presence and absence of abortion clinics in the region (Thomsen et al., 2022a), noting where there were providers (especially Planned Parenthood) and where there were none. Beth, for example, says, 'Also, all of our Planned Parenthood, local branches were closed. It's been a really long time now. So I think like the closest Planned Parenthood is like two and a half hours away' [Beth]. Likewise, Erin was with her parents in western Wisconsin and recognised that where she lived in eastern Wisconsin 'they do have more resources for that kind of thing' [Erin]. The absence of abortion clinics was particularly acute in North Dakota and South Dakota which each had one abortion-providing facility prior to *Dobbs*:

> I would have had to go out of state we actually don't have any abortion clinics in our state. We have a Planned Parenthood don't do abortion. […] There was like, uhm, there, in the state over, in Minnesota, there is, uhm, a place where you can have abortions. But it it just it was just so much driving that way, because I'm more in the east part of North Dakota, we're kind of in the middle east. [Claire]

> Uhm, so they do have, I know of two health organizations here that do have like OBGYN and maternity wards and stuff like that, but if you're if we're talking about like, Planned Parenthood or you know, pregnancy, uhm, prevention, past anything that is, you know, the the IUD or the implant or the pill there's not a lot of resources here to closest, I think the only Planned

Parenthood type of organization is in Fargo and that's, I think that's a six hour drive from me. [Lucy]

These rural women knew that abortion clinics were few and far between in the region and that getting there would be a significant effort. Yet, from participants' responses which suggest that the driving to pick up the pills 'wasn't too bad' [Claire] (see Chapter 5), even when multiple hours each way, it appears that traversing such distances for health care and other things is part and parcel of the rural experience. When asked about anything surprising she has learned about rural patients since starting JTP, Dr Amaon said:

I think the thing that I think was maybe a little bit different than what I expected is for our urban patients. They were not willing to drive very far right, like 30 minutes was more than they wanted to drive, our rural patients were really, I guess, used to driving long periods of time for grocery shopping at Costco or whatever you need to do. So they were much more willing to drive a couple of hours for care, which I don't know was surprising to me. Because I was like, Well, I would just figure that, you know, they would want it as close just like anybody else but they were like, 'oh, no, I always drive'. [Dr Amaon]

Dr Amaon indicates that rural patients were accustomed to their spatial isolation and all that it entails. However, the necessity of traversing rural distance—and taking the time to do so—can compound existing inequalities and interact with the social structures of rural community to jeopardise privacy and reproductive choice. As Statz and Pruitt elaborate, 'an expanse of rural distance is at once a bridge, connecting a profoundly felt reality to largely invisible sociolegal and spatial vulnerabilities and to opportunities for mobilization' (2019, p.1116). Distance is a 'rich concept' (Simandan, 2016) that is a 'timely and compelling locus for social, spatial, and legal experience' (Statz and Pruitt, 2019, p.1108). It 'illuminates—and quite literally spans—embodied, performed, discursive and quantified understandings of law and space' (Statz and Pruitt, 2019, p.1108). Rural distance reveals the invisible intersectional realities of

rural women of colour, particularly Black, indigenous, and immigrant women, and young rural girls and women (Statz and Evers, 2020; Statz and Pruitt, 2019).

In this section, I demonstrated that participants expect to drive long distances to access abortion care because of both the spatial isolation of rural communities and the general lack of abortion clinics in the region. Rurality is heterogeneous but is frequently defined by a set of common characteristics, including spatial isolation and small populations. The rural women in my study also mentioned the lack of things to do and the lack of services available in their local area as markers of how rural their town was. As such, they frequently drove long distances and were used to doing so. Participants' routine driving distances combined with their knowledge that abortion clinics were limited in number in their state to make the prospect of abortion travel not especially unusual. Indeed, although 'rural distance' is a hallmark of rural life, distance is not an inevitable or insurmountable barrier to care. Rural distance was anticipated as a routine barrier because it is a barrier to other health care needs, even where the distances might be farther. As such, although distance is frequently understood to be the prevailing barrier to abortion care—and health care more broadly—for people in rural areas, that may not be how it is experienced. That is not to say that these travel distances are fair, but to underscore that defining geographic barriers to care solely in terms of distance limits our understanding of how rural women anticipate and contend with practical, socio-cultural, and financial issues alongside distance in their pursuit of an abortion.

4.10 | Discussion

At the start of this chapter, I suggested that the prevailing focus on travel distance or time as a quantifiable barrier to abortion care—a 'travel-to-abortion burden' framework—has reified the inevitability and primacy of this barrier for rural women and pregnant people and pigeonholed our understanding of geographic barriers as time-space phenomena. Although my spatial analysis in section 4.2 confirms that there is indeed a disproportionate travel-to-abortion burden on rural women and pregnant people, I was concerned with how my participants understood and navigated this potential burden when making the decision to have an abortion via telemedicine *rather than* in a brick-and-mortar clinic. This departs from previous work

which has measured how far and how long women travelled to the clinic where they had their abortion. Considering the abortion landscape, my participants decided to access remote care instead of travelling to a clinic. However, as I will detail in the following chapter, this did not mean that they were not travelling at all. Moreover, my analysis does not consider these potential distances in isolation but rather seeks to understand the burden of distance from the perspective of rural women.

As I describe in the previous section, the rural women in my study were used to driving long distances to access health care, among other things. Despite what we might glean from previous studies, travel distance was not the most important barrier to abortion care for them. While not ideal and often inconvenient, as I will explore further into in the next chapter, they did not necessarily mind travelling long distances to access abortion care because that was part-and-parcel of the rural experience. That being said, we can recognise that this perspective has been shaped by the reality of rural health inequalities which limit the amount of health care resources available in rural areas and lead to many worse health outcomes for people living in those areas. We might consider whether it is unjust to put rural people on the move to access care, where this is possible, rather than making material resources available in their local area. Likewise, we might also question whether telemedicine is an appropriate substitute for local care, as it is so often lauded as a solution to rural health care inequalities.

The implications of distance as a barrier to care are not dissimilar to the implications of my discussion in this chapter around abortion restrictions and bans as a barrier to care. While participants understood that certain states were more hostile to abortion and therefore abortion was less available, they did not necessarily view the law as a barrier in and of itself. Nevertheless, we know that abortion restrictions and bans shaped the spatial configuration of abortion care and limited where, when, how, and why participants could access abortion. The combination of spatial isolation and the law may have positioned telemedicine abortion as the only feasible option, meaning that true 'choice' was not possible in this context. Yet participants had to make their abortion decisions within the existing legal, material, and spatial context. As such, they did not conceive of distance (or the law) as an inevitable or primary barrier to

care, but just one among several factors shaped by rurality which affected their ability to access care and have a caring experience.

In some cases, these practical, socio-cultural, and financial barriers were imagined and anticipated and therefore evaded, while in other cases, they were encountered and eventually overcome. Anti-abortion forces, especially 'sidewalk counsellors', loomed as a serious threat to a caring experience. While CPCs may have muddied the waters of participants' Google searches for abortion care, the potential of encountering protestors was an important factor in deciding to have an abortion outside of a traditional clinical setting. But this did not mean that anti-abortion attitudes were entirely evaded. Rather, participants encountered and felt abortion stigma at different stages of their abortion decision and experience. Though abortion stigma was a difficult individualised experience, it was the practical and financial barriers that were perhaps the most important in shaping the ability of my participants to access care. Firstly, the limited number of clinics meant less availability and longer wait times. Secondly, the cost of the abortion was potentially a catastrophic health expenditure for women on low or no income.

These are structural factors representative of a neoliberalised and anti-abortion health care and political system which makes independent sexual and reproductive health clinics responsible for abortion care. Given these challenges, JTP attempts to reduce the burden of time and cost on abortion seekers. They offer a care pathway which means that they can be seen within a few days—even if shipping takes a couple weeks—and that is generally less expensive because of no clinic operating costs and the offer of abortion fund support by partner organisations. Telemedicine thus does not inherently fix the problems underpinning the abortion care crisis but helps individual people navigate extant barriers to abortion in this context.

By looking at this constellation of barriers that was imagined, anticipated, encountered, and overcome, we can understand how barriers not only limit access to and caring experiences of abortion but also affect decision-making away from traditional forms of abortion care. This study does not capture people who did not overcome barriers to abortion care, but it attempts to reveal the reality of

telemedicine abortion care pathways in a context marked by so many barriers to care. Telemedicine abortion is not as straightforward as it appears on the surface, as I will continue to unpack in Chapter 5.

4.11 | Conclusion

In this chapter I have identified the geographic barriers to abortion care for rural women and pregnant people in their own words. Previous studies have portrayed distance to nearest abortion clinic as the primary barrier for rural women and pregnant people in accessing abortion care. Thus, geography has been defined by its time-space features within the health care landscape, rather than as a lens for analysing how place shapes abortion journeys and experiences. My data challenges this understanding of rural distance as the sole or primary barrier to abortion care. While distances to nearest abortion clinic were great and the burden of distance may particularly affect rural women, participants understood rural distance as an everyday experience. They were used to driving and were willing or even preferred to do so to access quality and private health care. As I will elaborate in the next chapter, distance was not an insurmountable barrier to care, even where inconvenient, but was understood by participants to merit the effort for the other benefits that telemedical care pathways offered. Rural distance was one of several barriers that participants imagined and encountered. Abortion exceptionalism has led to restrictions and bans on abortion care, over-regulation of clinics, and the prevalence of CPCs and 'sidewalk counselling'. Anti-abortion sentiment aligns with these barriers and presents itself in the form of abortion stigma which participants anticipated and experienced in their rural communities. Whether a clinic had availability and how much the abortion cost were additional barriers that shaped the arrangement of and decision-making around care—issues which were navigated before getting in the car. This combination of barriers constrains affordable, timely, and local abortion care and the experience of non-judgmental, empowering, or holistic abortion care for rural women and pregnant people. In the following two chapters, I explore how these barriers are evaded and encountered on the way to care (Chapter 5) and in pursuit of a caring experience (Chapter 6).

5 | ABORTION ACCESS VIA TELEMEDICINE

5.1 | Introduction

Telemedicine has been understood as providing a 'spatial fix for a geographical problem' (Calkin, 2019b, p.27). In the case of abortion, telemedicine makes the abortion pills, rather than the abortion seeker, travel across the 'large swathes of land' (Hennessy-Fiske, 2016) without an abortion provider, thereby promising to alleviate the burden of accessing care, if not the total state refusal to provide abortion care. The scholarship on remote provision of abortion pills has largely focused on extra-legal distribution by feminist networks in restrictive settings like many Latin American countries. This literature also examines the legal distribution of these pills via 'partial' or 'full' telemedicine in formal health care systems. Extra-legal distribution of abortion pills has enabled abortion care to occur outside of the formal health care system and, by travelling across and within regulatory borders, the abortion pills offer an 'alternative spatial arrangement that moves access beyond clinic space' (Calkin, 2019b, p.24, 2021b; Calkin and Freeman, 2019). Legal distribution of abortion pills via telemedicine, on the other hand, has reaffirmed abortion as biomedical while offering degrees of contact between the abortion seeker and the 'clinic'.

While both strands of research on remote provision of abortion pills have emphasised that telemedicine can be a 'game changer' for those living at greater distances from abortion clinics (Sethna, 2019, p.9), neither fully accounts for the telemedical pathways offered by Just The Pill (JTP). JTP is a legal provider of abortion pills in four states: Colorado, Minnesota, Montana, and Wyoming. Given their regional and even national perspective of service provision, patients must live in or travel to these 'legal' states to have their remote appointment with the doctor and pick up their pills. This means that the care is not entirely 'virtual', but they are also not going to a brick-and-mortar abortion clinic, as they might in 'partial' telemedicine. In this case, both the abortion pills *and* abortion seeker are put on the move, thereby challenging understandings of remote provision of abortion pills wherein the abortion seeker waits at home for the pills to arrive. As such, in this chapter I demonstrate that telemedicine abortion may or *may not* reduce the burden of distance, but that it

may be more available, accessible, and affordable than other options thereby addressing practical and financial barriers to accessing abortion and serving to fray or sever the rope that tethers abortion care to the clinic. I therefore challenge the notion that telemedicine is the be-all-end-all solution of rural health care inequalities due to it traversing distance and sending pills to patients' doors.

Telemedicine is widely understood to reduce barriers to health care, particularly the burden of distance in rural areas. Due to its mobility and portability, Cinnamon and Ronquillo suggest that mHealth is understood to 'expand the reach of health-care services to previously underserved populations, including those in rural and remote regions, representing an important step toward universal health coverage' (2018, p.279). However, the authors note that the overcoming of geographical distance and barriers is a 'trope' invoked in discussions of mHealth (Cinnamon and Ronquillo, 2018). This is evident in numerous research studies examining the efficacy and impact of mHealth interventions, such as in the use of distance as a key measure of service delivery following telemedical interventions in abortion care (Grossman et al., 2012; Kohn et al., 2019, 2021). Overall, researchers understand that 'telemedicine offers patients an array of potential benefits' given barriers to accessing clinic-based care (Upadhyay and Grossman, 2019, p.352). While results from the TelAbortion study highlight that these 'substantial barriers' are multi-dimensional (Kerestes et al., 2021; Raymond et al., 2019), in line with my results in Chapter 4, there is still a prevailing emphasis on telemedicine as a solution to the barrier of rural distance and lack of in-person abortion providers. A recent paper even suggests that '[t]elemedicine abortion is the *best* way to ensure meaningful access because it provides an avenue for patients to obtain the procedure' (Hunt, 2023, p.359, emphasis mine). Yet rural women do not hold singular views on health care access and telemedicine (Clure et al., 2023; Statz and Evers, 2020), as my analysis demonstrates.

Geographical scholarship has also highlighted how abortion pills are comparatively cheap, undetectable, and easy to move (Calkin, 2023b), and that their distribution is an effective method for facilitating abortion access in restricted settings, particularly in Latin America and Ireland (Calkin and Freeman, 2019; Freeman, 2017; Freeman

and Rodríguez, 2022; Sheldon, 2016). The distribution of abortion pills represents an important multi-scalar strategy for feminists and activists seeking to ensure access to abortion (Calkin, 2019b). Calkin discusses the ways in which telemedicine can provide a 'technical workaround for the growing distances between American women and abortion providers' (2019b, p.27), and makes the case that telemedicine abortion restrictions serve to tether abortion care to the clinic (Calkin, 2021a, 2023b). Although Calkin mentions that, '[s]ome people use virtual private networks to disguise their physical location when requesting pills from out-of-state providers, post office boxes in border towns to collect pills, or mail-forwarding services to ship pills via abortion-friendly states' use of 'post office boxes in border towns to collect pills', this is framed under the notion that '[w]here people cannot move, the medications are moved instead' (2023a, p.64).

Departing empirically from this work, my analysis in this chapter demonstrates that both people *and* medications are moving—and moving significant distances—in the pursuit of accessing a legal abortion, even with the use of 'virtual' telemedicine services. Thus, in tracing the labourious process by which abortion seekers obtain the abortion pills, my analysis in this chapter complicates the notion that telemedicine is necessarily the 'best' option.

In this chapter, I address the second research question for this project: to determine whether telemedicine addresses geographic barriers to abortion care for rural women and pregnant people, in their own words and from the perspective of providers. As I demonstrated in the previous chapter, patients of JTP lived upwards of five and a half hours from their nearest abortion provider, and greater distances particularly affected those in rural and remote counties and states. I also demonstrate that there were other practical, social, cultural, and financial barriers to abortion care that 'create an intricate series of obstacles, each entangled with the other' which may prove to be 'an insurmountable hurdle, even before the issue of travel distance or time arises' (Gomez, 2016, p.56). Extending the analysis in Chapter 4, in this Chapter I dig further into the distance, practical, and financial barriers presented barriers to *accessing* an abortion (while social and cultural barriers presented barriers to the abortion *experience*, as I will explore in Chapter 6).

I argue that abortion seekers are often just as likely to cross borders for telemedicine care and therefore it cannot be assumed to be a panacea for rural health inequality. Distance is still occurring as a barrier to care for women living in states without legal telemedicine, alongside practical and financial barriers, but the burden may be reduced or mitigated through other benefits of this particular telemedical care pathway. In effect, telemedicine abortion is not innovative for its use of mHealth technologies or 'virtual' care. Telemedicine abortion simply uses a mobile phone for calling or texting, and the self-management of abortion with pills has long been demonstrated to be safe, effective and acceptable to both patients and providers (Aiken et al., 2021b; Cleland and Smith, 2015; Gatter, Cleland and Nucatola, 2015). Rather, telemedicine abortion is innovative for the way providers and patients have co-created strategies for access using telemedicine in the face of state control— even where those strategies are reactive and maintain a degree of burden on the abortion seeker.

As each participant terminated their pregnancies, we know that these barriers were ultimately surmountable. But how? And how can we think more clearly about the practices of care required in healthcare to attain health support, advice, and resources? Findings from my research demonstrate that, in this context, telemedicine is not necessarily a 'game changer' for eliminating the barrier of distance to an abortion clinic, because abortion seekers are still travelling. Moreover, like clinic-based care, telemedicine abortion is vulnerable to state intervention, reliant on place-based infrastructure, including ICT, mail, and transportation, and situated within a privatised health care system. However, telemedicine pushes abortion care into new spatial patterns that challenge the re-territorialisation of abortion care. Telemedicine uses multi-scalar strategies to facilitate abortion access which makes abortion care more convenient irrespective of the burden of distance.

5.1.1 | Context of chapter: JTP and abortion provision in the United States
Abortion exceptionalism and stigma have combined with the market-based and often religiously-dominated health care system to create a limited number of free-standing abortion clinics that provide the majority of abortion care in the US. Until 2020, the

most common abortion method was the procedural or 'surgical' abortion performed by clinicians in an abortion clinic (Jones et al., 2022). For medication abortion, the mifepristone was prescribed, dispensed, and taken at the clinic and the misoprostol prescribed and dispensed for home use. Telemedicine abortion options had been explored but in these cases the patient was still in the abortion clinic and the provider was remotely connected into the room (Grindlay and Grossman, 2017; Grossman et al., 2012). Under an Investigational New Drug application with the Food and Drug Administration (FDA), the TelAbortion Study was the first to provide a telemedicine abortion in which the patient and the provider were both remote. However, they still required a number of in-person tests for the patient at laboratories or radiology offices (Raymond et al., 2019). They also stopped recruiting for their study in mid-2017 (ibid.). It was not until 2020, following the FDA rule change on the in-person dispensation requirement for mifepristone, that we saw the creation of fully remote telemedicine abortion services—with no physical facility presence—that required no in-person visits to an abortion clinic or other medical facility.

JTP was the first of these new services to be certified by National Abortion Federation (NAF). Other fully remote telemedicine services were created around the same time or soon after, including Hey Jane and Abortion on Demand. The key difference is that JTP is not-for-profit and relies on donations and grants whereas Hey Jane and Abortion on Demand are companies—the former being funded by venture capital. Other providers who had a physical facility presence began to offer full telemedicine services as part of their regular provision, such as Whole Woman's Health and Choix. JTP has no physical clinic presence but is the first abortion provider to launch mobile abortion clinics. Each of these providers, including JTP, works with abortion funds to facilitate access for low-income patients or patients who are travelling.

In addition to these abortion providers who are regulated by the US health care system, there are other options for accessing abortion pills remotely. Individuals can order pills from Aid Access, from an online pharmacy, or through the black market. The former two options exist in a legally grey area but have a wider geographic reach than any of the full telemedicine providers or brick-and-mortar clinics, because

they will send pills to you regardless of where you live. JTP, and providers like them, can only send pills to the states where they are registered to provide care and telemedicine abortion is legal. As such, the extra-legal options of Aid Access and online pharmacies might necessarily be considered more 'activist' because they are aiding and abetting abortion irrespective of the law.

Ultimately, JTP is trying to comply with the law to ensure that they can remain in operation while also advocating for reproductive justice and rights as well as trying to meet patients where they are, both literally and figuratively, through the provision of full and cross-border telemedicine abortion. As I describe in this chapter, this means that patients are still encountering barriers to care but that telemedicine abortion is nevertheless their preferred option.

5.1.2 | Structure of chapter

This chapter is structured around three aspects of the telemedicine abortion process with JTP: 1) finding and contacting JTP, 2) having appointment with the doctor, and 3) acquiring the pills. This structure enables me to show how telemedicine abortion consists of multiple pathways that are constrained by state laws, reliant upon place-based infrastructure, and situated within a privatised health care system. By walking you through the process of how abortion care is accessed in these ways, I can explore to what degree telemedicine abortion is addressing geographic barriers to abortion care as identified in Chapter 4.

In section 5.2, I detail how patients find out about and then contact JTP. I demonstrate that the discovery of medication abortion and telemedicine abortion served to disrupt the anticipation of the burdensome abortion journey. In section 5.3, I explain how and where abortion seekers have their appointment with JTP. I demonstrate that the promises of telemedicine are not fully realised in cross-border telemedicine abortion services.

In section 5.4, I describe how patients of JTP acquire the abortion pills, which occurs in three main ways: 1) 'full' telemedicine for residents of states where telemedicine abortion is legal, 2) cross-border telemedicine for residents of states where

telemedicine abortion is illegal who must travel twice to where telemedicine abortion is legal to have their appointment and pick up pills, and 3) mobile clinic for (primarily) residents of states where (telemedicine) abortion is illegal who must travel once to where (telemedicine) abortion is legal to have their appointment and pick up pills. In section 5.5, I discuss the implications of this chapter with respect to the purpose and potential of telemedicine abortion and extend the discussion of 'choice' from Chapter 4. I demonstrate that there are geographic inequalities in the telemedicine abortion care pathway.

5.2 | Finding and contacting JTP

In this section, I detail how patients find out about and then contact JTP. Women and pregnant people find and contact JTP because they need an abortion, but they may not have known about either medication abortion or telemedicine abortion prior to their experience. Abortion with pills now constitutes more than half of all abortions in the United States (Jones et al., 2022). However, film and television overwhelmingly depict abortion as in-clinic surgical procedures (Herold and Sisson, 2019), and when medication abortion is depicted it may inaccurately be shown to be ineffective in terminating a pregnancy (Engle and Freeman, 2022). Relatedly, Sisson and Kimport (2016) suggest that abortions in non-medical spaces are frequently portrayed as unsafe. These popular culture representations of abortion may contribute to an overall lack of knowledge about abortion with pills.

Although evidence on medication abortion knowledge is sparse, a recent study by KFF (the Kaiser Family Foundation)—a non-profit organisation focused on health policy research—found that just over one-third of women of reproductive age had heard of mifepristone or medication abortion (Kirzinger et al., 2020). This is likely to have changed since COVID-19 and actions by abortion activists following the *Dobbs* decision, but it is nevertheless a startling statistic and one that aligns with some of my respondents' experiences. While Jenny and Laura had previously had an abortion with pills and both Morgan and Alice were aware of the possibility, other respondents were not. In researching their options for pregnancy termination, they found out about medication abortion:

I actually had found out through Google, that that medicine was an option. I didn't actually know that you could do it that way. Like, Oh, wow. Well, this is just this is a game changer […] I need to get this. [Claire]

Yeah. I didn't even know that you could get like the pills and bring them home and all that, I didn't they were doing that, so. And then I started looking into things. [Helen]

These quotes from Claire and Helen highlight that many first-time abortion seekers are unaware of the option of a medication abortion. Prior to doing research online, they understood that an abortion required going to a clinic for a 'surgical' procedure and that this would be difficult due to the multi-dimensional barriers of distance, practicality, time, and finance (see Chapter 4). In the lack of knowledge about medication abortion, there is a kind of representational mobilities—the meanings associated with mobilities which shape and are shaped by mobility across space and society (Schurr, 2019)—which is discursively constituted through ideologies of the 'clinic' (Calkin, Freeman and Moore, 2022). The anticipation, capacity, and potential of travelling to the clinic is found 'in the dreaming of, planning for, or fear of mobility' (Leivestad, 2016, p. 143). By imagining what barriers they will have to overcome to get an abortion, participants embarked on mental journeys in which they are mobile, cross borders, and 'make mobility possible where it does not seem to be the case' (Cangià and Zittoun, 2020, p.645). These imagined geographies of abortion, in which care is centred on the clinic, elide the alternative mobilities which abortion geographers have shown through their work on abortion pills, including telemedicine abortion.

Amongst both those who had heard of medication abortion and those who had not, there was limited knowledge of telemedicine abortion. Prior to the Food and Drug Administration's decision to allow the mailing of mifepristone, telemedicine abortion had been practiced to some degree in the United States but required the dispensing of mifepristone in an abortion clinic before an individual could complete the abortion at home with misoprostol. In Iowa and Alaska, for example, telemedicine occurred *in* an abortion clinic with a physician remotely supervising the dispensing and

swallowing of mifepristone (Grindlay and Grossman, 2017; Grossman et al., 2012). The Gynuity Project's TelAbortion Study, on the other hand, was allowed to send mifepristone by mail under a new drug application but required patients to get in-person tests (Raymond et al., 2019).

Abortions outside of biomedical spaces were often depicted as unsafe (Sisson and Kimport, 2016), though evidence produced from these and other initiatives overseas demonstrated that medication abortion and self-managed abortion were safe, effective, and acceptable to both abortion-seekers and providers (Aiken et al., 2021b; Cleland and Smith, 2015; Gatter, Cleland and Nucatola, 2015). It was not until 2020 and 2021 that 'no-touch' or 'direct-to-patient' telemedicine abortion providers like JTP were able to operate. There is not yet evidence with respect to knowledge of telemedicine abortion options following the FDA rule change. Among my participants who were aware of medication abortion prior to needing it themselves, they had a vague idea of telemedicine abortion but had not considered it to be an option accessible to them:

> I knew it existed. And I knew I would have access to it, but I just didn't know who it would be located through, you know, like? […] If I can't find access in Minnesota doesn't mean I can't find access in another state, because it's telehealth. I don't need to be in the same location. So I know, so I knew it existed. I just did not know I could find one literally in Minnesota who would meet me at Walmart, you know? [Morgan]

> [My friend] was like Did you look into like, telemedicine. Is that possible? And I said, Well, I'm pretty sure that telemedicine abortion is illegal in South Dakota. She said, What about, you know, having it mailed to like, an address in Minnesota or something, I have a friend who maybe we could help you help you. And so then I kind of looked into it. [Alice]

Even where participants were aware of alternative care pathways, this knowledge was contextualised within the 'patchwork of laws' (Calkin, 2019b, p.23) restricting abortion. In their minds, mHealth was not accessible specifically because it was for

abortion. This underscores the tension between 'abortion exceptionalism' and the promises of mHealth to solve rural health inequalities. Combined with lack of knowledge about abortion pills, the fact that abortion is understood to be different to other health care led participants to be surprised about the possibility of telemedicine abortion:

> Uhm, it went through this long rabbit hole, searching for abortion availability and then, you know, going to all the sites of the state surrounding me and trying to find something like that. And then this little ad popped up. It was it was just a very small it wasn't an ad it was just a Google search results […] I don't even remember the exact terms that was I using, but it was, you know, JTP. You know, get abortion medication sent to you and I was like, "No, no way. No way. That's an option." [Laura]

> Took a pregnancy test and sure enough, three tests later, all of them are positive and I'm freaking out, because I know the kind of state that I live in. So I was frantically Googling and just trying to figure out like, Where can I go? What can I do? Because I didn't I didn't even know that telemedicine was an option for this kind of thing and then I found it and it was just this huge aha moment of okay, I can handle that, that I can do. [Lucy]

> Yeah, I kind of just clicked on it and wasn't sure like if it was really like true or if it was something I could really just do at home myself. I was kind of surprised. When I read a little bit further on it and realized that that's really what happens, I I figured I would try to see if it would work or if I could get 'em, if I could do it. I just kind of clicked on the different links or words on the website and got information and it actually worked. I was gonna say that I was like really, I was actually really surprised you could even do that […] I didn't know that there was such a service to do it at home yourself like that. [Helen]

Discovering telemedicine and JTP immediately changed the mental journey participants had been constructing in their minds in which they would have to go to

the clinic to access care. As we will see throughout this chapter and the next, participants 'measure their actual […] experiences against the backdrop of these imaginary geographies' thereby shaping their 'actual embodied experiences of mobility' (Schurr, 2019, p.110).

On the other hand, once Claire found out about medication abortion, she thought, 'Okay, you gotta be able to buy [the pills] online, right?'. This points to the temporal context in which participants researched their options wherein there has been an increase in use of online pharmacies to fill prescriptions alongside the proliferation of an 'Internet of Things' in health care, even prior to COVID-19 (Habibzadeh et al., 2020; Yang et al., 2021). After looking into telemedicine abortion and contacting JTP, Claire said, 'it seemed like a perfect option and it's gonna work out so I went that I went through that route'.

On the JTP website (justthepill.com), an individual can select the menu option or scroll down to 'Make an Appointment'. Under this tab, potential patients select from two options: 1) that they live in or can travel to Colorado, Minnesota, Montana, or Wyoming or 2) that they live in another state and cannot travel. In the latter case, they are directed to the National Abortion Federation or Aid Access for options in their area. In the former case, they are taken to another page to watch a four-minute video called 'Healthcare at Home' (Figure 5.2a) before proceeding.

This video starts by mentioning that JTP works with abortion funds that can provide financial assistance for abortion care if needed. It then mentions that they will fill out forms after watching the video and that they can choose whether they want to talk with a Patient Educator. It also reminds potential patients that medication abortion is most effective up to 10-weeks from the first day of their last menstrual period (LMP) with a visual explaining how to calculate LMP. After this, the video walks potential patients through the process of having an abortion with JTP, including obtaining and taking the pills, how to monitor the effects and when to get in touch with further questions or concerns.

Underneath the video there are two options for proceeding:

- 'I'm ready to receive my medication.'
- 'I still have questions. I would like to speak to a patient educator.'

If they are ready to receive their medication, potential patients are taken to a page that prompts them to, again, watch the Healthcare at Home video. After confirming that they have watched the video, potential patients then fill out their personal details and sign two consent forms through a HIPPA-compliant online form. If they still have questions or would like to speak to a Patient Educator, potential patients are taken to a page to fill out their contact details and preferred contact method (phone call, text message, email) so that a Patient Educator can reach out to them directly.

The Patient Educator said that most of their contact with patients is via text on Google Voice, which Dr Amaon elaborates upon:

> And I will say the only thing that has changed but that was not necessarily with Montana and Wyoming, but just for patients' comfort and request is we started to do our patient education in the very beginning for over the phone, but our patients really liked texts [… At the] height of COVID then, their kids were at home, they were homeschooling, they were trying to work and they were like, I can't take, you know, two phone calls. It's much easier to just text

back and forth […] So patient education happens via text, which people have been very appreciative of. [Dr Amaon]

This assessment by Dr Amaon relates to research on the use of text message interventions in abortion care. In various aspects of the care process, text messaging can reduce anxiety and emotional stress as well as ensure preparedness for bleeding, pain and potential side effects, and is often preferable to in-person visits (Bracken et al., 2014; Constant et al., 2014; de Tolly and Constant, 2014). The Patient Educator describes how JTP implements 'patient education' over the phone or via text message:

> Yeah, so we talk to patients, they submit, uhm, submission forms - like, uh, appointment requests, I guess, - and we go through that, and then reach out to them, to them individually, and tell them about like the process of JTP and how to get the medication and we also talk to them about, like taking the medication. If they have questions, we answer that, uhm, then we schedule their appointments and we do the payments - so we we tell them how to do their payment. And then, yeah, just answering any questions that they have. And the questions really vary widely from like, asking for tracking package tracking information, or like asking about the what kind of like, symptoms they'll experience from taking medication, or like some people talk about the decision and like not being sure about the decision. [Patient Educator]

As the Patient Educator explains, their role is responsible for organising appointments with the doctor and responding to questions from patients. This approach to patient-centred care may lead to more 'unscheduled communications' (Wiebe et al., 2020) with JTP. However, JTP is trying to provide a more holistic form of abortion care that reduces the burden on the patient. Their mHealth service does not entail additional 'work to make telemedicine work' (Nicolini, 2006) because it is not run *in addition* to clinic-based care but *in place of* clinic-based care.

Moreover, this approach of being available to answer any and all questions is part of what of makes 'full' telemedicine abortion acceptable and desirable, according to

recent research on the extra-legal provider Aid Access and on telemedicine abortion services in Australia, the US, the UK, and France (Aiken et al., 2018; Atay et al., 2021; Godfrey et al., 2021; Ireland, Belton and Doran, 2020; Madera et al., 2022). Coming into and remaining in contact with JTP throughout the process of the abortion assuaged fears about potential scams and shipping delays as well as built trust so that patients felt that the experience was 'more than just a transaction' (Madera et al., 2022, p.5). They not only received practical support but also emotional; communication was 'compassionate, caring, and individualized' (ibid.). This personal touch was important given the multi-dimensional barriers abortion seekers faced within a context of multiple marginalization and stigmatised and stratified health care.

In this section, I demonstrated that the discovery of medication abortion and telemedicine abortion served to disrupt the anticipation of the burdensome abortion journey. Participants had varied knowledge of abortion methods and care pathways, despite the prevalence of medication abortion today. Their anticipation of travelling to the clinic and encountering barriers to care highlights an imagined geography of abortion in which patients must move from A (their home) to B (the clinic) to obtain an abortion—a form of horizontal mobility which may be differentially available based upon geographical and social location. As such, participants were surprised by both the possibility of using pills to terminate a pregnancy and of acquiring and taking those pills without a clinical visit. Some thought that the use of mHealth for abortion would be possible because a lot of health care takes place online, while others thought that it would not be possible because abortion is exceptionalised in state regulations. JTP offered an alternative journey to abortion care which evaded in-personal clinical visits while also providing holistic support for abortion care. Abortion seekers viewed telemedicine abortion as a 'game changer' because it was perceived to reduce anticipated barriers to care that would be encountered on their journey to the clinic, including but not limited to distance, by displacing care from the clinic entirely.

5.3 | Having an appointment with JTP

In this section, I explain how and where abortion seekers have their appointment with JTP. After potential patients find and contact JTP, the Patient Educators assess a person's gestational age and their eligibility for medication abortion and determine their location, because the telemedicine care pathway differs depending on where they live. With respect to the initial appointment, this must take place in one of the states in which JTP is registered to provide abortion care—Colorado, Minnesota, Montana, or Wyoming—which is why the website contact form asks whether they live in or can travel to these states.

Although they must have a phone or video consultation with the doctor while physically located in these states, speaking with the doctor is the first medical contact of the care process—JTP's model of abortion care does not require in-clinic tests of any kind prior to prescribing the abortion pills. This is the 'no-touch' or 'direct-to-patient' model wherein abortion providers do not test for pregnancy or gestational age prior to the provision of the medication abortion regimen. Instead, the model relies on patients to confirm that they are pregnant and indicate their gestational age without the confirmation of a medical provider using a pelvic examination or ultrasound. As Raymond et al. explain, '[t]hese examinations may require substantial resources and time, they are uncomfortable, and they must be performed by personnel with specialized skills and equipment' (2018, p.293). Using self-reported date of last menstrual period (LMP) to determine gestational age, for those with regular menstrual cycles, is efficient and effective (Upadhyay and Grossman, 2019). Evidence indicates that ultrasound testing is not necessary for successful early medication abortion and that nine out of 10 women can accurately date their LMP (Blanchard et al., 2007; Raymond et al., 2018).

Tests prior to an abortion are also for determining risk of ectopic pregnancy, a phenomenon in which the pregnancy gets lodged in the fallopian tubes and requires surgical intervention. There are particular risk factors, such as a patient who is unable to date LMP, is uncertain about period regularity, had abdominal or pelvic pain and vaginal bleeding or spotting, had an intrauterine device in place when the pregnancy was conceived, had a previous ectopic pregnancy, or had surgery or damage to their Fallopian tubes (Aiken et al., 2021b). Although there may be a risk

of underreporting gestational age to obtain assistance (Gomperts et al., 2008), warnings about risk with later gestational age can be provided to patients. Moreover, the risk of undiagnosed ectopic pregnancy is not higher with medication abortion use (Shannon et al., 2004).

JTP does not assume that patients understand what LMP is. Their 'Healthcare at Home' video offers a visual guide to dating their pregnancy and the doctor can assist over the phone. However, that patients must determine gestational age raises some questions about the responsibility for care. For instance, abortion providers can date pregnancies through ultrasound testing and we might ask whether they should be doing this. However, this entirely defeats the purpose of telemedical care as it would require an in-person visit. Moreover, these clinical encounters are not neutral experiences in the context of pregnancy criminalisation and abortion stigma. At the same time, we might ask whether patients should then be made responsible for their own abortion care. 'Self-care' can be empowering but it might also be a necessity given the pressures of an un-caring health care system. In this case, however, patients receive support from JTP before, during and after the abortion.

Before the abortion but after gestational age and eligibility for medication abortion, ectopic pregnancy risk, and location are determined, Patient Educators schedule the telemedicine consultation with the doctor:

> So, uhm, once all of that information is collected, their gestational age makes sense based on their LMP [last menstrual period]. So the Patient Educators have red flags, and then they get put on my schedule then I do my pre-visit planning on the night before I look over all my patients see if there's anything we're missing. There's normally like a 10 to 15 minute appointment when they're talking to me on the phone. [Dr Amaon]

For this call to fully comply with the law, patients must be physically located in Colorado, Minnesota, Montana, or Wyoming. For patients who are resident in these states, this might take place in the comfort of their home, as it did for Beth (Minnesota), Helen (Montana), and Morgan (Minnesota). For patients who are non-

residents, they must travel to these states as my other eight participants who lived in North Dakota (Claire, Jenny, Lucy), South Dakota (Alice), Texas (Diana, Elena), and Wisconsin (Erin, Laura) had to.

These participants drove (or flew, in the case of Diana and Elena) across state borders to make a phone call. They had to find a safe place to park as well as adequate mobile phone connection or WiFi—perhaps at a service station or a shopping plaza, but generally in their vehicle in a rather mundane place. Alice, for example, said, 'I drove I was on my lunch break and uhm, drove up to the border and sat in a parking lot in my car' [Alice]. The car represents a private place (Sheller, 2004) in which care can be accessed:

> Oh, it was awful. It was horrible. I was like, I was doing things with my parents or family or friends. And I just have to be like, 'Okay, I'm gonna go make a phone call for 30 minutes in the car'. When it's like hot out, and people are around and just like yeah, I was just. I felt like I was hiding something. And I felt like I was very alone like, it was super difficult for me to go through it. Yeah, I just felt like OK I'm just having like a doctors appointments over the phone and hiding from everyone. But it was overall, it was for the best. So, yeah. [Erin]

Erin's experience shows that the car may be a mundane and private place to access care but may also be a site of stigmatisation. The car as a conveyance to and site of care may produce 'automotive emotions' which shape and are shaped by bodies, technologies, and cultural practices (Engle and Freeman, 2022; Sheller, 2004). Vehicles, roads and routes play an important role in the abortion care landscape (Engle and Freeman, 2022; Freeman, 2020b), even where the abortion travel is not to and from a clinic. Through the necessity of private transportation to speak to the doctor (and to pick up pills), we further see that the landscape of care implicated in mHealth for abortion is neither just 'virtual' nor emplaced entirely in the home (Thompson, 2021).

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Even before patients speak to the doctor, we begin to see how this kind of cross-border telemedicine abortion has not yet been accounted for in mHealth or abortion geographies. While telemedicine is widely embraced in health care in the US, several state laws restrict it specifically and exclusively in the case of abortion (Calkin, 2021a). Mifepristone is more regulated than similar prescription drugs because it is an abortifacient (Cleland and Smith, 2015). There is a stark inequality of access to mHealth that is not about access to digital technology, but about state laws. For those living in states where telemedicine abortion is legal, mHealth can be as simple as having a remote consultation in your home and waiting for the medication to come in the mail (though abortion care remains restricted in other ways). For those living in states where it is not legal, it is not so simple.

Abortion geographies has particularly spoken to extra-legal remote provision of abortion pills in restricted settings. These options are available in the US and may require less effort on behalf of the abortion seeker. For example, Aid Access and Women on Web can effectively operate outside of this legal framework and move abortion pills with relative ease, even to states where (telemedicine) abortion is illegal (Calkin, 2021a, 2023b). People can also directly order abortion pills from online pharmacies (Calkin, 2023b), but this can be troubling for abortion seekers (Madera et al., 2022). Scholars have questioned to what degree these abortion care pathways constitute 'telemedicine' (Berro Pizzarossa and Nandagiri, 2021). They exist in a kind of liminal space of (il)licitness insofar as they are not a part of the formal health care system in the US, which is regulated by the government and where private or public insurance are used to pay for care, but they do prescribe and provide medically-approved abortion pills. JTP, on the other hand, like other fully telemedicine abortion providers (e.g. Hey Jane), is a part of the formal health care system and therefore must adhere to its legal and regulatory standards.

However, even within these standards, there is variation that abortion geographies might speak to. For example, JTP asks whether patients can travel to Colorado, Minnesota, Montana, and Wyoming, but does not ask patients to confirm their location. Abortion On Demand (n.d.), on the other hand, explains to patients that their 'software will confirm you are physically in the state you selected at the time of

your scheduled video appointment'. As this step is not required by law, it feels unnecessarily punitive given the immense difficulty of accessing abortion in the US. Nevertheless, it is a step that they have likely taken to protect themselves from potential prosecution and therefore ensure the sustainability of the organisation. Moreover, we know that abortion seekers and activists are creative and will find ways around this, such as through VPNs (Calkin, 2023a; Plan C, n.d.). At least one of my participants took the initial telemedicine consultation without travelling, and it is likely that others do the same. However, JTP is not concerned with enforcing the law but trusting their patients to make the decisions that are right for them.

Nevertheless, requiring abortion-seekers to step foot—or more likely, drive their car—across the border to access care underscores the simultaneously arbitrary, porous, and deterministic nature of state boundaries. States with telemedicine have different requirements for how the telemedicine consultation must take place. In Colorado, Minnesota, and Montana it can be on the phone while in Wyoming it must take place via video chat [Dr Amaon]. Both phone and video pose problems for care, as Dr Amaon describes:

> So yeah, I mean, I don't think I think it's just been more obvious. You know, the broadband internet was something that we knew was going to be an issue. In fact, even just cell coverage in certain parts of rural Wyoming and Montana, for instance, not necessarily I've noticed as much in Minnesota, but still some, you know, cell service is sometimes really hard and then, you know, we're Wyoming technically, the way our lawyers understood it is that making a physician-patient relationship needs to be over video because that's the standard of care in the state because they don't do a lot of telemedicine. And so, you know, you know, it is, you know, less than 50/50 that I get a video visit to work for somebody who's in Wyoming depending on their, you know, cell accesses or their broadband internet so that's just become way more like we knew that was an issue but like, we are seeing it. So it's definitely an issue. [Dr Amaon]

Dr Amaon's discussion of the particular requirements of Wyoming relate to wider discussions around telemedicine which suggest that prior relationships or face-to-face interactions are necessary for quality care (Hoffman, 2020). This, in turn, is related to the idea that proximity and pre-existing relationships are necessarily better for care, which geographers have contested (Hamper and Nash, 2021; Watson, Lupton and Michael, 2021). This has been a particular discussion with respect to whether rural populations are being short-changed in the push for telemedicine (Cutchin, 2002).

But the requirement of video calls is often more of a practical challenge, as Dr Amaon details. According to data from independent research organisation Broadband Now, Montana, South Dakota, and Wyoming are three of the worst states for internet coverage, prices and speeds (Cooper and Tanberk, 2021). Mobile phone coverage is a bit better, but significant areas of the western states are not covered by either voice or data by the four largest carriers in the US (Federal Communications Commission, 2021). Perhaps it goes without saying that many of these gaps in service are in rural and remote areas of the US—the specific group of people that JTP is attempting to target. The question of whether telemedicine is a 'game changer' (Sethna, 2019, p.9) for those living in these areas certainly needs to consider ICT infrastructure. This is not just an issue for people in their homes but also for those on the move: 'and, you know, they're driving somewhere, kind of they're you know on the highway or maybe we get a different spot […] at one of the welcome centers that have WiFi or whatever' [Dr Amaon].

At this point, participants expressed some discontent which challenge both the promises of mHealth as convenient and reducing the burden of travel and the notion that resolving the 'digital divide' will necessarily improve rural health outcomes. Having to go to another state 'just to have a consultation phone call with the doctor […] and go back to pick it up, you know, when it came about a week and a half later' [Alice], was seen as very inconvenient by participants. Laura said, 'that's the only sucky part was that you had to be in Minnesota, which isn't far from [here] but I had to physically get into my car and drive just to talk to a doctor which you know, it worked out'. Their complaints call to mind my previous work on the 'abortion road

trip' in which a protagonist laments, 'all this way, all this money, for a five-minute procedure' (Engle and Freeman, 2022). However, as I will discuss in the next section, this was generally seen as more convenient than picking up the pills because, while both required presence in a different state, the telemedicine consultation required crossing the border rather than going to a specific location which may be further away. This underscores the tensions Thompson relays in an autoethnography of digital health care: '[m]y access to healthcare, however frustrating, is expanded significantly' (2021, p.4).

Once participants are physically located in the correct state and connect with JTP via phone or video chat, these 10-15 minute appointments are relatively straightforward. Dr Amaon reiterates this process:

> Like I said Wyoming is specific needs to be a video visit. If that doesn't work, we'll do it over the phone. Minnesota and Montana is a phone conversation. We kind of review your health history. We have a great little [Healthcare at Home] video that ED made […] So they've already seen that, uhm, and I'm just kind of making sure they understand how to take the medicine […] taking each pill, about our 24/7 call line, what are the reasons that we would want you to reach out, and then for Minnesota specific have to read that silly non-medically necessary 24-hour consent beforehand for everybody else they don't have to. [Dr Amaon]

The appointment described here is about providing patients with the information they need to successfully self-manage their abortion at home. Lucy explains, 'They asked me, you know all the typical health questions you know, "Have you-did you have a positive pregnancy test?" "How long has it been since your last period?" And, you know, it was it was very professional and but it was professional but compassionate' [Lucy]. Dr Amaon then ensures that patients understand the medication abortion process initially described in the Healthcare at Home video, as shown by Erin's experience: 'Yeah, definitely, like seems pretty simple, like kind of all of the same answers online and the instructions from Julie like, yeah, it was just a very, like

reinforced process for me. And yeah, so overall, like, Julie, she was, like very, very helpful, for sure' [Erin].

But Dr Amaon also mentions the requirement of mandatory counselling prior to patient's abortions, which was previously required by the state of Minnesota in order to dissuade abortion seekers (see for example Sonalkar et al., 2017). (Although mandatory counselling and waiting periods were present in the states participants lived in, it is the state in which they access care whose law is followed.) JTP attempts to safeguard participants by 'prefacing the script' with a phrase such as 'the state requires me to read the following…'; this is a 'practical strategy abortion providers employed to balance the obligation to comply with state law with personal and professional responsibilities to provide tailored care, emotional support, and serve the patient's best interests' (Buchbinder, 2016; Buchbinder et al., 2016, p.10). Unlike other forms of mHealth and remote abortion pill provision, telemedicine abortion providers serving out-of-state residents must grapple with restrictions on where, when, and how abortion access can take place.

In this section, I demonstrated that the promises of telemedicine are not fully realised in cross-border telemedicine abortion services. The model of 'no-touch' or 'direct-to-patient' telemedicine abortion does not require patients to have an ultrasound, pelvic examination, or other tests which would confirm and date their pregnancies. Instead, the model relies on self-reporting of gestational age based upon LMP, which is safe, effective, and acceptable. Patients are also not required to go to a clinic to speak with the doctor, but to speak with them over the phone or by video chat. While these initial aspects of the abortion care process align with other forms of mHealth and remote abortion pill provision, the difference in the care pathway emerges when we consider place: where is this care legally required to take place? Abortion seekers privileged enough to live in a state with legal telemedicine abortion can take the phone call wherever, while those who do not must get in the car, drive to another state, and park somewhere before taking the phone call (and then drive back). This creates not only a spatial inequality but also a temporal one—it takes time. Time and energy that must be spent before any interaction with the medical professional takes place. It also shapes an emerging landscape of abortion care wherein care is neither

entirely in the home nor the clinic. At this stage of accessing abortion via telemedicine, geographical inequalities emerge and shape patient experiences.

5.4 | Acquiring the abortion pills

In this section, I describe how patients of JTP acquire the abortion pills, which occurs in three main ways. As I have previously explained, the telemedicine care pathway differs depending on where they live. Just like the initial appointment, patients must acquire the pills in one of the states in which JTP is registered to provide abortion care: Colorado, Minnesota, Montana, or Wyoming. If they live in these states, the abortion pills can be mailed directly to them. If they do not, they must travel to these states to pick up the pills from the post office or from JTP's mobile clinic.

Of the 11 women I interviewed, just three were residents of the states in which JTP can directly ship the medication to your door: Beth, Morgan, and Helen. However, Beth did not need the pills because of an early miscarriage. Morgan had her appointment during the period in which mifepristone was re-restricted (January-April 2021) and therefore met up with JTP's temporary mobile clinic that operated in Minnesota, meaning her experience more closely aligns with the cross-border travel to acquire the pills.

It was only Helen who received pills at her door to subsequently terminate the pregnancy at home. As such, there is limited comparative analysis to be completed on the process of receiving abortion pills in the mail from JTP. Nevertheless, the vast majority of JTP's patients from 2020-2021 were resident in three states *with* legal telemedicine abortion services—Minnesota, Montana, and Wyoming—which is evident in my GIS analysis from Chapter 4. My participants, on the other hand, over-represented patients living in states *without* legal telemedicine.

Eight of the 11 women I interviewed lived in states where telemedicine abortion is illegal: Diana, Elena, Erin, Claire, Lucy, Laura, Alice, and Jenny. This meant that they had to travel across state lines to areas where telemedicine abortion is legal and JTP can therefore provide care. Erin, Laura, Alice, and Jenny drove to Minnesota and Claire and Lucy drove to Montana to pick up the abortion pills from a

post office. Morgan and Jenny, who had two abortions with JTP, drove to get pills from the temporary mobile clinic during January-April 2021, while Diana and Elena flew to Colorado to have their telemedicine appointment and receive the pills from JTP's current mobile clinic

5.4.1 | 'Full' telemedicine: abortion pills to your door

Just one of my 11 participants was able to receive the abortion pills to their door, as a resident of one of the four states JTP is registered to provide abortion care. 'Full' telemedicine, as defined by Parsons and Romanis (2021), is an abortion care pathway in which each aspect of the patient-provider interaction is done remotely. Unlike abortion pills acquired remotely through feminist networks or online pharmacies, 'full' telemedicine is situated within the formal health care system. Although Helen originally tried to make an appointment at an abortion clinic in Montana, she decided to go with JTP because 'it's just it's hard to get in with like scheduling, you know, the wait was really long and it was a matter of like driving there and driving back and all that' [Helen]. This underscores that the barriers faced were not just the distance to the abortion clinic but whether the clinic had any availability. As Helen is on a low-income and has caring responsibilities, the cost and convenience of the abortion pills was also a factor in her decision-making. Moreover, making comparisons with a previous surgical abortion in the southwest, Helen explained that it was 'just kind of like a less involved service […] it was just kind of matter of fact'. For her, it was 'just easier to do the JTP thing'.

5.4.2 | Cross-border telemedicine: abortion pills at the post office

If patients do not live in Colorado, Minnesota, Montana, or Wyoming, they must travel to these states to pick up the pills from the post office (or from JTP's mobile clinic, as I discuss in the next sub-section). Six of my 11 participants drove from their home states of North Dakota, South Dakota, and Wisconsin—where telemedicine abortion is illegal—to Minnesota and Montana for both their telemedicine consultation and to get their pills. The promise of telemedicine abortion to reduce if not eliminate the burden of travel distance to nearest abortion provider has thus not been fully realised. For abortion seekers who live in states without legal telemedicine abortion, they must engage cross-border travel not once but twice to access care, in

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some cases travelling as far as they would to go to a clinic in the first instance. Although extra-legal provision of abortion pills might preclude this movement by mobilising the medication rather than the person, within the formal health care system we can observe this serious and frustrating limitation of telemedicine abortion services. What is especially difficult is that patients may not understand why they have to jump through these hoops in order to access care:

> That's the only thing that sucked. It couldn't be delivered to a Wisconsin address and I'm like, really? So that was the only thing I have a complaint about is they couldn't deliver it to my home address. […] So, uhm, yeah, that's the only thing that I just I'm like, really? I I don't understand. I don't know the research of it. I don't understand why they can't deliver it to Wisconsin, like why do you have to do Minnesota? [Laura]

> And then because online I think it said something about the mail only. But they couldn't mail it to a North Dakota residence, I think. I think I had to go into Minnesota to get it or something with me having to go into Minnesota, then they could treat me but they couldn't treat me in North Dakota. [Jenny]

Although abortion providers, activists, and scholars are up-to-date with the latest developments and nuances in abortion law, it is unreasonable to expect the average person to be as well. Laura rightly points out that it the requirement of inter-state travel lacks sense. State borders are porous, meaning that pills and people can travel freely across them, but they also hold a discursive and material power which shape health inequalities on either side of the boundary.

While those who lived in towns near the border of Minnesota and Montana travelled fairly short distances, for others living in central areas of North Dakota, South Dakota, and Wisconsin it was a long journey. Alice, Laura, and Jenny lived in towns nearby the Minnesota border. Alice had about a 25-minute drive each way between South Dakota and Minnesota for both the telephone consultation and picking up the pills at the post office. She recognised that this placed her in a good position to access care: 'Well and I'm lucky too since we since I was so close to the border, but,

you know if I were living somewhere else in the state it would probably not have been feasible.' While a short distance, it was around Christmas time and the roads were 'very icy'.

To have the telephone consultation, Laura drove about 15-minutes from Wisconsin to Minnesota but later drove about an hour each way to her parents' house in Minnesota to pick up the pills (rather than at the post office). While 'inconvenient' [Laura], Laura explained that it was a shorter distance than making two trips to the Twin Cities, where she had previously had abortion care. Jenny also had about a short 10-minute drive each way between North Dakota and Minnesota for both the call and to pick up the pills. This was closer than the town she drove to further into Minnesota when she met JTP's temporary abortion clinic in January-April 2021. She compares the two, 'So I didn't have to drive all the way to [that town], but still had that "we can treat you if you're live in North Dakota but you have to come to Minnesota to receive it"' [Jenny].

For Erin, Claire, and Lucy, the other three participants who acquired the abortion pills from a post office across the border, the driving times were much greater because they did not live near the border. While Erin was initially at her parents' house near the Wisconsin-Minnesota border, after picking up the pills in Minnesota she drove straight home to eastern Wisconsin which was about a five-hour drive: 'I had time to read the instructions and prepare' [Erin]. Claire had a similar trip length to Erin from North Dakota to Montana and back for each trip: 'It was five and a half hours, so it wasn't too bad' [Claire]. Lucy also downplayed the length of her three-hour journeys between North Dakota and Montana: 'it was about an hour and a half to get to the town where I picked up the medicine and then an hour and a half back. And then that's it. That was it. I didn't have to do any more driving.' Like Lucy, Laura downplayed her hour-long journey into Minnesota by comparing it with her previous experience of accessing abortion care in Minnesota which involved two four-hour trips to the Twin Cities.

These three women drove a total of 6-10 hours to access abortion care—not to go to a clinic, but to speak on the phone to the doctor and then pick up the pills from the

post office. The acceptance of this burden was something mentioned by Marie at Midwest Access Coalition who talked about the 'resiliency' of Midwesterners:

> We have people, uhm, and I this isn't definitely like, unique to the Midwest, but the resilience of people that I happen to see because I'm from the Midwest and I focus on the Midwest, is it's astounding but it's also scary, like folks that are regularly they'll be working on getting the money for the procedure together and they're like, Okay, I have to have gas [?]. I have to be able to get there. And the folks that are paying on just sleeping in their car. And that, that like growing up in the Midwest, like Yeah, peop- like folks, it's, it's, I think, something that a lot of people don't cons- are willing to do or seeing what people are willing to do to access abortion care. And when that how people are stepping back and prioritizing, literally like base level comfort and safety for themselves, because they're like, oh, shoot, I need the money for the procedure. I need to figure out how to get there. But the other things that folks cast off or or are more No, like, oh, I should have this. Like how can I make it work is really really scary and terrifying. [Marie, MAC]

As Marie highlights, many women go to extreme lengths to ensure that they can terminate their pregnancies. Recent research has shown that many rural women are willing to travel farther distances to access 'better' care and, for various reasons, they may be unwilling to access closer options (Statz and Evers, 2020). Statz and Evers suggest that '[in] conjunction with the socio-spatial barriers rural women report, the interpersonal costs of physician shortages, insufficient payment models, and an increasingly stressed and limited health system create negative experiences that compound rural women's ability and willingness to seek care' (2020, p.5).

For example, Helen requires some specialist health care which is not available locally and therefore she must go to Idaho or Washington State; Beth finds the quality of care in her local hospital lacking and would prefers to drive two hours away for better care; and Morgan wants to maintain as much confidentiality as possible so uses mHealth for mental health services. Thus, it is not just the abortion care landscape in which rural women are navigating health care inequalities, but the

supposed solutions to the lack of abortion access are not necessarily available due to abortion exceptionalism. While Statz and Evers (2020) find that some rural women will forego health care due to perceptions about local care, that is not really an option for these women. Indeed, they are unwilling to continue their pregnancies to term and therefore willing to go to great lengths—literally and figuratively—to access abortion.

Marie also points to the dangerous nature of 'resilience' and, indeed, the concept of resilience has come under significant critique since its inception in the 1970s in environmental science. Resilience is ultimately concerned with contingency and uncertainty and the potential for 'coping' with these (O'Malley, 2010). The resilient subject may be created through (neo-)liberal logics or government 'buck-passing', but '[i]n either case, resilience redistributes responsibilities – and possibilities of blame' (Dunn Cavelty, Kaufmann and Kristensen, 2015, p.7). There are limited local options for abortion care in North Dakota, South Dakota, or Wisconsin because of anti-abortion government intervention, but the responsibility for obtaining care is the onus of the abortion-seeker—a private burden rather than a public responsibility (Brown, 2019b). While these women may be lauded as 'resilient' we must reveal why it is they must be resilient in the first place.

Understanding the state and federal governments' role in creating this uncaring context, JTP attempts to reduce the burden associated with travel as much as they can by finding the closest pick-up location over the border, whether that is a US Post Office, UPS, or FedEx:

> Uhm, no, they were they were actually really apologetic. They're like, "We're sorry. We can't ship it straight to you because of where you live, but we can find the closest place that you would be able to pick up" and they did they found a town that's just right across the border. It was super easy to get to, uhm […] they asked me where I was living and, you know, what place would be easier for me they gave me options on how to pick it up, when to pick it up, where to pick it up. There were they were great. [Lucy]

In Lucy's assessment of the arrangement of picking up the pills, she does not find fault with JTP but rather praises them for being 'great' [Lucy]. Indeed, despite the fact that the burden of travel distance is not solved through this iteration of telemedicine abortion, this did not mean that it was necessarily seen as entirely inconvenient by my participants.

The data reveals that there are degrees of inconvenience that factor into patients' selection and experience of telemedicine abortion. It underscores Kelly and Tuszynski's assessment that abortion seekers who are made to travel 'are reminded at each step of their journey that they are undeserving of medical care at home' (2016, p.26). Having to go to another state *just to* 'have a consultation phone call' [Alice]/'talk to the doctor' [Laura] was seen as inconvenient by participants, just as it was inconvenient to have to talk go back to pick up the pills rather than simply have them delivered to your home:

> Uhm, I I was kind of annoyed. Because, I mean, so I had to drive to [Minnesota] to talk on the phone, which is […] 15 minutes, OK, not a big deal. But… that I can handle. The inconvenience that it's not delivered to my own mailbox? That is… very inconvenient. Because, you know, my parents had they not been working, they would have, you know, drove here to drop it off. But they had to work and I wanted to go get it. So I had to take the day off of work to go drive down there and get my pill and drive home. [Laura]

Driving an hour into another state and back was understandably 'very inconvenient' for Laura. Nevertheless, Laura qualified this assessment by explaining that this process of acquiring the pills from JTP rather than at a brick-and-mortar clinic was 'just *more* convenient, being that I, you know, I work full time, I'm a single mom […] it's more convenient doing what I did, than going down to the clinic […] Because I only had to drive an hour, you know.' [Laura, emphasis mine]. Like Lucy, Laura pointed out the inconvenience of cross-border travel and the simultaneous convenience of this option in terms of time commitment and physical experience of an in-clinic procedure:

I mean, really, the only the only downside to the telemedicine thing is pretty much due to my location. Uhm, and because of having to go outside stateliness: go somewhere else, pick it up, come back. And the the shipping time. […] Uhm, but, you know, compared to that, and where I was living in Minnesota having to drive an hour to to get to the clinics, and then, you know, do the whole standard procedure of getting the the tests, the ultrasound, uhm… I am beyond happy that with telemedicine I didn't have to do another frickin' probe ultrasound those hurt so bad. [Lucy]

As Lucy explained, not going to an abortion clinic was a boon in favour of telemedicine even if the abortion clinic was theoretically closer than the state border and post office. Despite the burden of travel distance, involving two round-trip journeys across state lines, my participants saw JTP as the most convenient option to terminate their pregnancies because it was easier to pick up pills than go access care in a clinical settings, as Claire explains: 'But driving over the border to Montana, just to stop at a post office to pick up some medicine was a lot quicker to do. Cheaper, easier. I don't know, it just it was was a lot easier'.

One aspect of this process that can complicate matters is the length of time for the abortion pills to be shipped, as Lucy indicates above. Whereas with mobile abortion clinics the pills can be handed directly from provider to patient, with cross-border telemedicine abortion and 'full' telemedicine abortion, they have to be dispatched from an online pharmacy. In the latter case, they will come directly to your door while in the former, abortion seekers must pick the pills up at a residential address (as with Laura's parents) or at a courier collection point across state lines, such as the US Post Office, UPS, or FedEx.

While in Minnesota, JTP can offer a choice between services in Minnesota, options in their other states are more limited. In addition to Minnesota, the Californian mail-order pharmacy which uses FedEx is licensed to dispense to Wyoming and American Mail Order Pharmacy in Michigan which uses UPS is licensed to dispense in Montana [Dr Amaon]. Dr Amaon explains that, depending on where you're located one is better than the other or faster'. For these private services, they do general or

expedited shipping, which takes an average of two-seven days. However, if they are using the post office, it takes 'sometimes two weeks which is unfortunate'. Two weeks is a *long time*, when many individuals, particularly young people, do not discover they are pregnant until about 6-7 weeks gestation (Ralph et al., 2022), but must terminate their pregnancy before 10-11 weeks. The Patient Educator gave a recent example of how this has impacted their patients:

> But so I would say definitely from Minnesota, an issue for people in rural areas, is that they usually have to use the post office to uhm... [pause] Or like, people, I guess I should say people traveling from neighboring states that go to like pretty rural areas like over the border. They have to go to the post office to pick up the medication instead of like a FedEx or UPS center. And recently, for the past many months, the UPS or USPS has been so slow, and it's like really delayed, uhm, [to] pick up packages. So like today, I was just talking with someone who paid for expedited shipping, and it's already been a week and they haven't received it yet. And they were traveling to like a very small town on the border of Minnesota. And they're traveling from North Dakota, so. [Patient Educator]

As highlighted by the Patient Educator and Lucy, receiving things in the mail can be particularly slow in rural areas:

> Uhm, that's that's the problem with living out out here is that no matter what it is, no matter if it says two day shipping one day shipping overnight, it takes minimum four or five days. [..] Uhm, and if we have any type of like winter weather—which wasn't a factor, you know, at that time—but if if we have anything like that, you can expect it to be delayed by almost a week. [Lucy]

As such, JTP has started to move away from using the US Postal Service (USPS) because of these immense delays. These examples provide some nuance to discussions of the USPS as 'the largest abortion provider in America' (Facundo, 2022). Earlier this year, the USPS increased its delivery standards (i.e. the length of time for a package to be considered 'delivered') for first-class packages, which

includes prescription drug orders, especially if they are travelling long distances (such as from mail-order pharmacies to locations across the country) (Chappell, 2022). Moreover, pre-dating the COVID-19 pandemic, the USPS is chronically understaffed and the existing employees illegally overworked, contributing to delays (Heckman, 2022). While the USPS is indeed delivering more abortion pills than many other entities, it is not doing it timely—and abortion is a time-sensitive procedure for many reasons.

As they wait for the mail to arrive—to their home or to a designated point across the border—patients are pushed later and later in gestational age with serious implications for legality and embodied experiences of care. In effect, women and pregnant people are pregnant for longer than they want to be. Moreover, being at the beck and call of shipping notifications makes arranging the pick-up tricky, especially if you need to take time off work or arrange childcare. Lucy explains, 'We weren't sure you know, the the delivery date was gonna match up with the dates we had taken off, but we got really lucky' [Lucy]. Because the pills are coming from the US, shipping times were shorter than those with providers like Aid Access which could take from one to three weeks and even up to five (Madera et al., 2022).

The USPS has been called the 'hidden legal abortion provider' (Facundo, 2022), but they are no longer hidden. The US government has opined that the USPS can ship abortion pills to states with abortion bans (Gerstein and Ollstein, 2023). However, with the shared understanding in the US that abortion is controversial, picking up the abortion pills in small town post offices made these women nervous. However, the pills are discreetly packaged:

> I mean, it was a little like, I wasn't sure if. Like picking it up if the person knew like where they're coming from or whatever, but I didn't really care at that point. And uhm, yeah, I'm trying to like show my ID and there was just like this kind of young dude working and he handed it to me. I was like thanks. [Erin]

And I was just able to pick up the medicine in a little uh-, in a little shitty post office. But they did uh, they did get a little mad at me because they were like you can't send stuff if you don't live here. And I was like, Sorry, it's just a one time thing […] I I think they did check my ID just to make sure you know, it was me picking up a package with my name on it. [Claire]

They had no idea what it was. They they were none the wiser. They just saw that somebody else came to pick up a package and it was just another day. [Lucy]

No, I was really nervous. Uhm, I thought, I don't know what I thought, if I was, it was still in a in a rural town in Minnesota. Even though Minnesota is a more progressive state. Uhm, but, you know, the western Southwestern Minnesota is still very conservative and rural so I was afraid but, uhm, I think the packaging was discreet enough that they didn't ask any questions. [Alice]

These participants successfully picked up the pills despite concerns that they might be found out, though Claire shares that the staff were displeased with an non-state resident receiving mail there. Dr Amaon says that, 'you can have one or two issues with the post office, with people holding the mail. Well, you're not allowed to do that. But they, you know, it's just, they guess they thought something bad was in it'.

In effect, despite not being allowed to, if a postal worker who is anti-abortion suspects that a parcel contains abortion pills they may withhold the package. Government workers have a history of these forms of 'civil disobedience' against gender- and sex-based rights (a notorious example is Kim Davis [Diaz, 2022]), and we are increasingly seeing medical providers and others refusing to provide prescriptions that could be construed as abortifacient (Wedell and Gutiérrez, 2022). So, while there is not yet evidence that this is happening, it is certainly not outside of the realm of possibility.

JTP is moving towards private courier companies like UPS and FedEx to deliver pills, which may be more efficient and less interested in abortion politics. Either way,

both the public and commercial postal infrastructure has proven itself to be critical to abortion care. By sending abortion pills in the post, telemedicine abortion providers hope to reduce the burden of distance for abortion-seekers. But in this complex patchwork of abortion laws, abortion pills *and* patients—*and* providers—are being put on the move.

5.4.3 | Mobile clinic

If patients do not live in Colorado, Minnesota, Montana, or Wyoming, they can either travel to these states to pick up the pills from the post office, as described in the previous sub-section, or from JTP's mobile clinic. There have been two iterations of the mobile clinic to date. The first operated temporarily from January to April 2021 when the FDA re-restricted mifepristone and it was no longer possible to send the medication in the mail. They rented a small van and made multiple trips around the state of Minnesota to hand-deliver abortion pills to patients at a pre-arranged location. Morgan and Jenny both utilised this service at that time. The second iteration is currently operating in an undisclosed location in Colorado. One vehicle operates like a locker for medication abortion pill dispensing. The other vehicle has been retro-fitted to provide procedural abortions but is not currently in operation. In this case, the telemedicine consultation and pill pick up take place on the same day, meaning that one round-trip is required. Diana and Elena both utilised this service.

5.4.3.1 | Description

There are approximately 2,000 mobile health clinics in the US, which are considered an innovative health care delivery method, especially for serving rural and remote areas of the US which might otherwise not have access to local care (Malone et al., 2020; Yu et al., 2017). However, the mobile abortion clinic is entirely new and poses challenges that other mobile clinics would not. Given the history of violence against abortion providers in the US, as well as an uptake in laws permitting vigilantism for the crime of abortion, the mobile clinics have to operate under the radar. The requirement of discretion sharply contrasts with the 'unruly, unmappable, and ungovernable' mobile crisis pregnancy centers (CPCs) (Thomsen et al., 2022b), which can go anywhere and, pretty much, do and say anything in the service of their anti-abortion agenda. The mobile abortion clinics, while publicly unmappable, are

necessarily disciplined and governable so that they do not make themselves targets for harassment or withdrawal of their ability to practice medicine. Rather than being unruly and ungovernable by entering 'ban' states, they arrange and await the arrival of patients from out-of-state who must cross those borders to access care where it is legal.

For the temporary mobile abortion clinic, the Executive Director and Dr Amaon rented a small and non-descript RV. Dr Amaon said that they 'rented a few different make [sic] and models in the beginning', but eventually purchased a standard and ubiquitous Winnebago. Like that Winnebago, the two mobile abortion clinics that have launched in Colorado are entirely discreet on the outside. The Executive Director borrowed the phrase 'stealth camping' from Jessica Bruder, author of *Nomadland*, to describe the external appearance of the mobile abortion clinic: '[i]t's where you are right out in plain sight, but you equip your vehicle to look like you're not actually living in it' [Executive Director]. 'Stealth camping' or 'stealth parking' is a strategy to avoid harassment or interference by people or the police. Bruder explains that stealth parking was about 'blending into one's surroundings to avoid getting the dreaded "knock" of a police officer tapping on the door, a drunk pounding the walls, or passersby squinting through the windows, asking "Is someone living in there?"' (Bruder, 2017, p.143).

The mobile abortion clinics have different but related risks to those living in their vehicles. JTP is operating within the law in Colorado, but the legality of abortion has never prevented violence against abortion clinics or harassment of abortion-seekers. Speaking to me before the *Dobbs* decision, Susan explained:

> But I do worry about, yeah, I worry about it big time or, you know, wanting to go into certain areas with JTP and having to be always concerned about these other states where it's become where it's gonna become illegal. And these other states are, you know, really aggressive like Texas and turning people in and stuff like that. Yeah, I definitely worry about that and I worry about, you know, our doctors and, I mean, we just we just spent I don't know about like $50,000 on bulletproofing our mobile units too, so, you know, like

violence I'm yeah, I worry about for for the doctor and for patients and the country has a history of that, but... but in terms of like Roe v Wade, being overturned, yeah, that's that's really frightening because then we have to be really careful which states we can you know, we can prescribe medicine for and all that stuff. It will be really bad and I do worry about that. Yeah. [Susan]

That these mobile clinics must be bulletproofed demonstrates the real stakes of providing abortion care in the US. For safety of both patients and providers, the units must be stealthy in terms of appearance and location. Susan says, 'I think we are very undercover in a lot of ways. We have like signage that can be taken down and put back up and stuff like that' [Susan]. The idea is that passersby would just see an RV and have no way of knowing that abortions are being provided inside: 'so we have two vans [...] they're both pretty small and nondescript, pretty intentionally just kind of look like, uhm... if they were parked outside your home you think you were getting electrical work done or plumbing or something like that, so' [Executive Director]. The frequent movement of the clinics—likely on a weekly basis [Program Director]—will also afford a degree of protection. Susan explains,

Uhm, and so it's just gonna be about moving from place to place and never staying in one place for too long. And also, parking the vehicles really securely so that they can't be found [...] And, and I think we've talked about like all this stuff about you know, maybe being permanently located in a particular parking lot that you can get locked and stuff like that for the the you know, the vacuum aspiration procedures, the ones that are done in the in the mobile units, but you know, yeah, I mean, if people find out where we are and I don't know I mean, yes, who knows how far they'll go like driving this mobile unit through the states. [Susan]

The ability to be discreet and change location gives the mobile abortion clinics flexibility in maintaining the safety of patients and providers—a strategy that brick-and-mortar clinics cannot employ. However, though bulletproof, these mobile abortion clinics are not invulnerable. Susan also mentions the different requirements of the mobile clinics based upon the methods of abortion they will offer and how that

affects their safety concerns. The temporary mobile clinic in 2021 was not retrofitted to specifically meet the needs of an abortion provider, but the Colorado iterations have been. The manufacturer which JTP used was able to meet their needs without any qualms about facilitating a politicised form of health care:

> Mhm, so it was we used a mobile clinic manufacturer that we that was recommended to us. Uhm, one of our friends who does well care used this this mobile clinic manufacturer, and they're, they're just very accustomed to doing this for rural communities for things like dental health or colonoscopies or mammograms. These mobile clinic manufacturers are pretty be able to be flexible with with what your needs are. [Executive Director]

The mobile clinics are retrofitted by US-based manufacturers to meet the requirements for different forms of health care provision. JTP has two mobile abortion clinics in Colorado. Susan says, 'one is for procedures and one is for is like a locker with the medication abortion stuff' [Susan]. The Executive Director clarifies that both units are able to dispense the abortion pills while just one is equipped to provide surgical abortion procedures (Figure 5.4a), though it is not currently doing so. When it does, the latter will therefore be able to provide abortion in later gestational ages:

> Uhm, so in the mobile clinics, we're providing the procedural abortion to 12 weeks and starting off with just a local sedation. So it would definitely want you would definitely want to make sure that the patients that that's what they're looking for that they're not looking to be heavily sedated. And yeah, yeah, those are really the only I mean, we wouldn't treat someone that was you know, high risk for the medical procedure in a mobile clinic but even an outpatient clinic doesn't treat high risk patients, so. [Executive Director]

The Executive Director highlights what kind of abortion care can be provided in the mobile clinic. Due to the size of the unit, there is a procedure area but no waiting room or recovery room so they will only be able to have one surgical patient inside at any given time. They will partner with a community organisation to provide a 'waiting

room' during group travel situations [Program Director], which will be a key strategy to convey people in 'ban' states to the mobile units in Colorado.

Figure 5.4a | Drawing of the inside of JTP's mobile abortion clinic which will provide surgical abortions in Colorado (Image: JTP)

5.4.3.2 | Location

According to JTP, the purpose of the mobile abortion clinic is to meet abortion seekers where they are—or, at least, as close as they can. Their long-term aim was to raise money for permanent units, which they have been doing for about two years [Executive Director]. While it was originally their intention to do this in the state of Minnesota and provide full-spectrum reproductive health and primary care, the context of ongoing and forthcoming abortion restrictions in the United States led them to focus exclusively on abortion on the borders of 'ban' states:

> Yeah, I mean, I guess the way it's changed is we're looking at the national map instead of the state map, and whereas before we had the opportunity to look at remote rural communities, uhm... Now, we're thinking about things in terms of like, *big swaths of of land, like entire states where there won't be access*, uhm... and you know, originally it was, abortion was one component of just of reproductive justice that we were hoping to be able to encompass in our services, so. You know, the mobile clinics were always about improving health outcomes, uhm, for pregnant people and giving them

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options, and, so. Whereas our first, you know, our first mobile clinic was always intended to also provide pregnancy sup- support pregnancy dating, well, well, exams... now, we've had to focus exclusively on abortion, because that's just because it's just a completely different world than when we started. So that's, that's that was a hard really hard, uhm, decision to have to make that... that, you know, do we go deep, putting our roots down in Minnesota and just focus on all aspects of pregnancy support in Minnesota? Or, because we're the only ones that actually, that are doing mobile clinics, we're the only ones to take that first step. So many want to do it and talk about doing it, but we have them for abortion. You know, so what's our responsibility to take that to like a larger stage, uhm? And so I brought it to the board and it was their decision, you know, about it I think, I don't it was hard for them, but I think to a certain extent, it wasn't because it was just, you know, seeing what was going on in Texas, seeing that it wasn't going away, it wasn't going to be challenged in any way that would make a difference, it, you know, I feel like you've got to do something. [Executive Director, emphasis mine]

As the Executive Director says, they are broadening to a regional if not national perspective on abortion access and provision. Their goal to provide full-spectrum care is just 'postponed' [Executive Director]. For now, there is still a need for JTP's services—if not a greater need for their services than ever before. They are the only providers operating mobile abortion clinics at this time, something that the 2022 National Abortion Federation conference identified as a key strategy for the post-*Roe* context [Executive Director]. JTP's daily patient requests increased from 20-25 per day to more than 260 total in the three days following the leaked *Dobbs* decision (Pifer, 2022). When choosing a location for their mobile abortion clinics, JTP wanted to work in coordination with existing brick-and-mortar clinics:

I mean […] we want to go where, you know, where people don't have access. That's still our number one mission, you know, to go legally where we can, you know, so like on the Texas border, or, you know, and we're in and that gets really tricky because there are other providers there too. So we

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don't want to step on, on toes. But, uhm, yeah, that's still is our main, our main goal is to be there where people cannot get to the clinic. [Susan]

The state of Colorado was therefore a strategic geographical choice by JTP. Colorado is on the border of Oklahoma and not far from the Texas border—in the latter, abortion access has not been secured since SB8 went into effect (Arey et al., 2022), and in both states abortion is now banned after the overturning of *Roe* and *Casey*. JTP has been anticipating patients from these two states 'first and foremost' [Executive Director]. Colorado has also recently enshrined some abortion access into law, 'so that was one of the reasons it just seemed like a better place to start' [Executive Director]. Before launching their services, JTP worked to build connections within the state and in the 'ban' states which they are attempting to serve through their border work: 'We are talking to, just getting to know people, talking to the community, talking to supporters, local doulas and abortion funds and just getting to know Colorado' [Executive Director].

Another advantage for Colorado is that they do not have a physician-only law, which restricts the provision of abortion care to doctors. JTP has hired nurse practitioners to provide medication abortion care, which itself 'doesn't take very long to train on', though abortion aftercare and potential complications require more training [Dr Amaon]. For any procedural abortions requiring sedation, they will have an anaesthetist [Executive Director]. The clinicians will not be the only people working for the mobile abortion clinics. There will also be staff to drive the units, which require an electrical generator and are contracted for disposal of medical waste [Program Director]. Another key role is the travel coordinator. The Executive Director explains that the travel coordinator position was created to support Texas abortion funds who lack the capacity to serve the increased number of abortion-seekers. The travel coordinator will handle 'kind of the actual arrangement of logistics and travel and things like that, not the not paying for it, but the sort of like here's how to book a flight or you know, that kind of thing' [Executive Director]. They will also help patients to get their travel paid for through abortion funds. The travel coordinator is supported by the experience of individuals on JTP's board who work for abortion funds and practical support organisations.

To what extent are the mobile abortion clinics able to leverage mobility to ensure access to abortion care in this setting? The central premise of this strategy is for JTP to get *as close as they can* to states where abortion is banned to prevent 'a desert for care' [Executive Director] by reducing distance between areas where abortion is inaccessible and places where it is available. JTP emphasises that they have the 'flexibility' to do this, but practically speaking these mobile abortion clinics are not entirely flexible. As research on other mobile clinics has shown, these units may be able to change location, but they are not strictly 'mobile' insofar as they require access to electricity and medical waste disposal (Lehoux et al., 2008). Setting up these systems and connections with local partners, for safe places to park and a waiting room for group travel, took a significant amount of planning and effort by JTP. So, while the Executive Director says that they can 'move to another location' if law or need changes, this would take time. Their location remains static as they await the arrival of patients from a different state.

5.4.3.3 | Travel to

Whereas for the temporary mobile clinic in 2021 individual patients drove themselves to a pre-arranged location to meet JTP, for the current mobile clinic in Colorado many patients are travelling in groups from Texas, including my participants Diana and Elena. Just as abortion travel is 'not new' (Freeman, 2020a, p.897), neither is the third party organisation of abortion travel, including in groups. As Calkin (2023b) discusses in her book, in the 1990s there were at least 20 companies in Poland which operated as abortion referral and travel agencies. While the degree of involvement varied, some of these companies organised bus trips from Poland to neighbouring countries where Polish women could access abortion (Calkin, 2023b). In the United States, it has been feminist, non-profit organisations who have arranged and funded abortion travel within and between states. Dr Amaon told me that group travel—as opposed to individual travel—was piloted as an access strategy in response to SB8 in Texas by a local organisation. They obtained a discounted rate with a regional airline two-three weeks before the travel date, provided the names of 20 abortion-seekers and their 'buddies' 72 hours in advance, and the group then travelled to New Mexico for the abortion procedures and back in

the same day. Because JTP is targeting a similar group of patients in Texas and Oklahoma, they have utilised group airline travel to their mobile abortion clinics in Colorado.

Their goal is to work with local abortion funds and practical support organisations to fund and arrange travel for multiple patients at a time to travel to JTP's current location to receive their medication and return home the same day [Dr Amaon]. However, like picking up a package from the post office, to board intra-state transportation services like the Greyhound bus and domestic airlines, you need some form of identification. Moreover, buses in the southwest pass-through internal border checkpoints, while many people will have never flown before and do not have the 'comfort level' to arrive at and navigate an airport [Dr Amaon]. These potential barriers are not limited to travel for sexual and reproductive health, but applies to other forms of health care travel or medical tourism. Considering this, Dr Amaon explains that they are 'just looking at options' for how to get people to their clinics and back, safely, efficiently, and with care: 'So that's kind of the idea is what d- what does it look like?' [Dr Amaon].

Practically speaking, pre-abortion checks and post-abortion follow-up happen while the person is in their state of residence. The airport, plane, and coach which takes the group to the mobile clinic then acts as a kind of abortion clinic waiting room insofar as each person knows the others are having an abortion. On arrival, they are taken to a partner organisation to have their telemedicine consultation and then are dispensed the pills from the mobile clinic.

The experience of acquiring the pills from the mobile clinic differed between the Minnesota (2021) and Colorado (present) iterations. With respect to the Minnesota mobile clinic, in addition to the non-descript nature of the van, as discussed above, the locations in which patients met JTP were mundane, such as in the car parks of Starbucks, Dairy Queen, Wal-Mart, or libraries—places which were central in a town, off the highway, and easy to find for a quick stop to pick up abortion pills. These are banal, commercial places which every mid-sized town in the US contains. People live, work, and raise families around these places and are familiar with them. Yet,

because of the spatiality of abortion in the US, they are certainly not places associated with abortion care. JTP was not offering 'back-alley' abortions but was nevertheless dispensing abortion pills in a parking lot—outside of biomedical spaces. Because of these factors, Jenny expressed that she had been sceptical about whether the process was legitimate:

> It was like across the street in [town], just in the library […] in a random parking lot. And I was like, OK, this is where this is where stuff is gonna get weird. Like there's, and like it was like just like a regular old RV. Yeah. This is like, I was like whatever though, like all right. And, 'cause they didn't have anything on the van either it was a plain van […] We don't want to be seen or like don't want to draw attention to themselves. Like it wasn't a huge RV. [Jenny]

The 'plain van' used by JTP at once served as a stealth measure, which Jenny identifies, and as a visual representation of the dislocation of abortion care from the clinic. The mobile abortion clinic as a site of care disrupts the spatiality of abortion in different ways than the mobility of abortion pills through extra-legal channels. In a very tangible way, this provision strategy demonstrates that abortion need not be tethered to an abortion clinic. Not unrelatedly to this spatial transformation, Jenny expected the process of obtaining the abortion pills from JTP to be more arduous due to her prior understanding of abortion care:

> And then, I thought it was gonna be like a whole physical type, like having to do another pregnancy test or something like. But they they were very like, 'we will take your word for it', like not like that people would lie about it but like, they didn't want judge you, I guess is the best way of putting it. Because like everywhere else, they were like, well, you need to get a test. Like okay, but I have, like four at-home tests that are positive. And you just need a picture from like a doctor doctor at a medical center. I was like I can see that but, like that's kinda- not degrading but like... makes us feel like they don't believe you or like, I don't know, ashamed even. [Jenny]

Jenny was surprised to discover that JTP offered non-judgemental care. Her experience highlights that distrust of patients can be detrimental to care while trust can be beneficial. Indeed, Jenny was really worried about barriers to care even as she was reassured about the legitimacy of JTP's operation:

> But this is me and my two kids, and I was like, I cannot have another kid right now. Like there's no way. I'm not like struggling struggling, but I'm struggling. I was like […] I don't know, something bad's gonna happen if I have another kid right now. And they were like, 'No, we get it, that's what we're here for'. And then I went into the van and I think she asked like name, to see my ID, and then they had uhm like they had another nurse with them that would go sit with... 'cause I was like I'll have my kids can they come in or can they like? What what about that, like I don't have daycare? And they had another nurse that was in the car with a bag of like crayons and drawings and stuff to keep them occupied. [Jenny]

What is particularly striking is that JTP's mobile clinic was prepared for both childcare and abortion care. It is well-evidenced that the inability to get childcare can be a barrier to access (see for example Baum et al., 2016). As discussed in Chapter 4, children are often not allowed in abortion clinics and therefore abortion-seekers must arrange and often pay for childcare, in addition to procedure, travel, and lost-work costs—something that Jenny was experiencing prior to finding JTP. In rural areas, where formal childcare is limited and informal networks are relied upon, many women and pregnant people do not want to use their supports because that might prompt involuntary disclosure, which is particularly related to the burden of travel (Barr-Walker et al., 2019). For the mobile abortion clinics in Colorado, childcare is again an important part of their vision of abortion care. JTP has created an Amazon Wishlist for supporters to purchase donations from, which features colourful 'fidget' toys, colouring book reusable bags, and a mini watercolour paint set for children, alongside emergency contraceptives, gift cards for Uber, Southwest Airlines, and Safeway, self-care products, snacks, and disposable dishware.

Jenny's experience highlighted the potential for mobile clinics to serve patients in ways that reduce barriers they might face at the clinic, including childcare and also time:

> And I think I was less in there less than five minutes. And she asked me about the pregnancy test like, explained how to do the take the pills and like how it would feel, how it would like, how everything would happen. And then when you were expected to be like not back to normal but like, complete and like, I don't know, good to go, I guess. And then she said to me, if you have any questions, call, text, email […] And then she just like handed me the bag of stuff that she's like 'That's it!' And I was, that's when I was like, 'This this is it? Like this this is it?' She was like 'Yeah, this is it, it's that easy.' And I was like, I was like alright and that's when I asked her for a hug and on the way home. [Jenny]

Jenny was at the mobile clinic in the library car park for a short amount of time was on her way back to North Dakota. This contrasts rather significantly with the experience of patients going to the Colorado mobile clinic. Based upon my notes from interviews with Diana and Elena, it is evident that going to the mobile clinic took up a full day of their time. They departed on early morning flights, arrived to Denver, and were driven to the 'waiting room' operated by a partner of JTP. They told me that each of the women took turns having their telemedicine consultation in another room, which took a few hours. Then each was called outside to have the medication dispensed from the mobile clinic lockers. Once everyone had their medication, they could begin the return journey home. They were home later at night.

Although JTP's mobile clinic initiative is called 'Abortion Delivered', the fact that patients are engaging in cross-border travel to get to the mobile clinic calls into question to what degree it can really be considered 'mobile'. It is mobile in so far as the mobile clinic can be moved to a different location and, in fact, for safety concerns it may need to so. But it is not really using mobility in the service of reducing the burden on the patient. In this case, the provider and the pills wait for the patient to arrive—in effect replicating the stasis and movement attendant to a traditional brick-

and-mortar clinic abortion in which the patient travels to the clinic to have a procedure or receive the pills. Nevertheless, by situating itself in Colorado, JTP has made a strategic calculation in their regional and even national picture of abortion provision following the overturning of *Roe v. Wade* in 2022. Even while the mobile abortion clinic is not exactly meeting people where they are, insofar as it does not traverse the borders of 'ban' states to provide care, it is providing another desperately needed option to fill the demand left in the wake of abortion bans in Oklahoma and Texas, among others.

In this section, I demonstrated that there are geographic inequalities in the telemedicine abortion care pathway. I extended the analysis in section 5.3 to reiterate that telemedicine abortion does not necessarily reduce the burden of distance for rural abortion seekers. While the promises of mHealth and remote abortion pill provision may be realised for JTP patients in Colorado, Minnesota, Montana, and Wyoming, they fall short for patients in neighbouring states. In addition to travelling across state lines to speak with the doctor, they must also travel to pick up the abortion pills from the post office, by car, or JTP's mobile clinic, by plane. In some cases, this travel is just as far if not farther than they would have travelled to an abortion clinic. Nevertheless, although patients are still being put on the move to access care, the mobile clinic and telemedicine pathways offered by JTP were seen as more convenient and easier than going to the clinic. This underscores that distance is not in fact the primary barrier to abortion care for rural women and pregnant people, but that abortion care decisions are made with consideration of multiple barriers and understandings about health care and abortion.

5.5 | Discussion

In other contexts, the remote provision of abortion pills by feminist networks and activists can be described as a multi-scalar strategy for abortion access. I likewise said at the start of this chapter that cross-border telemedicine abortion in the US is innovative because providers and patients co-create strategies for abortion access in the face of state control. In the case of JTP, they enable patients who live in 'ban' states or states without legal telemedicine abortion to access this care pathway by getting both the pills and patients to the border with as little burden as possible. By

travelling across borders to access abortion care, JTP patients attempt to navigate and perhaps resist restrictive abortion laws and policies. However, there is a lingering question of whether cross-border telemedicine is a proactive strategy or a reactive strategy to facilitate abortion care, and whether this distinction matters given our current context. Strictly speaking, cross-border telemedicine abortion is only necessary because telemedicine abortion or abortion in general is prohibited in certain states. If full, direct-to-patient telemedicine abortion was available for my participants, as it is for most of JTP's patients, they would logically choose that option because cross-border telemedicine abortion required two roundtrips to another state. However, because it is not available, participants still consider this pathway to be comparatively more convenient than other options.

This raises further questions about choice and other abortion care options. In the previous chapter, I suggested that the combination of spatial isolation and the law may have positioned telemedicine abortion as the only feasible option for participants. This combination reduced the number of clinics and the availability of existing clinics and limited the circumstances under which a person could access abortion care. Within this abortion landscape, participants felt that telemedicine abortion was a 'game changer' and something that they could handle. Telemedicine abortion with JTP was thus presented in stark contrast to in-clinic care that was considered too far away, too expensive, too much effort, or too intimidating. While some participants specifically expressed that they did not want to go to a clinic or to have an aspiration abortion, others did not explicitly frame a medication or telemedicine abortion as their preferred choice at the time, but as the best option available. True reproductive 'choice' has been available only for the most privileged in the US since the *Roe* decision legalising abortion, which reproductive justice advocates and activists have pointed out for decades. It is difficult to know whether participants would have chosen telemedicine abortion had there been full-spectrum reproductive health care available locally. At the same time, despite the necessity and inconvenience of two roundtrips, participants told me that they would still choose this option in the future because it was still better than anything else that was available.

It is possible, though, that participants had not been aware of options like Women on Web or Aid Access that in practice offer full telemedicine abortion services regardless of state of residence. This means that participants could have ordered these pills online and had them delivered straight to their door with a lower cost and no travel. As explained above, these services operate outside of the formal US health care system. They are not regulated by the federal government or state governments and thus they are not subject to its restrictions and do not provide abortion data to these bodies. These organisations are also outside of the legal jurisdiction of the US, meaning that they are able to continue shipping abortion pills to any state. Although some countries have attempted to seize abortion pills, this is not easy or generally worth their effort. However, individual abortion seekers' criminal or civil liability for self-sourcing abortion pills and self-managing abortion within both ban and legal states is more complex. We do not know whether all abortion seekers are willing to access abortion within this grey area. If they are, both organisations offer 24/7 email support. Online pharmacies, which would have been another no travel option, do not offer clinical support and may mark up prices. Both also take longer to ship than domestic telemedicine abortion services.

All this is to say that cross-border telemedicine abortion exists on a spectrum of abortion options in terms of convenience, cost, legality or (il)licitness, and other factors. Because of the other benefits that telemedicine abortion was perceived to have, as I elaborate in Chapter 6, the presence of an abortion clinic does not and would not necessarily mean that abortion seekers would choose in-person care over telemedicine. As such, understanding abortion decision-making and reproductive choice is not straightforward, but it is evident that the latter is seriously constrained in the US. Cross-border telemedicine abortion is currently a necessary stop gap measure, but more broadly cannot be reduced to a care fix. With a dearth of clinics and 14 state bans on abortion, telemedicine abortion is filling important gaps in care that the state has created or will not address. Nevertheless, we know that it is safe, effective, acceptable, and frequently preferred to have a medication abortion outside of clinical settings. At its full potential, telemedicine can make this process convenient *if that is the person's choice.* At the same time, procedural abortions are still required and may be a preference for many people. Telemedicine abortion

services thus cannot be understood as a *substitute* for abortion clinics, but one offer amongst a comprehensive set of options. Telemedicine abortion is thus not a panacea for rural health inequalities, but a promising pathway for abortion care.

5.6 | Conclusion

In this chapter I have demonstrated how the telemedical and mobile clinic care pathways offered by JTP do not fit neatly into our understandings of mHealth as a panacea for rural health inequalities, especially abortion. The potential for remote abortion pill provision to change everything about abortion access is not realised in this case, because abortion seekers are still moving to access care just as they would to go to an abortion clinic. However, even when making two roundtrip journeys into another state, patients of JTP still saw telemedicine as a more convenient and easier option than going to an abortion clinic. Due to the requirement for travel to speak to the doctor and to pick up the pills, we see that cross-border telemedicine abortion does not entirely constitute 'virtual' care. It relies on place-based infrastructure, like the postal system, and is subject to dynamic state laws which seek to eliminate abortion or limit it to traditional clinical settings. But it is still innovative insofar as JTP has co-created strategies with abortion seekers to ensure access in the face of state control, by seeking to leverage mobilities and allow patients to make their own care decisions, to the extent this is possible.

6 | ABORTION EXPERIENCES WITH TELEMEDICINE

6.1 | Introduction

Telemedicine is understood as a method to improve health care outcomes by reducing barriers to access. In the case of abortion, telemedicine enables abortion seekers to procure the pills without going to a brick-and-mortar clinic, even where they may have to travel across state lines to pick up the pills. What is less understood is what happens next—after the telemedicine appointment and after the remote delivery or retrieval of medication. The possibility of self-managed abortion with pills is often emphasised with more attention to the acquisition of abortion pills, legally or otherwise, and less attention to what the experience of taking the abortion pills outside the clinic is like, particularly in the context of telemedicine, rural health, and increasing restrictions on abortion in the United States. Health, medical, and care geographies have together considered the home as a site of health and social care (Bowlby and Jupp, 2021; Buse, Martin and Nettleton, 2018; Buse and Twigg, 2014; Langstrup, 2013; Power and Mee, 2020). Scholars have examined how care work and medical technologies are emplaced in the home (Danholt and Langstrup, 2012; Weiner and Will, 2018), but this work rarely focuses on sexual and reproductive health or acute forms of care (see for an exception Whitson, 2018). While abortion activists and scholars have increasingly drawn attention to the potential of abortion 'self-management' or 'self-care' with pills (Aiken, 2018; Assis and Larrea, 2020; Erdman, Jelinska and Yanow, 2018), there has been limited attention to the relationality of care-giving and care-receiving in these models (see for an exception Duffy, Freeman and Rodríguez, 2023). Moreover, feminists remind us that the home is not categorically a space of comfort or safety, and it is important to consider how telemedicine assumes that it is an appropriate caring place.

In this chapter I demonstrate that the abortion pills, accessed via telemedicine, enable a non-judgemental, empowering, or holistic experience of abortion care outside of clinical settings. Telemedicine has temporal, material, and spatial dimensions that shape the abortion experience. For Buse, Martin and Nettleton, the concept of materialities of care provides 'a novel way in to examining "practices of care" as they unfold in a range of formal and informal settings, and in relational

ways, whereby embodied, routine and often unnoticed actions of caring are constituted through and between the relations between bodies, objects and spaces' (2018, p.245). Materialities of care may refer to physical or intangible 'things', which are 'spatially and temporally enfolded' (ibid.), that shape, enable, or constrain caring practices. The time-space of care has been brought to the fore by the frameworks of cares/caringscapes, therapeutic landscapes, landscapes of care, and infrastructures of care (Gesler, 1992; Bowlby, 2012; Ivanova, Wallenburg and Bal, 2016; Milligan and Wiles, 2010), which suggest an 'examination of the actualities and possibilities of the social patterning of time-space trajectories through a range of locales significant to caring' (McKie, Gregory and Bowlby, 2002, p.914) and an 'appreciation of temporal shifts and elements of care that are connected to sociostructural processes as well as to the individual' (Milligan and Wiles, 2010, p.740). Together, the materialities, temporalities, and spatialities of care constitute embodied practices of care and can '"stand in" for relations of caring' (Buse, Martin and Nettleton, 2018, p.249).

Although care is commonly understood as a unidirectional activity from care-giver to care-recipient, health and care geographers have argued that care involves a reciprocal relationship in which care is co-produced (Fine and Glendinning, 2005; Milligan and Wiles, 2010)—what Tronto (2016) refers to as 'caring with'. The relationality of care leads Danholt and Langstrup to suggest that there is 'no "self" in self-care' and that 'the discursive articulation of self-care overshadows and downplays the individual's dependence on a collective' (2012, p.514). There has been a discursive focus on self-managed abortion and abortion as self-care in recent years (Aiken, 2018; Aiken et al., 2019, 2020, 2021a; Assis and Larrea, 2020; Braine and Velarde, 2022; Erdman, Jelinska and Yanow, 2018; Yanow, Berro Pizzarossa and Jelinska, 2021). However, work from abortion scholars has highlighted the 'constellation of actors' involved in SMA and abortion accompaniment in many contexts (Berro Pizzarossa and Nandagiri, 2021), which begins to challenge the 'self-care' discourse.

Care is also affective and embodied. Affective atmospheres refer to 'the feelings that are generated by the interactions and movements of human and nonhuman actors in

specific spaces and places' (Lupton, 2017, p.1). Affective atmospheres enable us to 'reflect on how something like the affective quality, or tone, of something can condition life by giving sites, episodes or encounters a particular feel' (Anderson, 2016, p.137) as well as to understand 'how people anticipate the environments that atmospheres imbue' (Sumartojo et al., 2020, p.29). In this way, affective atmospheres can be understood as 'an embodied experience of the material world that is attuned to their spatial affects' (Bille, Bjerregaard and Sørensen, 2015, p.33). Atmospheres are not nebulous but actively created and can be assessed through their production and operationalisation in the built environment (Martin et al., 2022). The concept of affective atmospheres has not been extensively used in geographies of health, illness, and health care (Lupton, 2017), but scholars have drawn attention to how space and place shape patient and provider experiences of health care, such as in therapeutic landscapes, medical settings, and, increasingly, the home (Conradson, 2005; Danholt and Langstrup, 2012; Ivanova, 2020; Langstrup, 2013; Thompson, 2021). I am concerned with how telemedicine abortion care at home is produced as an alternative to the abortion clinic, through the material and time-space dimensions of the abortion pills, the relational practices of abortion care via telemedicine, and the affective and embodied experience of abortion care at home.

In this chapter, I address the second research question for this project: to determine whether telemedicine addresses geographic barriers to abortion care for rural women and pregnant people, in their own words and from the perspective of providers. In Chapter 4, I concluded that participants in my study anticipated a combination of geographic barriers which constrain affordable, timely, and local abortion care and the experience of non-judgemental, empowering, or holistic abortion care for rural women and pregnant people. Chapter 5 was concerned with evading and encountering these barriers in the abortion journey while in this chapter I explore how telemedicine addresses these barriers vis-à-vis a caring experience. I argue that telemedicine abortion not only affects how individuals access abortion but also how they experience abortion. After the abortion pills are 'put into women's hands' (Jelinska and Yanow, 2018), they have a degree of choice about when to take them, where, how, and around whom and what. To the extent possible, these

choices shape a caring affective atmosphere of abortion and enable the management of their embodied and emotional responses to the abortion.

6.1.1 | Structure of chapter

This chapter is loosely structured around the chronological process of participants' abortions after they acquired the pills. This structure enables me to emphasise the time-space dimensions of having an abortion via telemedicine and how materialities, embodiment, and emotions are temporally and spatially situated. My participants did not share strictly linear narratives of their abortion, but their narratives often shared common features in terms of time, space, and affect. I start with how participants began to take the pills, then move on to how the pills work and what the symptoms of the abortion are, and then move towards how participants felt while having the abortion and how this is shaped by their location and support networks. By describing the abortion process in this way, I highlight that telemedicine abortion is not only about access and getting abortion pills into women's hands, but also about experience and understanding how women take the abortion pills.

In section 6.2, I discuss how women chose the timing of their abortion, how long the abortion takes, and how temporalities shape the abortion experience. In this section, I demonstrated that telemedicine abortion with pills offered a degree of flexibility and convenience, with respect to time, that in-person procedures may not offer. In section 6.3, I consider the material properties and effects of the 'abortion pills' mifepristone and misoprostol. I demonstrate that the abortion pills, accessed via telemedicine, offer an alternative material experience of abortion care. In section 6.4, I reveal the corporeal and embodied effects of medication abortion and how the these are managed across time and space. I demonstrate that telemedicine abortion necessitates the self-management of the effects of abortion. In section 6.4, I explore how the space and place of care shape affective atmospheres and experiences of care. I demonstrate, by displacing care away from clinical settings to the home, telemedicine abortion enables person-centred care.

6.2 | Abortion timing

In this section, I discuss how women chose the timing of their abortion, how long the abortion takes, and how temporalities shape the abortion experience. The concept of time is critically important to understanding abortion care. As Erdman points out, '[t]emporal categories such as trimesters, temporal measurements such as gestational age, and temporal concepts such as viability figure prominently in the legal regulation of abortion' (2017, p.30). The law also mandates waiting periods before an abortion (Chapter 1), abortion clinics have waiting lists for appointments due to demand outweighing capacity (Chapter 4), and gestational age determines which procedures are available and how much they cost (Donovan, 2020; Foster, 2020; Roberts et al., 2014). Though abortion is needed throughout pregnancy (Kimport, 2022), abortion seekers prefer to terminate their pregnancies sooner rather than later but often face barriers to care which push their pregnancies into later gestational ages (Baum et al., 2016; Finer et al., 2006; Foster et al., 2008). Telemedicine abortion, like medication abortion more broadly, can be used in the first trimester of pregnancy. As discussed in Chapter 5, this care pathway may be less time-intensive than going to the clinic. Moreover, whereas with in-person aspiration procedures and medication abortion provision, women and pregnant people are at the mercy of clinic schedules, with telemedicine abortion they can choose when to begin the process. Once the mifepristone is taken, the misoprostol must be taken 24-48 hours later in specified time intervals. The temporal dimensions of telemedicine abortion with pills allowed a degree of flexibility and convenience in the abortion experience that was appreciated by Just The Pill's (JTP) patients.

Some participants chose to take the pills immediately, while others opted to take them at an arranged time. Returning to pick up the pills from the post office, Claire took the mifepristone in her car before driving home: '[a]s soon as I hopped in the car, I took the first two pills' [Claire]. She explained that she had a 'time crunch' because of an upcoming trip and '[s]o I was like, gotta get this done now' [Claire]. Like Claire, Alice had an upcoming trip and so took the first pill 'right away as soon as I got the package' [Alice]. They did not feel side effects from mifepristone while driving—what might be referred to as 'queasy affects' (O'Malley, 2019)—but the chemical was nevertheless beginning to act in their bodies to stop the hormone progesterone and therefore end the pregnancy. In the case of cross-border

telemedicine, by requesting, picking up, and taking the abortion pills in the car, we see that landscape of telemedicine abortion care extends beyond the home. External time pressures led them to take the pills immediately rather than waiting till they got home.

For the most part, participants timed the abortion around their work and caregiving schedules. Morgan and Laura explain that they chose to take the pills at home when it was a good time:

> I waited till I got home, just 'cause it like coincided time-wise with like my time that I would have to go to work and days off. Like having that flexibility to plan okay, this is today I will do it because we have two days off in a row… Uhm, so I waited till I got home. It, I mean, it was it was painful, but like a a total now I've had eight miscarriages […] Instead of being a victim to what's inevitable, I could literally plan it and control it. This is the day that we're going to do this instead of I might be in the Walmart parking lot, or I might be in my car on my way to Milwaukee. Both of those have happened, you know? [Morgan]

> And it was that's kind of another reason why I chose the pill because I can still go to work. It'll be in my mailbox. I can do it over the weekend, and I can go back to work on Monday. […] It basically just makes life a lot easier. Because for people who work full time, you don't have to take the time off of work. You can take the pill on a Friday after you get off work or whatever, you can recover over the weekend, because like, the second or third day, I was good. Like, I didn't go to the gym or anything or running, but back to work! So it's just a lot more convenient for people who work full time. [Laura]

While Morgan emphasised the 'control' that telemedicine abortion provided her, particular to her history of miscarriage, both Morgan and Laura expressed that this pathway offered flexibility and convenience for working women. At the same time, these quotes highlight that the flexibility of telemedicine is situated within a neoliberal context which promotes individual responsibility and self-management not only in

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terms of health care, but also in terms of employment. Bloomer et al. (2017) argue that abortion access is a workplace issue, which implicates practicalities and disclosure. The seeming benefit of telemedicine may obscure the economic conditions in the US which place financial and other pressures on individuals to not miss work, including limited access to both personal and medical leave. That most abortion seekers are living on low-income underscores these pressures (Jones and Chiu, 2023). These pressures are also visible in unpaid care work insofar as telemedicine abortion was considered by participants to be flexible and convenient for caregivers, as Laura further explains:

> Yeah, so I share 50/50 with their dad, but they were actually at their dads that weekend. Okay. Yeah. So that's kind of how I wanted it planned. So oh, they go to their dads. So I'm gonna plan for this weekend. […] Because the first time I went ahead, three years ago, the pill, my kids were home, like, Oh, I'm not planning on that again. [Laura]

Laura previously had to take the mifepristone at an abortion clinic and then complete the medication abortion at home with her children around. This time, she was able to time the abortion for when she did not have caring responsibilities herself. Likewise, Helen, who cares for both her father and son, found a 'good opening' and 'kind of waited till it worked' for her schedule [Helen]. That women may have caring responsibilities while undergoing abortion care underscores that 'time is enmeshed in social relations' and that '[s]everal processes may intertwine simultaneously' (Davies, 1994, p.280).

While the presence of dependents is not always ideal, participants often wanted their partners or other support networks to accompany them during their abortion experience, which affected their timing. While Claire was alone for the first few hours of the process while waiting for her boyfriend to get home from work, Morgan and her husband 'both decided we're taking two days off' so that he could be at home with her [Morgan]. Lucy and her boyfriend 'planned it surprisingly well' and 'got really lucky' because the delivery of the medication matched up with the time they took off

of work [Lucy]. Again, we see that the convenience of telemedicine abortion is positioned against the inflexibility of work schedules.

While telemedicine abortion generally afforded most participants the opportunity to plan their abortion timing, forces external to the care pathway affected others. On an individual scale, Alice experienced 'terrible' timing [Alice]. Alice found out she was pregnant in December and the pills were delayed due to holiday shipping times, so she took the mifepristone right away and the misoprostol on Christmas Eve. She was on a family trip and was keeping the procedure a secret from everyone but her husband. She said, 'you don't really get to choose, uhm, when you're going to when you're going to need an abortion and I didn't want to just cancel the trip, you know, everyone was so excited and I didn't know what to expect, honestly, I didn't know what it was gonna feel like' [Alice].

On a larger scale, patients of JTP's mobile clinic and those who now live in 'ban' states are asked to 'take both medications in the state that it is prescribed' to help 'minimize risk' [Dr Amaon]. Complying with this request means that neither time nor place is in their hands but is instead shaped by state laws. While a procedural abortion is short, a medication abortion is a multiple day process meaning that taking both medications in the state it is prescribed requires patients to be displaced for longer on top of the enforced travel. Should they return home following the misoprostol, they might experience symptoms or even pass the pregnancy en-route (Baird, 2019; Freeman, 2020b; O'Malley, 2019). However, JTP does not enforce this policy and it is likely that many of their patients choose not to follow it because it is unfair and it constrains the choices that telemedicine abortion is supposed to afford.

While the medication abortion can begin at a flexible and convenient time for participants, it is a multi-day process with a prescribed schedule for taking the five pills (one mifepristone, four misoprostol). JTP's 'Healthcare at Home' video—which patients watch prior to their telemedicine consultation and can refer to later—instructs patients to:
- take mifepristone with a glass of water,
- wait 24-48 hours,

- after 24-48 hours, put four misoprostol in cheeks, let dissolve for 30 minutes, and swallow.

This is one of the most common medication abortion protocols in legal settings. In restricted settings where it is difficult to obtain mifepristone, a misoprostol-only regimen can be used. In this case, an individual must take a total of 12 misoprostol with four misoprostol put in the cheeks to dissolve over 30 minutes every three hours. Participants could jump-start the protocol by immediately taking the mifepristone after acquiring the pills or wait for a preferred time. In either case, there is a prescribed schedule: the mifepristone is consumed and 24-48 hours later the misoprostol must be dissolved. Jenny explains that there is a window in which a person can start the process but that the medications had to be timed after that:

> [T]hey give you like a timeframe to take it. […] I think it was like a week where you had to take it. But then like anytime within that week, and then you had to time the two apart from each other. And so I personally just took, I took it at some point, so that the main, like the pain or the the process would happen like around like, early early morning, like two or three in the morning so that like I'd be asleep or like, 'cause I didn't want to be like wide awake at the like the high point. So, they told you you about the, it was like you, uhm, you alternate the Tylenol with the ibuprofen and this and that. So I timed the pill when I took it. [Jenny]

In this quote Jenny brings up another interesting point about the temporalities of abortion care – that side effects can be managed through timing. Jenny timed the pills so that cramping would occur overnight rather than in the middle of the day when she was fully conscious. Others also attempted to sleep through any pain and bleeding. Where someone was awake, the timed use of ibuprofen was key to pain management. Within the prescribed medication schedule, participants engaged in a degree of 'tinkering' (Danholt and Langstrup, 2012) that facilitated their desired embodied and emotional experiences of abortion care. The different approaches participants took to taking the pills highlights that '[c]are is difficult to locate within fixed time slots, because it is shaped by the unpredictable temporality of bodies and

care needs' (Buse, Martin and Nettleton, 2018, p.248). The combination abortion regimen 'prescribes certain behaviour, but it is nonetheless *de-scribed* and accommodated to the practices of the patients, in and by the way in which they make use of the treatment' (Danholt and Langstrup, 2012, p.519). Whereas telemedicine abortion was considered the most, albeit not entirely, convenient option in terms of procuring the pills across state lines compared with other options, in terms of taking the pills it was considered the most convenient because of the ability to time the abortion with work and care schedules and to 'tinker' with the medication. Meah and Jackson suggest that care and convenience are 'slippery terms whose meanings and the values attached to them are acquired in specific social contexts' (2017, p.2077). Care and convenience are not mutually exclusive (ibid.).

Yet, in the context of abortion care, the term 'convenience' has been levelled against abortion-seekers seen to be terminating their pregnancies for 'frivolous reasons' (Millar, 2017, p.93). Abortion has been depicted as an 'arbitrary decision based on convenience' (cited in Sanger, 2017) as well as a 'lifestyle choice' (Purcell, Hilton and McDaid, 2014). Discussions of convenience relate to the notion of abortion 'on demand' as well as the idea that women are using abortion as a form of birth control. Brown suggests that the argument 'abortion is not birth control' is an unhelpful one, 'designed to make women sound like they surely are very good girls, avoiding abortion at all costs, and that abortion is a regrettable last resort' (2019a, p.11). A consciousness-raiser quoted in the same section asks '"Why not? Why shouldn't it be? […] if anything, it is the most directly true birth control that exists"' (Brown, 2019a, p.11). Lewis (2022) recently argued that the 'desire not to be pregnant is sufficient reason in and of itself to terminate a gestatee', something that she argues should be easy. Nevertheless, these ideas are extremely pervasive in the US and perpetuate abortion stigma, even amongst my participants who had an abortion. Jenny, for example, expresses complicated feelings about the use of abortion for birth control:

> I don't like to think of it as like a Plan B or like contraceptive, like. Like, if you don't want to be pregnant and like you know there are steps to prevent pregnancy but if you're just out there like not prepared and then getting a

procedure every every other month or something like to a great extent sort of like. Like I am not so bad but I guess if it happened like that's not bad luck, but things happen, I guess I don't know. […] Because I don't think of it as like, like there's things to do to prevent pregnancy like you know, contraception and then this is for like, you know like, it's not an oops, but something happened and now like if you didn't take the precautionary steps, now you gotta do something after the fact. Think of it as like, as a birth control, like just going out there doing whatever. And then [pause] like, you should take steps to prevent it like you know, like you use condoms to not get pregnant so you don't have to have an abortion, right. Just like not using condoms and then continue to get pregnant and continue to do that, like, if you're not ready, you know, like, I don't know, tie your tubes or like like people aren't out there trying to get pregnant just so they can ' I had an abortion' and like, people are out there trying to get my condoms and birth control so they can prevent it. […] I feel different things but at the same time, like at the end of the day like at the end of the nine months, they're not, you know, they didn't have a baby. Whether it was the condoms or the abortion or whatever it was. [Jenny]

While suggesting that people should do everything they can to prevent pregnancy, Jenny recognises that the tangible effects of contraception and abortion are the same: unpregnancy. Moreover, she argues that getting an abortion should be easier:

I was like no matter what the reason like that, this is hard enough. And it was so easy, but at the same time like like if this is hard enough, but it was easy and then all the other people with like 10 times more obstacles. And they just... I don't know, more people just need to know about this. [Jenny]

Jenny is specifically referring to how easy it was to have a medication abortion with JTP. Alice agrees that it was easy and suggests that legal telemedicine abortion would be a boon in rural areas:

And it reflects the time and the way that a lot of people like to access healthcare in general. Not everybody feels comfortable going to a clinic for any health care needs. And so, I think the telemedicine aspect is usually convenient to a lot of people and if you if we're thinking about rural South Dakota is more rural, and there is a lot of work in place that blocks medicine, abortion, I think it would be huge for a lot of people. [Alice]

Alice mentions political efforts to block medication abortion. Anti-abortion groups feel that the availability of medication abortion will make abortion too comfortable, too straightforward, and too easy, 'leading women to approach abortion with less hesitancy' (Millar, 2017, p.123). An in-clinic, procedural abortion is seen to ensure that women and pregnant people *really consider* their choice. But, as Millar (2017) argues, this is just another way to restrict abortion. Those seeking abortion are not unaware that an abortion will terminate the pregnancy—'that is its very point' (Sanger, 2017, p.23). Indeed, participants had little or no doubt that they wanted to have an abortion, but they wanted the process to be as easy as possible.

In this section, I demonstrated that telemedicine abortion with pills offered a degree of flexibility and convenience, with respect to time, that in-person procedures may not offer. Time is of paramount importance to abortion access because gestational age of the pregnancy affects where, how, and why someone can get an abortion and how much it is going to cost. Although medication abortion can be effective beyond the first trimester, abortion is generally available up to 9-11 weeks gestation and therefore there is an urgency to getting the pills (Chapter 5) and taking them. Participants lauded the convenience of telemedicine abortion because they could take the pills at the weekend and still go to work on Monday. This time pressure is separate from the issue of gestational age and is instead shaped by capitalist working conditions in the US. Requesting leave might require abortion disclosure—if that leave is available at all. Nevertheless, given this reality, participants felt that telemedicine abortion was ultimately convenient because of its flexibility in timing. This was demonstrated in terms of the embodied effects of abortion and the ability to time the pills around potential cramping and bleeding. The discussion of the telemedicine as a convenient form of care cannot be separated from anti-abortion

discourse which shames women for 'abortions of convenience' or laws which aim to make abortion less easy to access. Where available, telemedicine abortion may alleviate the broader challenges in accessing abortion within the neoliberal and anti-abortion context in which abortion seekers live.

6.3 | The 'abortion pills': mifepristone and misoprostol

In this section, I consider the material properties and effects of the 'abortion pills' mifepristone and misoprostol. A medication abortion generally involves taking a combination regimen of one mifepristone and four misoprostol or 12 misoprostol alone to induce a miscarriage. Mifepristone is a 200 mg tablet that blocks the hormone progesterone, which is needed for a pregnancy to continue. Side effects of mifepristone include nausea and cramping (NICE, 2022). Because mifepristone is specifically indicated for abortifacient use, it is more regulated and less accessible in restricted settings (see for example Lafaurie et al., 2005). Participants, especially those without prior knowledge of medication abortion (Chapter 5), were not necessarily aware of the over-regulation of mifepristone which restricts who can prescribe it and where it is stocked and dispensed. Mifepristone is 'super regulated' [Dr Amaon]. Thinking that medicines should be fairly easy to access, Erin was shocked to discover that local pharmacies and primary care facilities did not offer the abortion pills:

> I called like a pharmacy in my town or like a clinic. Just 'cause it it kind of seemed like a simple thing like a just like pill, like doctor appointment pill. […] I had like a friend in my small town that works at the pharmacy and I like reached out to her. I was like, hypothetically, if somebody needed the like, medical abortion pill, do you have it? And she's just like, we don't even have that. How do you not even have that? Like nobody? I mean, not that I was like, that's like, completely illegal and not good, but like I was just shocked to even hear that she yeah, didn't have that. [Erin]

Just as Erin was confused by the regulation of the abortion pills, Jenny highlighted the absurdity of the rules regulating where the abortion pills could be picked up: 'it was the same thing whether you pick it up or from the person and mail it to you or

anything they don't watch you take the material' [Jenny]. This calls to mind Sheldon's (2016) discussion of the requirement that mifepristone be dispensed in-person: 'how can a state control swallowing?'. With the FDA overturning its in-person dispensing requirement, telemedicine abortion has disrupted the biomedicalised material practices of mifepristone.

Misoprostol, on the other hand, was developed to treat stomach ulcers. Its abortifacient properties were discovered by feminist activists in Brazil who experimented with dosage after noting pregnancy warning labels on the medicine (De Zordo, 2016). In Latin America, where abortion is mostly illegal, misoprostol has a 'double life' as a prescribed ulcer treatment and as an off-label abortion pill (De Zordo, 2016). Misoprostol expels the pregnancy from the uterus, which causes bleeding and cramping for which basic pain management can be undertaken. In the combination regimen, misoprostol can be taken directly after the mifepristone or 24-48 hours later, depending on provider recommendations. Misoprostol can be taken vaginally, buccally, (put in the cheeks), or sub-lingually (under the tongue). Although misoprostol can be taken orally (swallowed), it is less effective this way (Tang and Ho, 2006). For the misoprostol-only regimen, four 200 mcg pills are taken in this manner every 3 hours (a total of 12 pills). Side effects of misoprostol include flu-like symptoms (NICE, 2022), in addition to bleeding and expelling the products of conception. Because it is mifepristone that is 'super regulated' [Dr Amaon], additional misoprostol can be ordered to a local pharmacy if the combination regimen is for some reason ineffective. Should mifepristone be banned, as has been threatened by the US justice system (Tuma, 2023), JTP is prepared to prescribe the 'off-label' misoprostol-only regimen (Rinkunas, 2023). Misoprostol is also used in the treatment of spontaneous miscarriage and therefore, if there is no vaginal residue from the pills, there is no way to differentiate between induced (abortion with pills) and spontaneous miscarriage.

The inability to distinguish between induced and spontaneous miscarriage is a critical aspect to the materialities of abortion pills. Although the abortion pills can be taken vaginally, it is widely recommended that they are taken buccally or sub-lingually so that there is no visible, material evidence of the abortion. Should

someone have a pelvic examination following their abortion, residue might provide the basis for criminal prosecution (Jayaweera, Moseson and Gerdts, 2020). While scholars working on the materialities of medicine have suggested a focus on the social use of pharmaceuticals and how they are 'articulated, elicited, and informed within a meshwork of experimental, regulatory, and care settings' (Geest, Whyte and Hardon, 1996; Hardon and Sanabria, 2017, p.126), Freeman and Rodríguez (2022) argue the need to understand the chemical structure and biological effects of medicines.

To follow Freeman and Rodríguez (2022), I turn to the medicine, its administration, and its bodily effects. My research shows that the materialities of the abortion pills shaped participants' decisions to have a medication abortion via telemedicine. In particular, participants viewed medication abortion as less invasive and more natural than a manual vacuum aspiration procedure (alongside perceptions of barriers to in-person procedural care [Chapter 4]). The Chair of JTP's Board, Susan, explains that at Whole Woman's Health of the Twin Cities, 'we used to call it the surgical [abortion] but a lot of people don't want to call it that anymore because it's not really surgery, so we started calling it aspiration abortion'. While a medication abortion is a multiple day process, an in-person procedural abortion can be 'done right then and there' [Susan] with local anaesthetic. However, participants had some negative perceptions of the method. Jenny, for example, said:

> Like that, just like I realize it's the same thing but like something about it just made me think of like the old times the hanger and the infection and like if there's like pills with hormones and chemicals and this and that. They'll do the same thing, like naturally, not affect future births or whatever. You can do it sooner, you know, less painful or less of a process […] [Jenny]

Jenny's associations with 'coat hanger' or 'back-alley' abortions are especially interesting given the prevailing assumption that safe abortions must necessarily take place in a clinical setting. This is imagery and discourse that has been used in response to the *Dobbs* decision—'banning abortion only prevents safe abortions'—but the experiences of Jenny and other participants demonstrates that an at-home

abortion with pills can be safe and, indeed, preferable to the 'surgical' method. Claire understood that the surgical method was an aspiration procedure, but nevertheless said that, 'I didn't want anybody going up into me with a little suction tube' [Claire]. Lucy, on the other hand, said, 'I personally am somebody that has a really hard time with anything that's surgical. My body does not respond well to any type of anesthesia. I can actually die from it' [Lucy]. As with other research, participants viewed medication abortion as less invasive and more natural—more like a heavy period, miscarriage, or morning after pill (Broussard, 2020; Cappiello, Merrell and Rentschler, 2014; Ho, 2006). These perceptions of the abortion pills are situated within a broader context.

As Freeman and Rodríguez (2022) explain, the micro-geographies of misoprostol cannot be separated from the broader socio-political, regulatory, legal, and economic context in which they are taken. Abortion takes time and is a bodily experience that is located within frequently uncaring spaces and places, as the authors articulate elsewhere (Duffy, Freeman and Rodríguez, 2023). In these contexts, accessing the abortion pills is insufficient without understanding how to use them (Freeman and Rodríguez, 2022). Thus, the mobility of pills and information about their use constitute the 'scaffolding' on which misoprostol becomes a technology of abortion (Freeman and Rodríguez, 2022). Put another way, mobility and information form 'the more or less embedded "tracks" on which care may "run", shaping and being shaped by actors and settings along the way' (Danholt and Langstrup, 2012, p.515).

As Freeman and Rodríguez (2022) argue, information about how to use misoprostol is vital. While this has been particularly explored in settings where abortion is restricted and misoprostol is the only available medication abortion regimen (De Zordo, 2016; Jayaweera, Moseson and Gerdts, 2020; Walsh, 2020), in my study information on the use of the abortion pills was also critically important. JTP provides ample information during the telemedicine consultation and online for the self-use of abortion pills, alongside their text and phone hotlines (Chapter 5). But participants also expressed feelings of doubt about whether the medications would be effective:

Yeah, I'd say like the confidence thing is a big thing because I could have definitely, you know, done my research and read instructions. And, mm, and kind of trusted that it was going the right way, like, you know. But there are a lot of like doubts I was having and concerns and whatnot, that talking to a human being about this is how, this is how it's supposed to happen was just […] comforting. [Erin]

The only the only added stress about the pill abortion was, you know, "is it going to work?" which is naturally a fear no matter what, uhm. But that, that deadline that, you know, "am I going to get this done in time?" "Am I going to is it going to reach me in time for it to actually be fully effective?" [Lucy]

Erin and Lucy highlight that we might also consider the material differences between a procedural and medication abortion and how these affect patients' perceptions of efficacy, and how these put additional time pressures on the experience. With a procedural abortion, there is no doubt that the pregnancy has been terminated, because a medical professional confirms it, while with a medication abortion, individuals must assess their level of bleeding and whether foetal tissue has been expelled to determine whether the termination was successful. This positions the patient as the arbiter of whether the medication abortion was effective. However, with most remote abortion pill options, including telemedicine abortion, they are not making the judgement unsupported.

In addition to information on how to take mifepristone and misoprostol safely and effectively, JTP also provides information on legal risks which intersect with the time-space and material dimensions of the abortion pills. In Chapter 5, I raised questions about the 'where' of abortion care in the post-*Roe* context and the potential for criminalisation. Dr Amaon explains that this is something they are concerned with:

And then working on that's the I guess the biggest thing that we're working on now, how do we make relationships in their home states if something went wrong or we're not sure and they need extra care? […] Because I don't know, you know, what organization they're going to be seen at, what they

think of and I also, unfortunately have to tell my patients depending on where they live. You can tell people you had a miscarriage. You don't have to say that you took the medication abortion. They don't, there's no test right. They can't they do the treatment is the same […] I've told people If we have to go to the ER—which is a rarity, most of the time you can manage most of the stuff over the phone and online and stuff—uhm, but if we do I say you know, feel free to tell people if you're not comfortable and you had a miscarriage, the the treatment would be the same and then you're not treated differently. [Dr Amaon]

As Dr Amaon outlines, medication abortion rarely results in complications requiring emergency care, but it is possible. Where emergency care is required, a patient can present with a spontaneous miscarriage rather than an abortion induced with pills, because the results and symptoms are the same if the pills are taken buccally or sub-lingually. Nevertheless, the declaration that you had a miscarriage may not provide sufficient protection against prosecution should an individual encounter the medical system in a 'ban' state or even elsewhere. Women who have miscarried have been tried for abortion in a variety of contexts and there is a history of pregnancy criminalisation in the US, particularly for pregnant women and pregnant people of colour (Gurr, 2011b, 2011a, 2014; Roberts, 2017; Ross, 2017). The Executive Director explains the concern and the some of the things they are exploring to address the risk:

I think I think I'm worried about patients who return to their state after having abortions and seek medical care and just like misinformed medical personnel, like, you know, feeling like they have... to turn them in. I think that's, that's probably my biggest concern. And and it was like, so we're having conversations along the line of like, you know, the Know Your Rights campaigns for folks that like are targeted by ICE and, uhm, you know, like, what if we were to provide like cards that are like Know Your Rights, you know, your right to not disclose, or abortion looks the same as miscarriage, so they know that whatever we say it's like, okay, but you also want people to be able to trust their medical providers and so it's just this awful position

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of... and we really haven't come to any answer on that like. [Executive Director]

The Executive Director rightly expresses concern about the potential for medical personnel to 'turn [patients] in'. The materialities of the abortion pills can shift the time-space of abortion care away from biomedical settings where women's bodies are criminalised. Telemedicine abortion thus represents an important responsive strategy for avoiding these spaces of criminalisation. But it also reflects the responsibilisation of providers, activists, and individuals for abortion care when these spaces are or become hostile or un-caring. Moreover, telemedicine abortion cannot entirely avoid these risks because an emergency can quickly push someone into these spaces. This is why JTP, like other independent abortion providers, is involved with the emancipatory struggle of the broader reproductive justice movement.

In this section, I demonstrated that the abortion pills, accessed via telemedicine, offer an alternative material experience of abortion care. The combination regimen of mifepristone and misoprostol (or misoprostol alone) stop the pregnancy from continuing and expel its contents from the uterus. The effects are indistinguishable from a spontaneous miscarriage. This material effect allows for diverse understandings of the abortion pills—that they are more natural, less invasive, and potentially less painful as well as similar to birth control or emergency contraception. Although an in-person procedural abortion was considered more invasive, the method enables patients to have immediate confirmation of the termination by a medical professional. A medication abortion, on the other hand, requires knowledge of where and how to use the pills and how to confirm that the pregnancy has passed. This is why access to the abortion pills must be accompanied by information about their use and, in the case of the US, about the risks involved in their use. The historical and contemporary criminalisation of pregnancy in the US leaves little doubt that abortion bans will be enforced in the post-*Dobbs* era. The material effects of the abortion pills facilitate claims of miscarriage, rather than abortion, but this may not be an effective safeguard against prosecution. Moreover, it reveals the injustice of having to lie about abortion to avoid criminal consequences.

6.4 | Passing the pregnancy: blood, tissue, pain, and emotion

In this section, I reveal the corporeal and embodied effects of medication abortion and how the these are managed across time and space. An abortion with pills can be messy and painful, and the materialities of blood and foetal tissue and feelings of pain were omni-present in participants' experiences of their abortion. Broussard suggests that 'the experience of medication abortion is more visceral than the surgical procedure since the woman herself is in control of initiating the abortion, choosing the environment, and monitoring her own body for symptoms or signs of complication' (2020, p.4). Every termination of pregnancy, whether spontaneous or induced, results in 'products of conception' that are expelled from the uterus. In the case of aspiration abortion, which until 2020 constituted the majority of abortions in the US (Jones et al., 2022), abortion clinics dispose of the foetal tissue as medical waste. Clinicians also manage pain by administering local anaesthetic during the procedure. In the case of abortions completed with pills, however, the pregnancy is passed outside of medical spaces. Blood, tissue, and pain must therefore be managed by the person experiencing the abortion. Participants had diverse experiences of bleeding, passing the pregnancy, and disposing of these products of conception.

The visceral materialities of blood are expected by patients because of the information provided by JTP. Their Healthcare at Home video advises that on 'misoprostol day', patients should 'expect cramping and bleeding like a normal to heavy period'. Patients are advised to 'use pads to monitor your bleeding for the next 2 days'—if the bleeding is too heavy, this is potential cause for concern. After two days, if they 'haven't had bleeding like a period or heavier' they are advised to contact JTP. This is for one reason that Erin expressed that a doctor's appointment is 'very necessary' for abortion care:

> I don't think that just you know, handing out the instructions and being like, okay, good luck is necessarily really like a good thing because it was like a lot of blood and a lot of pain and like, knowing that the process was like happening the way it should and that kind of thing is like very comforting. [Erin]

This statement from Erin underscores the notion that telemedicine abortion, while self-managed, cannot entirely be considered self-care because of the ongoing support offered by the provider, which I explore further in the next section. In the self-managed use of abortion pills, blood serves as proof of the abortifacient nature of mifepristone and misoprostol and as a reference for the potential need for further care to complete the termination. JTP tries to determine whether the abortion has been successful through a series of questions. On patient request, they will follow up in 7-14 days and ask four questions:

- Did they bleed as much as they would during their menstrual period?
- Did they pass clots and/or tissue?
- Do they feel like they passed the pregnancy?
- Are the pregnancy symptoms going away?

The women I spoke to were undoubtedly prepared for the abortion to produce a lot of blood. They were ready with menstrual management materials to care for themselves throughout, equipped with an arsenal of supplies that anyone with periods is familiar: pain reliever, heating pads or hot water bottles, and pads[14]. Lucy even purchased absorbent puppy pads, 'so I could just lay on my bed and not worry about it' [Lucy]. JTP also gives or sends patients care packages with menstrual pads, disposable heating patches, tea bags, and snacks, as a material component of the telemedicine abortion with pills assemblage. Claire said, 'It was kind of nice. I used it for a later period' [Claire].

The physical experience of the women's abortions was primarily described in relation to the blood. Jenny, for example, who had two abortions with JTP, discussed differences in the size of the 'blood clot' based upon the later gestational age at which she had the second abortion: 'it was a bigger… when it comes out' [Jenny]. The fact of the pregnancy being passed was alluded to but not named explicitly. Likewise, while Claire described mifepristone in specific terms as stopping the

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[14] Although tampons and vaginal cups are frequently used in menstrual management, these cannot be used during a medication abortion.

hormone progesterone, she described misoprostol as the pills 'that actually, uh, do *everything else*' [emphasis mine]. Likewise, during the abortion, she 'cleaned everything up that… *you know, whatever*' [Claire, emphasise mine].

Broussard (2020) couches her discussion of women's understandings of the products of conception in terms of stigma and it is possible that the anticipated stigma discussed in Chapter 4 shaped my participants perceptions as well. Yet these perceptions cannot be separated from a culture with competing discourses around the foetus. On the one hand, the anti-abortion movement presents images of the foetus as a fully-formed baby with fingernails and a heartbeat (Evans and Narasimhan, 2020; Hann and Becker, 2020; Lambert, Hackworth and Billings, 2023; Lentjes, Alterman and Arey, 2020). On the other hand, there is a ubiquitous pro-choice message that the foetus is just a 'clump of cells' (Becker and Hann, 2021). When understanding the contents of the uterus in this way, describing a medication abortion as akin to a 'heavy period' is both physiologically and cognitively consistent. Through 'practices and processes of resurfacing' the products of conception are 'brought into being through different registers of understanding' (Colls and Fannin, 2013, p.1093).

For others, the foetal tissue may hold more significance. An issue arises when the expectation of the 'clump of cells' does not meet the reality of size or mess which patients encounter at certain gestational ages. Activists have recently expressed reservation about images published in the *Guardian* (Noor, 2022) from the MYA Network, a network of clinicians and activists seeking to expand abortion access in primary care settings. These images show a sanitised view of the products of conception because the blood and menstrual lining (decidua) were rinsed off for the photographs, which may mislead abortion seekers about what they can expect when the pregnancy is expelled.

Alice, for example, was the only participant who specifically referred to the pregnancy as 'tissue' and unfortunately did not feel sufficiently prepared to see it. While she thought that the abortion would be like a heavy period, 'that was not not quite what it was' and it was 'one of the most upsetting' aspects of the experience

[Alice]. The other aspect that upset her and 'made it complicated' was how to dispose of the tissue. Because it 'felt horrible [to] just leave the tissue in the garbage' [Alice], in a public place, she carried it around for a few days until she and her husband could bury it and process what happened together. Alice's experience calls to mind Colls and Fannin's (2013) discussion of the cultural practices around placenta burial, which may be constrained by its treatment as medical waste in clinical settings. We might think of the products of conception as a 'material mediator' (Colls and Fannin, 2013, p.1100) which shapes and is shaped by understandings of pregnancy and abortion and by relations to the body and with others.

That other participants did not express reservations about disposing of the foetal tissue speaks to individual circumstances around pregnancy and abortion as well as to the broader issue and implications of viewing the foetus. While mandatory ultrasounds *prior* to an abortion are intended to be a deterrent, many pregnant people appreciate the opportunity to see the foetus and do not change their minds (Foster, 2020; Kimport, Weitz and Foster, 2014). Likewise, patient-centred viewing of foetal remains *following* an abortion may be offered in independent clinics for 'choice, closure, and access to honest [and accurate] information about abortion and fetal development', as in the case of miscarriage, stillbirth, and termination for foetal anomaly (Hann and Becker, 2020, p.10). For the most part, viewing the foetal remains does not make the abortion emotionally more difficult, though it may for some women (Wiebe and Adams, 2009). At the same time, Alice appreciated the opportunity to handle the remains in the way that she and her husband wanted—something that is made possible by the time-space and material dimensions of telemedicine abortion with pills.

Alice explained, 'I still feel like I know I lost the pregnancy. I still feel like it. I should be allowed to mourn that, but it's just not a discussion that's part of the public conversation around abortion' [Alice]. While anti-abortion policies like foetus funeral laws in multiple US states 'undermine reproductive autonomy by inscribing fetal grievability into the law', Leach argues that feminist responses are 'inadequate insofar as they fail to engage the affective or ontological aspects of pro-life

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discourse, re-assert embodied selves' boundaries, or disallow constituting fetuses as persons' (2021, p.161). I would add that they also fail to engage with the visceral materialities of abortion or, perhaps, the 'vital mobilities' of abortion wherein the 'external circulation' of abortion pills and menstrual management assemblages enable the 'internal bodily circulations' and their external manifestations (Sodero, 2019, p.121). None of these women were in doubt that they were ending a potential life and that it would be '*messy*' [Erin, emphasis mine] in some way shape or form, but they differed in their embodied and emotional responses to the abortion and its messiness.

Emotionally, having an abortion was the right decision for all my participants but their feelings about their abortion varied considerably. The research highlights that emotional responses to an abortion are related to personal and social contexts, rather than the abortion itself (Rocca et al., 2020). Most people who have abortions experience a feeling of decision rightness, and the most commonly reported emotion after an abortion is relief (ibid.). The effect of personal and social contexts is evident in the emotional responses by participants, whose emotions ranged from indifference to devastation. Claire, for her part, was indifferent, but expressed reservations about sharing these feelings:

> I don't know, not to sound kind of like sociopathic. But I was just as soon as like, I knew I was pregnant. I knew I wanted to have the worst You're like, oh, I don't really care about it inside of me, I just want it out. I do not want to grow and be a baby in nine months, it can just go away and nothing as it came to be nothing. [Claire]

Claire just wanted the pregnancy to 'just go away' because it was 'nothing'. Of course, I assured her that she was not 'sociopathic' and that this—and any response—is a normal and valid one. Morgan was also somewhat ambivalent because she knew her body would not be able to carry the pregnancy to term anyway, due to her history of miscarriages. The abortion pills allowed her control over the process that she described as 'inevitable' [Morgan]:

I guess because I know my body and I know what's wrong with my body and I know what it's going to do, like, there was no like, mourning or sorrow. There was, you know, like, we already knew that this was going to happen whether I made it happen or my body made it happen. [Morgan]

Morgan's previous miscarriages made her feel more emotionally prepared for the abortion decision and experience. On the other side of the spectrum, Alice was very sad about her abortion. She feels like she lost the pregnancy and wanted to be able to mourn that loss: 'I mean, it was, it was so hard. I felt I felt very sad. And to be honest, I cried most days' [Alice]. Despite feeling this way, she said, 'You know, I know that that was the best decision for me and for our family' [Alice].

Physically, the anticipation of bleeding akin to a heavy period was paired with an anticipation of cramping—a primary embodied effect of abortion. Women's perceptions and experiences of pain during a medication abortion have not been systematically reported or studied (Fiala et al., 2014). Discordance between expectations and experiences of bleeding and pain may limit satisfaction with medication abortion (Teal, Dempsey-Fanning and Westhoff, 2007). At the same time, experiencing more bleeding and more pain than anticipated did not necessarily mean that patients would not choose the method again (ibid.). For some women in my study, the pain was less than they anticipated:

Like I'd never had one before for I didn't know like how bad it was gonna hurt or. 'Cause I don't really have cramps either […] I was like, well I don't get cramps, I don't know. I don't know, it's not that bad. [Jenny]

It was OK. […] It wasn't it wasn't as bad as I was expecting it to be, really. […] I'd say, I was expecting the worst but it really wasn't all that bad. [Helen]

Jenny and Helen, without previous experience of abortion, imagined the process to be bad and found that it was not as bad as they expected. For Morgan, the pain was also not too bad. She said that the cramping caused by the abortion pills was like a 'really bad period' [Morgan]:

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It, I mean, it was it was painful, but like a a total now I've had eight miscarriages. But like would I compare it to a miscarriage pain? No. It was more like… mm… I have endometriosis as well. So I get really bad periods, really bad cramping. Uhm, so I would compare it to that level. Like a really bad period. [Morgan]

Compared with spontaneous miscarriage and endometriosis, which is a understudied and extremely painful condition (Merone et al., 2021), Morgan felt that medication abortion was more like a bad period. On the other hand, for Alice, Laura, Claire, and Erin, the pain was a lot more significant. As previously mentioned, Alice had unfortunate timing with her abortion throughout a Christmas trip. Her embodied experience of the abortion was shaped by being in-transit and in public spaces where the abortion was kept secret:

And then I ended up passing the pregnancy, uhm, in the early afternoon the day after Christmas. […] Yeah, and then I actually when when it passed when it happened I mean I had terrible cramping like all day like, you know, ibuprofen and, uh, Tylenol weren't really doing it. And then all of a sudden, uh- we were it was awful. We were at the bowling alley, uhm. And like I wasn't even sure if I was gonna be able to go because I was feeling so bad. Uhm, and then I just felt like a big a big gush and I went to the bathroom and there it was and it was just [pause] really sad. [Alice]

Alice's quote brings up a key point with respect to the temporalities, spatialities, and materialities of abortion care via telemedicine: whereas during an in-person procedural abortion the patient receives local anaesthetic, during a medication abortion the patient must treat pain themselves. As described above, they might time the pills to attempt to sleep through the pain. Or, they can time the use of ibuprofen alongside other material remedies like heating pads to reduce feelings of pain. But, as Alice points out, they may not be fully effective in eliminating pain. Laura similarly took ibuprofen in response to her painful embodied experience of the abortion, which came into full force after she had taken both the mifepristone and misoprostol: 'I was

like, eh, a little crampy, like a period. No big deal. But that was it. You know? And then obviously, the second pill was fully good god this hurts' [Laura]. Claire described the pain as 'terrible' and went so far as to say it was the 'worst thing I ever felt' [Claire]:

> Uhm, after the 30 minutes, I immediately started bleeding, uhm. And I had, like, hot flashes, I was feeling really hot, and I was feeling really cold. And I was just sweating, I was sweating. [emphatically] I had never sweat so much in my life! My shirt was absolutely soaked, my pants - I didn't even know my pants could get soaked. They were soaked, I was soaked. My hair was all wet. I was laying on the floor, I felt like I had the worst fever of my life [laughs] I was just like bobbing in and out of consciousness for... uhm, about an hour to two hours before I fell asleep, and I woke up to be more sweaty and I crawled into bed after going to the bathroom, cleaned everything up that.. you know, whatever. Getting- crawled back into bed was still just feeling awful, uhm. And I just kind of repeated that for the next few hours of sleeping and waking up and cleaning myself up and going back to sleep. And then... the next day, I felt a lot better. I felt a lot better the next day, it was 10 times better. It wasn't as bad. The first two weeks just felt like a really heavy period after that first night, uhm. And then I had an extra week of some light bleeding and that's when I was [on vacation]. [Claire]

This detailed account from Claire gives a picture of how long an abortion takes and what it might feel like and how that is shaped by the space in which it takes place. The abortion on the 'misoprostol day' is an acute medical event with intensities of blood, sweat, and tears, whose effects may last for weeks with spotting and cramping. By taking the pills at home, these embodied effects can be managed according to the individual within an environment that they shape to their needs.

Whether these women correctly estimated the degree to which they would bleed or experience cramping, they said they would still choose JTP if they needed another abortion. Claire quips that, in any case, the abortion is less painful than childbirth: 'I remember saying I never want to do this again. But I see a lot of videos about how

worse childbirth is. Honestly, I think I would do it again in order to avoid actual childbirth' [Claire]. The abortion pills undoubtedly create a painful embodied experience, but which nevertheless was satisfactory and offered the kind of abortion care that participants needed or preferred.

The participants in Broussard's (2020) study similarly point to the embodied and emotional benefits of being outside of the clinical setting. However, those women ordered abortion pills from Women on Web and some expressed fears of medical complications and legal repercussions (ibid.). These fears were less present with participants in my study. Although Women on Web and Aid Access have contact options available, there is perhaps a difference in the provision of abortion care via legal telemedicine services with a domestic clinician who patients spoke on the phone with prior to their prescription and could reach out to specifically. Participants described Dr Amaon as 'like a friend' [Morgan]. The availability of Dr Amaon and her staff was evident when Erin had concerns that she had 'some kind of infection' [Erin]:

> Yeah, and then I kind of like freaked out in that sense too 'cause I did call JTP and they're like... it was like, one or two days I think was like two - one day for sure. But then like another day, I'm not so bad, but it was really bad pain and I'm still trying to work and it was supposed to be like all like pretty much good by then, so I was getting really worried. And I called JTP, like the doctor, and she was like well if you feel like you need to go into, you know, a hospital, like you should […] Like okay, so I'm like, I have to go through all this again, going to have to like explain my situation and like who knows whose gonna be helping me like, of course it's a doctor who like should be very just helpful anyway, but I ended up not having to do that. So that was good. [Erin]

Erin explains that she was really worried about the pain she was continuing to experience after the pregnancy was passed and that she reached out to JTP for guidance. We know that complications from abortion are rare, at less than a quarter of one percent; abortion has a similar complication rate to colonoscopy and is safer than treatment for wisdom teeth (Upadhyay et al., 2015). Perhaps due to the

individualised experiences of pain and the fact that women self-manage their abortions with limited medical supervision, there may be more anxiety around whether symptoms are normal and signs of the termination being successful or whether they are cause for concern. JTP now has a text line for patients to reach out to Patient Educators with any questions, which is open from 8 AM to 8 PM (CST). After 8 PM there is an emergency phone line available. The Patient Educator explains that some of the common questions are around the embodied effects of the medication abortion:

> Yeah, people often text after they've had their appointments and ask about like, symptoms that they're having, or like wanting a follow up appointment or asking about package tracking information - that's really common, uhm. And yeah, and […] if if they think the process is or isn't complete, or they might need more miso[prostol], things like that. [Patient Educator]

As the Patient Educator indicates, JTP is available to answer patient questions about correct levels of bleeding and pain and ultimately whether the abortion was completed. Thus, JTP offers an 'ambient' (Madianou, 2016) or 'intimate' (Hjorth et al., 2015) co-presence with abortion seekers which is 'digitally bridged across distance' and 'sustained over time' (Watson, Lupton and Michael, 2021, p.147). Their model of telemedicine abortion challenges understandings that physical proximity is necessary for care. This care pathway has shaped new material and embodied experiences of abortion which are in turn shaped by time, space, and caring relations.

Embodied experiences of abortion must also be considered within the context of an uncaring state. While telemedicine abortion enables more choice with respect to the temporalities and spatialities of care, this choice is constrained by abortion restrictions. As with abortion timing, if a patient of JTP complies with the policy on taking the abortion pills in the state they are prescribed, their abortion may begin while travelling home rather than in the home. This issue has been given attention in the England-Ireland abortion corridor or trail (Bloomer and O'Dowd, 2014; Broussard, 2020; Calkin, 2021b; Freeman, 2020b), but has not been considered

extensively in the US because abortion travel has been generally understood as being for procedural—not medication—abortion. This can result in a difficult emotional and uncomfortable embodied experience, as Alice who by circumstance was travelling during her abortion:

> Okay, so the nausea was really bad the first uh I'd say? like 12 hours and I had I had anti-nausea medication… the bleeding, uh, was pretty bad too. And that was while traveling that way like on the plane and constantly paranoid that I was gonna bleed through just tried to change change pads as often as possible. [Alice]

The negative experience Alice describes demonstrates how important space and place are to a caring abortion atmosphere. For those who were at home during the abortion, there was no paranoia involved in the management of blood. Furthermore, in the context multiple state abortion bans, blood and bleeding en-route is an 'incriminating marker' (Freeman, 2020b, p.5) of abortion. At once it demonstrates that abortion seekers have followed the law and taken the pills where they were prescribed, but does not necessarily protect them from criminalisation with state efforts to re-territorialise abortion across and within state boundaries. In a *Guardian* article, Cohen says that he 'think[s] states are not going to rest with just saying "there won't be abortions in our state"' (Schreiber, 2022). 'Ban' states are going to attempt to spatially re-locate their borders beyond the geographical limits of their state boundaries. As Freeman notes, fear is 'clearly present even when traveling for a legal abortion, but it is exacerbated when abortion is illegal and unsafe' (2020b, p.6). Attention to how blood drips or is lost in a 'place that is not their home' (Speier, Lozanski and Frohlick, 2020, p.114), as illustrated in Murray and Khan (2020), highlights the connection between abortion mobilities and vitalism. Blood is 'vital materiality that sustains life' and is 'more than symbolic' (Speier, Lozanski and Frohlick, 2020, p.114). The contexts in which pregnant people are made to be 'sometimes migrants' (Murray and Khan, 2020) are 'not just created in and of themselves' (Kearns and Reid-Henry, 2009, p.559). Rather, these 'vital orders' are operationalised through spatial control, based on particular logics, and create certain

vulnerabilities (2009, p.559), such as inequality in access to local, affordable abortion.

In this section, I demonstrated that telemedicine abortion necessitates the self-management of the effects of abortion. Overall, participants knew that abortion was going to be messy and likely painful and were therefore prepared with things that could alleviate these symptoms. Blood was a key lens through which participants made sense of their embodied experience of abortion, in terms of how much blood they shed and how long they bled for. The level of bleeding should also indicate that a termination has been successful. While some understood the products of conception as 'blood clots' in line with descriptions of medication abortion as like a 'heavy period', others mentioned seeing foetal tissue or vaguely alluded to the materials that had been expelled. These understandings were in part shaped by attitudes towards their own pregnancy and were reflected in the diversity in emotional responses to the abortion. An abortion with pills at home forces people to confront these materials in ways that an in-person procedure may not require, but this was not a deterrent. The pain experienced has also not precluded the use of abortion pills in the future. JTP offered support that enabled participants to feel that they could manage these effects and determine whether the abortion was ultimately successful. The embodied and emotional experiences of the abortion were experienced in relative privacy, rather than on an exam table, in a recovery room, or in a parking lot thronged by anti-abortion protestors. By changing the site of care from the clinic to the home, abortion pills offer an alternative space of care where embodied and emotional effects can be experienced on women's own terms.

6.5 | Abortion outside the 'clinic': home comforts and relational care

In this section, I explore how the space and place of care shaped affective atmospheres and experiences of care. The discovery by Brazilian feminists that the drug misoprostol could be effectively used as an abortifacient was ground-breaking for abortion care (De Zordo, 2016), by facilitating abortion in restricted settings and demonstrating that abortion can be safely and effectively completed outside of the clinic. Calkin has particularly explored how the proliferation of abortion pills has created an 'alternative spatial arrangement that moves access beyond clinic space'

(2019b, p.24). While abortion geographers have begun to understand what accessing care looks like outside clinical spaces, there has been less attention to the experience of care in these alternative spaces (see for an exception Broussard, 2020). Feminist and health geographies have considered the displacement of care from medical spaces and the emplacement of care in the home, or throughout (therapeutic) landscapes of care, but this work has not yet considered the experience of at home abortion. This section brings together these strands of work to explore how abortion care is enacted and experienced within the spatial context and affective atmosphere of the home and other places of care. Borrowing from Whitson's exploration of homebirth, I suggest that the 'place of the home is a critical component in the way that women understand and narrate [their experiences]' (2018, p.143) of telemedicine abortion.

The home was the primary site of abortion care for the women in my study; it was where they took the pills and passed the pregnancy. Telemedicine abortion necessitates that participants self-manage abortion care in their own homes. In this way, it maps onto the dichotomy between home and clinic that has been articulated in other forms of sexual and reproductive health care, such as in assisted reproductive technology and birth, and in health and social care more broadly. In this dichotomy, the clinic is posited as following a biomedical model of care while the home is associated with more holistic care (Worman-Ross and Mix, 2013). However, Hazen (2018) argues that this binary distinction requires more nuance. First and foremost, the home cannot categorically be considered a place of empowerment for women. It may be a site of oppression or coercion (Longhurst, 2008), such as with the emplacement of technologies (Mort, Roberts and Callén, 2013; Oudshoorn, 2012, 2018; Petersson, 2016), and there 'is no universal experience of the home that guarantees more private encounters' (Hamper and Perrotta, 2022, p.5). In my research, participants viewed the home as a safe place to have their abortion, but it is possible that people who had a negative experience of their at-home abortion would not have self-selected into the study. As such, it is important to understand the home as a *potential* site of holistic abortion care when material and relational conditions make it possible. Secondly, people may have diverse reasons for seeking care in a clinical setting versus at home, which may not align with the distinction

between biomedical and holistic care. In my research, telemedicine abortion was selected for a variety of reasons. Having an abortion *at home* was an explicit factor for some participants, while for others it was an incidental benefit or not as central to their experience.

At home, my participants felt that they could create a caring atmosphere and receive support from friends and family, thereby generating feelings of safety, security, and comfort. The home and its materialities play 'a constitutive and generative role in the performance of care' (2020, p.494). The arrangement of space, including the people and mundane objects within that space (Buse, Martin and Nettleton, 2018), enable the self-management of abortion care at home (Langstrup, 2013). Although telemedicine and health care technologies have been documented as disruptive to the sense of home (Buse and Twigg, 2014; Langstrup, 2013; Twigg, 2000) this was not a theme that emerged in conversations with respondents. In fact, following Weiner and Will, abortion care was fitted into the 'embedded and established practices' of the home wherein its objects and people were a 'resource' that allowed abortion care to happen (2018, p.280). The time-space dimensions of telemedicine abortion enabled participants to feel *at home* during their abortion.

Home was '*already* defined […] as the place where "care" was located, as both affective and practical action' (Weiner and Will, 2018, p.280, emphasis mine). Lucy, for one, described herself as a 'homebody' who does not necessarily like talking to other people if she can avoid it: 'everything I can do at home, I will do it at home [laughs] I mean, and that's in terms of, you know telehealth, that's in terms of food, entertainment, everything, I'll do everything at home' [Lucy]. With respect to her abortion experience, Lucy describes the presence of her partner:

> We just sat at home and watched TV and it was normal. There was some
> cramping but, you know, that that was normal, I expected that. It all
> happened quickly. There was no weird side effects. I, you know, I had
> already been taking anti-nausea medication because of the way I was
> feeling prior to the abortion, so I just kept taking that and I felt fine. […] You
> know, he took care of me as much as he could, you know, he ran me hot

showers, he, you know, he brought me my favorite snacks and my favorite drink and it was just a very relaxed thing. There was a lot of a lot of respect in like, we both made this decision together. […] I mean, it was it was kind of a bonding experience. [laughs] Uhm, it was just a very, very unified thing. [Lucy]

Lucy's partner accompanied her throughout the abortion and provided material and emotional support. Likewise, Claire's boyfriend and Morgan's husband were present during their abortions. Claire explains the support she received:

The first few hours I was [alone], 'cause my boyfriend was at work. It was one of his last shifts. Working as a receptionist then, uhm. And then he came home and he laid with me and he asked me if I needed anything, you know, helped me out, uhm. So it was nice, but I don't remember too much because I was just really tired, falling asleep. [Claire]

Claire's boyfriend was able to help her during the abortion after he returned from work. It is not just partners who were able to provide support for participants, but also friends:

Uhm, I had a friend stay with me. Uhm, so, my best friend. She had, uh, stayed with me Friday night, she- and then went home, uhm, Saturday evening. […] I told her I said, you know, I don't I don't want you to sleep on my couch and hear me screaming in my bedroom on Saturday night like. And she's like, "well if you want me to stay I c-", I said, "No, I want you to go home to your family, you have a husband and kids". So I, no, I basically needed her just for the support of driving there more than anything. [Laura]

While Laura sent her friend home before she took the misoprostol to expel the pregnancy, the friend provided emotional support for the start of the abortion and offered to be there for Laura. It was the same friend who had previously driven her to the abortion clinic in Minnesota for a prior abortion. The intersections between friendship and care have not been extensively explored in geography. Drawing on

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Conradson, Bowlby (2011) argues that the 'complex negotiations of trust, disclosure and vulnerability that are central to giving and receiving care [show] how care is woven into the fabric of particular spaces and communities' (Conradson, 2003, p.453). The issues of trust, disclosure, and vulnerability are particularly pertinent given the issue of abortion stigma (Chapter 4) and the myriad people my participants chose not to involve or disclose their abortion decision to, such as Beth's husband. Indeed, while friends or family can 'reduce physical, mental, or emotional burdens and facilitate access to timely medical care in cases of an emergency, their help can also be experienced with ambiguity or, at worst, can represent an additional source of stress, for instance, in cases where they oppose the pregnant person's decision' (Duffy, Freeman and Rodríguez, 2023, p.621).

Moreover, the 'role of friends and kin in care and support is influenced by the wider socioeconomic relations within which they are embedded' (Bowlby, 2011, p.610). Scholars have critiqued the 'community turn' (Macmillan and Townsend, 2006) in health and social care which directs responsibility of care to third- and private-sector organisations or friends, family, and neighbours and reinforces care as an underpaid or unpaid activity (Dowling, 2021; Milligan and Conradson (Eds), 2006; Wiles and Rosenberg, 2003). In the case of telemedicine abortion, moving caring responsibilities to the community is both a reactive response to the neoliberal health care system and anti-abortion state as well as a potential benefit vis-à-vis experiences of abortion care. The ability for family or friends to accompany the abortion is particular to the affective atmosphere of the home. While abortion patients must receive a ride home after the use of local anaesthetic, they are not normally accompanied by someone they know during the abortion or in the recovery room. Telemedicine abortion with pills facilitates a relational form of abortion care which is predominated by people the abortion seeker chooses to surround themself with. Overall, proximal, informal, and unpaid care from social networks was important to producing positive embodied and emotional experiences of care for participants alongside care at a distance by JTP.

However, it is not only the human but the non-human materialities of home which shaped the affective experience of abortion care for participants. These materialities

co-exist with the mobile phone as an everyday digital technology which temporarily acts as the mechanism for telemedical contact with an abortion provider. Like with Lucy and Claire above, 'everyday objects' (Lovatt, 2018) like furniture, food and drink, entertainment, and pets enabled a caring experience of abortion. Women situated themselves where they were most comfortable and surrounded themselves with people and things that promoted feelings of home. Laura describes her experience:

> Uhm, yeah, I mean, like, the first day, obviously, not a whole lot. You know, I took the dog for a walk, did my thing, you know? Uhm, but when, you know, Saturday when I took the second pill I had I binged watch and if you've ever heard of this show called *Shameless*? So I basically, that Saturday. I knew that, you know, I was gonna take this pill soon and I'm like, I'm okay. I'm gonna take some I think I took some ibuprofen about a half hour before I took the pill. And then, uhm, just kind of relaxed and watched a lot of Shameless and cuddled with my dog. [Laura]

To this description of what she was doing during the abortion—watching TV and cuddling with her dog—Laura added that she liked being able to be in her 'own home' where it is more 'comfortable', 'convenient', and 'cozy' [Laura]:

> You can have your own blankie, your own, you know, pillow and stay warm. And you can put the heating pad on your stomach, 'cause the cramps start. And then I'm like, Yup, heating pads going on my belly. That's for sure. [Laura]

The 'mundane domestic objects' (Weiner and Will, 2018, p.280) Laura mentions, like a pillow and blanket, combined with menstrual management assemblages to create a caring affective atmosphere that would perhaps be difficult to achieve in a clinical setting. The creature comforts of home are, in a sense, prescribed by telemedicine abortion providers to help patients get through the process physically and emotionally. JTP's Healthcare at Home video, for example, instructs that on the misoprostol day patients should 'Watch TV, take a nap or spend time with loved

ones'. Materialities are 'not just what care passes through but rather what makes relationships, and therefore the potential for care, possible' (Brownlie and Spandler, 2018, p.267).

The importance of these human and non-human materialities in telemedicine abortion care at home is reflected in the research around homebirth. Whitson's participants, who chose homebirth, 'saw the home not only as a space where they were able to control their own bodies and movements, but also a space which they were able to control more generally' (2018, p.152). This took two forms: 1) controlling and 'creating' the space through mental and material preparations and 2) controlling the presence and movement of others during the process. My participants engaged in similar efforts to create a caring atmosphere in their homes. In this way, having a telemedicine abortion was not only a choice of 'decorating schemes, familiar objects, [and] the trivialities of a "homey" atmosphere' but might also be a choice 'to control one's own body and space' (Rothman and Simonds, 2005, p.102). While for Whitson's (2018) participants it was important to be surrounded by their own germs, space, stuff, and smells, Hazen's participants wanted 'the home space "clean" of the mess of birth' and to instead find a 'relaxed and pleasant space to deliver away from the chaos and everyday responsibilities of the home' (2018, p.136). They wanted a 'homelike environment' but with the perceived safety of a clinical setting by choosing a birth centre. Telemedicine abortion likewise offers a 'compromise' between the biomedicalised clinic and the perceived danger of clandestine abortion in the US, because it takes place at home but is ultimately 'clinician-led, underscored by concerns of risk and safety' (Duffy, Freeman and Rodríguez, 2023, p.626).

The affective atmosphere of an at-home abortion sharply contrasts with how participants perceived the affective atmosphere of an in-clinic abortion. While Martin et al. (2022) use affective atmospheres to show how hospital can produce feelings of safety and security, the exceptional regulation and movement against abortion means that the affective atmosphere of the abortion clinic is shaped not only by the built environment and clinicians but by literal and figurative outside forces. In-clinic abortions therefore depart slightly from other hospital- or clinic-based sexual and reproductive health care in that they are not only subject to the biomedical,

'gynecological gaze' (Levey and McCreary, 2022), but also explicit shaming by anti-abortion protestors and 'exceptional' regulating by the state. While Erin wanted the contact with medical professionals to ensure the abortion was completed safely and effectively, underscoring that the 'community model' of telemedicine abortion is still medicalised (Duffy, Freeman and Rodríguez, 2023), this did not mean that she wanted to go to a clinic to receive care. The abortion at-home was specifically contrasted with the prospect of care at the abortion clinic (see also Chapter 4):

> Uhm, and not having to go not having to deal with the anxiety of already going to the doctor, not having to deal with the anxiety of the protesters, not having to deal with the overt auditory stimulation of people screaming and hearing the noise outside the window, and just the knowing that people are outside those door, people are like, they're out there. There's so much anxiety and fear that comes with doing those those in-person appointments, and it's through no fault of the facility – it's just the people surrounding them. […] You can't do anything about the fact that the things that those people are saying will echo in your head. It will happen that experience amps you up significantly because it's so much more stress. Even when you're you know even when you leave the clinic and you're on your way home, there's still a massive time period of having that wind down before you're comfortable again. [Lucy]

Lucy focuses on the affective atmospheres that radiate around the abortion clinic itself, which made her previous abortion a distressing experience. Moving the abortion to the home and enabling women to produce their own caring atmospheres results in what might be described as 'ordinary affects' rather than extra-ordinary affects marked by stigma, shame, or trauma (Latimer, 2018). This underscores that the relevance of spatialities, temporalities, and materialities to embodied and emotional experiences of care. Whether the home setting is an explicit reason for telemedicine abortion or not, this model of care functions to create alternative spaces of care (Calkin, 2019b; Hamdan-Saliba and Fenster, 2012; Hazen, 2018; Whitson, 2018) and, I would argue, 'alternative pathways for empathetic feminist abortion care' (Duffy, Freeman and Rodríguez, 2023, p.624).

How participants made their abortion an affectively positive and caring experience necessarily raise concerns about when the home is not necessarily a safe and secure space, or when abortion care takes place neither in the home nor in the clinic. Erin, for example, was home but alone and without social support during the process:

> Yeah, because I had wanted to come to [city] anyway, but I because I had work here, but I like took work off so that I could I just, it was like, a week process of shipping and like actually receiving the medical abortion and, so I finally got it and I made my way back to [city]. And then I was like, in my apartment by myself. I just, it was really painful and like, it was really hard, I thought I was gonna pass out if I do throw up and I was like, what if I do these things and like, I'm alone in my apartment. But I ended being okay, I kind of prepared fairly well I got like a heat pad and some painkillers and but it was like a whole day of just kind of misery it was like yeah, a lot of very messy. [Erin]

Without support present in the room, Erin had an abortion experience that was 'really hard' and miserable. Whereas Erin had her abortion in a private space, Alice had a difficult abortion experience because of being in public spaces or in private spaces in which the abortion was kept secret. As previously mentioned, Alice had her abortion during her family's Christmas travels. She was bleeding on the flight and eventually passed the pregnancy in a public place, which made the experience more emotionally challenging than if she had been able to terminate the pregnancy in the comfort of her home. She had chosen telemedicine abortion so that she could have 'things around me that I knew how to make myself feel better' and 'feel my emotions more privately for most of the time' [Alice]. She contrasted this with her anticipated experience of going to the abortion clinic: 'I didn't want to feel like I had to be like on or you know like professional, be my professional self in a situation that was so personal. Maybe I would have felt that way in a clinic' [Alice].

This further draws attention to the affective atmospheres that are shaped when someone must terminate a pregnancy in another state, due to the illegality of the procedure in their state of residence, where vehicles, roads and routes may be the site of care and affective atmospheres (Bissell, 2007; Engle and Freeman, 2022; Freeman, 2020b; Lupton, 2017). Although lodging programmes have existed through abortion funds and many people posted online offers of accommodation following *Dobbs*, safety and security in these instances is not guaranteed [Shayla, Our Justice]. Moreover, many people would rather be in a hotel, alone, rather than in a stranger's home [Shalya, Our Justice]. Telemedicine abortion in the US is not restricted by limited definitions of 'home' like it is in the UK (Parsons and Romanis, 2021), so telemedicine abortion care can take place in a number of settings, like a hotel or someone else's home. Nevertheless, the necessity of this abortion travel may create atmospheres of fear, stigma and criminalisation.

Because travel remains a fundamental component of cross-border telemedicine (Chapter 5), my research has demonstrated that telemedicine is not a panacea for rural health inequalities. However, in terms of the abortion experience, telemedicine offers a quality form of care which may fulfil patients' preferences for privacy, convenience, and a more 'natural' method which moves care from clinical spaces to the home. Borrowing from Frohlick's discussion of 'reproductive vibes' in pregnancy conception, I would suggest that the home may be a therapeutic affective atmosphere which is 'life-enhancing' and *potential-life-ending*—rather than being 'life-generating' (2020, p.130). As the locus of the abortion, the home is 'imbricated in reproductive labour' (Power and Mee, 2020, p.494) and challenges the notion that proximity is necessary for 'good' care.

Regardless of any inconveniences faced in accessing the pills (Chapter 5) or pain experienced during the abortion, participants had nothing but positive things to say about the JTP. As above, one aspect of this was that JTP empowered women with information about the abortion pills and process so that they felt ready to self-manage at home:

Yeah, I any questions that I had getting through right up front. They were, you know, more than forthcoming with any information. They asked me, you know all the typical health questions you know, "have you did you have a positive pregnancy test?" "How long has it been since your last period?" And, you know, it was it was very professional and but it was professional but compassionate. [Lucy]

Yeah, I do. I felt, Yeah, definitely, like seems pretty simple, like kind of all of the same answers online and the instructions from Julie like, yeah, it was just a very, like reinforced process for me. And yeah, so overall, like, Julie, she was, like very, very helpful, for sure. [Erin]

Erin refers to Dr Amaon by her first name, which goes some way to indicating the comfort that patients felt with her as their provider. Both Lucy and Erin discuss the importance of information from JTP and being able to ask questions in advance of receiving and taking the pills. Participants also emphasised JTP's respect, compassion, and understanding for them and their decisions:

Honestly, I'm more trustful of abortion care providers than I am any other doctor, because they're open-minded and they listen and they don't... They're the only doctors that don't judge you for your decision and for your your bodily autonomy, they respect it more than any other. […] There was so much respect and and understanding, both in those offices and over the phone. [Lucy]

But they were very like, we'll take your word for it [her pregnancy]. I like, because I already knew it was real, or, you know, they helped me like, I knew it was a real thing. For me, they really did help. […] Not that it was so like, easy and smooth and like, feel like it was okay. We're not gonna judge you. [Jenny]

Between Lucy, Jenny, and other participants, the non-judgemental approach of JTP was really important to their experience of care. They would likely have received

non-judgemental care from in-person abortion providers as well, but to access that care they would have encountered 'sidewalk counsellors' calling them baby killers. This approach of non-judgement is something that JTP emphasises as well:

> Yeah, I think a big part of our mission is to really positively influence the abortion care community. We you know, we, we came up in these clinics. We learned so much from our time there. I was, I was at a clinic for two decades and... uhm. There's so much to be learned, but I think we also have our own vision for what abortion care should look like. And it involves more... uhm, it's really about worker autonomy, workers' rights, caring for employees, caring for patients, but also like being really patient-centered and not... you know, I think sometimes we have this assumption that if someone is needing an abortion, that they're they're hurt or sad or need to be like coddle- coddled and cared for, like a mother caring for a child and... that's not really how we approach our patients. We definitely are just like, what do you need and if it's crying, we're there for you. If it's, I'm angry about these laws, we're there for you, you know, and if it's like, I just need my pills because my three year old's screaming and I gotta go pick up my five year old from school and you know, like we're there for you to... just being really careful about the assumptions that we're making. [Executive Director]

It is not so much non-judgement that the Executive Director articulates, but a person-centred approach that meets people where they are. Person-centred sexual and reproductive health (PCSRH) is defined as 'care that is respectful of and responsive to people's preferences, needs and values, and which empowers people to take charge of their own SRH' (Afulani, Nakphong and Sudhinaraset, 2023, p.2). It 'promotes reproductive autonomy, is free of reproductive coercion, elevates individual's decision-making and is supportive and empowering' (ibid.). Something that evidences this in particular is their approach to prescribing contraception. Typically, contraception is offered following an abortion—'post-abortion contraception'—because it can prevent future unintended pregnancies and therefore 'repeat abortions' (Gemzell-Danielsson and Kallner, 2015). Some of my participants used contraception, while others did not. Some have had previous abortions, while

for others this was their first experience. Hoggart, Newton and Bury (2017) demonstrate the complexity of women's reproductive histories, the difficulty in establishing causal patterns for more than one abortion, and the potentially stigmatising language around 'repeat abortions'. Dr Amaon explains that '*if* birth control is an option we always offer that' but 'most people are just kind of focused on I would like to get this abortion done right now, we'll talk about contraception later' [Dr Amaon]. By not foisting contraception onto patients, they are working with patient needs in that moment. Participants felt that Dr Amaon went above and beyond:

> They were very, very kind, very understanding. The doctor that I actually talked on the phone with she was actually available for me to ask her a couple of unrelated questions later on, which I thought was super cool. She has no obligation to do any of that, but she did. [Lucy]

> [JTP] was like everything I needed. [laughs] Like, it was efficient. I'd already, uhm, talked to the provider over the phone multiple times prior to meeting in person so like I already felt like I already knew her… uhm, and she was really, I mean, she texted me constantly: "Hey, we're just leaving the Twin Cities", "this is my ETA", "will keep you posted if the weather kind of turns things around". Uhm, and I was like, I can meet you somewhere else closer to the city - that may be because it was snowing there but it hadn't been started snowing here yet. Uhm, so it's it's really genuinely like just kind of talking to a friend. Like, it was really, really easy. And then the meeting was quick and easy, about 15 total minutes… just making sure I had no questions, how to use and what order to use the medications. Uhm, and again, because we'd already been talking weeks prior, she's like if you have any questions literally afterwards, shoot me a text or give me a call, so. It was better than meeting with any doctor, you know? [laughs] But I feel like I could literally text her right now and say, "Hey, I was prescribed Nuvaring and I think I'm having some problems with it". I feel like she would text me back, you know? [Morgan]

What Lucy and Morgan say here about feeling comfortable enough to message Dr Amaon about other issues gets at the particular relationalities of the JTP care model as well as the potential for PCSRH to meet patients' needs. Telemedicine abortion care is provided at a distance but does not need to be proximal to be effective or respectful of individual autonomy. Patients came into contact and re-contact with the provider who they see as 'like a friend' [Morgan], which they would likely not following in-person care. Morgan went so far as to say that her experience with telemedicine abortion was 'better than meeting with any doctor' [Morgan]. Bringing it back to the Executive Director's quote from above, we might wonder to what extent patient-centred care may affect employee care, particularly in terms of burn out and boundaries. Either way, Dr Amaon has chosen to make herself available to patients and it is something that they valued highly as part of an affective experience of abortion care outside the clinic. The feelings generated by the interaction between patients and JTP were critical to shaping a respectful atmosphere of abortion care, which was non-judgemental, empowering, and holistic.

In this section, I demonstrated that, by displacing care away from clinical settings to the home, telemedicine abortion enables person-centred care. Home was the most common place in which participants took the abortion pills and had their abortion. Their experience of telemedicine abortion was understood in opposition to the imagined or previous experience of in-clinic abortion, including for those who had their abortion alone or on the move. Like homebirth, participants were largely able to control the presence of others during their abortion and 'create' the space with 'everyday objects'. This was not a trivial process, but an explicit strategy to create caring and respectful atmosphere. But the home was not a strict departure from biomedical understandings of abortion. Telemedicine abortion offered a 'compromise' between the comfort of home and the feelings of safety attendant with clinical supervision, even at a distance. In addition to this security, participants felt that JTP offered a person-centred approach to abortion care which was non-judgemental and empowering. Although limited in its potential to offer a radical form of abortion care, JTP has created alternative spaces of and pathways for empathetic and relational abortion care in the context of the US. The home is therefore a

potential site of holistic abortion care when material and relational conditions make it possible.

6.6 | Discussion

At the start of this chapter, I observed that more attention has been paid to getting abortion pills into women's hands than where, when, and how they subsequently have the abortion. This research has revealed which other barriers to abortion exist, beyond distance, and how these may disproportionately impact rural women and pregnant people in terms of access to and experience of abortion care (Chapter 4). Although cross-border telemedicine requires patients to travel to pick up the pills, they do not have to cross the threshold of an abortion clinic (Chapter 5). In this way, access remains difficult for the very people telemedicine purports to help, given the constraints of legal provision in a restricted setting. However, telemedicine abortion has also supported a shift in the spatial configuration of abortion care by re-scaling abortion care away from clinical settings. For the most part, this means that telemedicine abortion care is taking place in people's homes, which necessitates or *allows* for four key things: choosing the timing of the abortion, managing symptoms, disposing of the products of conception, and shaping the abortion space. Although it is important to recognise that the home may not always be a safe or empowering place, my participants viewed these aspects as only being possible within their own homes—or outside the clinic. Telemedicine abortion enabled a home-based abortion with a respectful abortion atmosphere, given the potential for participants to shape the atmosphere, the provision of person-centred care, and the availability of clinical professionals to support their journey safely and effectively.

This respectful abortion atmosphere, and the abortion care provision and activism that underpins it, has overlaps with but does not directly compare with the autonomous health movement of abortion accompaniment in Latin America (Braine, 2020). *Acompañantes* have created 'alternative infrastructures beyond the state to address an immediate need and to disrupt the view that abortion should only be provided by the state' (Duffy, Freeman and Rodríguez, 2023, p.625). They are 'distinguished by their rejection of the clinic-based, medicalized model as the only safe form of abortion care' (ibid.). They 'construct an infrastructure of care where

abortion is embedded within communal and community relationships' (Duffy, Freeman and Rodríguez, 2023, p.626). While JTP is addressing an immediate need through telemedicine and would be unlikely to argue that the state should be the provider of abortion care, their model is compliant with state and federal law and is regulated by the health care system. Telemedicine abortion at home in the US does not displace medical models, which was evident with participants who felt safer having JTP on stand-by. At the same time, this model challenges whether abortion care must be provided by clinicians *in clinics*.

Perhaps JTP's model stops short of the mutuality and collective nature of *acompañamiento* (Braine, 2020, 2022; Duffy, Freeman and Rodríguez, 2023), but I would suggest that their 'community model' is nevertheless relational and person-centred towards creating a supportive environment—or caring atmosphere—for abortion. From my participants' perspective, JTP was a necessary and beneficial actor in the abortion care experience. Although they 'self-managed' their abortions at home, participants were reliant on JTP for information and support throughout the process, alongside the human and non-human materialities of home. This departs from traditional models of abortion care in the US where clinical interactions are limited to the patient and medical professional being physically co-present in the space of the clinic. It also departs from our understandings of self-managed abortion where the pills are acquired and taken as a form of 'self-care'. Rather, the self 'is an actor who is thoroughly dependent on, and are ineluctably interconnected with other actors and entities in infrastructures, to become a self-caring subject' (Danholt and Langstrup, 2012, p.514). An Danholt and Langstrup argue, 'the discursive articulation of self-care overshadows and downplays the individual's dependence on a collective' (2012, p.514). JTP's telemedicine pathway allowed for 'safe, effective, respectful, and empathetic abortions' (Duffy, Freeman and Rodríguez, 2023, p.628) where patients felt empowered and autonomous, albeit within the potentially limited understanding of abortion as necessarily medical and legal. Rather than enabling self-care per se, I suggest instead that the abortion pills enable a respectful and relational experience of abortion care in an uncaring state.

6.7 | Conclusion

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In this chapter I have shown that the material and time-space dimensions of the abortion pills, the relational practices of abortion care via telemedicine, and the affective and embodied experience of abortion care at home make telemedicine abortion care at home a viable alternative to the clinic-based care. Telemedicine abortion allowed for participants to choose when to take the abortion pills. This contrasted with the limited availability of abortion clinics and the potential time that a patient had to be in the clinic to receive the pills. Participants spoke about the convenience and flexibility of the medication abortion, especially in relation to employment and care responsibilities, highlighting the expectation in the US that both paid and unpaid work is more important than individual health or wellbeing. Mifepristone and misoprostol allowed participants to have what they viewed as a more 'natural' abortion than the procedural abortion, which participants viewed as invasive. From the perspective of the providers, medication abortion provides a degree of protection against criminalisation because its embodied effects are indistinguishable from a miscarriage. These embodied effects, including bleeding, nausea, and cramping had to be managed by the individual, but most felt prepared to do so. Handling the tissue that was expelled was slightly more contentious and underscored the varying emotional responses that participants had to their abortion, even as they knew it was the right decision. These often-positive aspects of the at-home abortion were only possible when the home was a safe place, but were also supported by the person-centred approach taken by JTP. Although still embedded within legal and biomedical systems, JTP's model practically and holistically supports the individual to safely and effectively self-manage their abortion care at home and away from the clinical space.

7 | CONCLUSION

7.1 | Introduction

This research asked: to what extent does telemedicine abortion reduce, eliminate, or help to reimagine geographic barriers to abortion care in the United States? Throughout this thesis, I have shown that telemedicine abortion provision is not straightforward, given the anti-abortion and neoliberal health care and political systems in which it has been implemented in the US. Drawing on evidence from my empirical case study, which centres the lived experience of telemedicine abortion patients in rural areas of the US, I nevertheless argue that telemedicine abortion can reduce geographic barriers to abortion care, including and beyond the burden of distance. From the perspective of service users, with respect to access, telemedicine abortion is often quicker, less expensive, flexible in terms of timing, and considered convenient, even where requiring travel. With respect to care experience, telemedicine enables an abortion in the comfort of one's own home with the safety of medical supervision at a distance. Both these aspects are contingent upon abortion care provision outside of the abortion clinic. My discussion of these throughout the thesis and particularly in Chapters 4-6 has ultimately raised broader questions about abortion care: Who should provide abortion care? Where and how should abortion care be provided? In this chapter, I review my findings and extend their discussion to provide some further reflections on these questions.

7.2 | Geographic barriers to abortion care: who should provide abortion care?

My first research aim was to identify the geographic barriers to abortion care for rural women and pregnant people. In Chapter 4, I found that there were multiple barriers to abortion care for rural women and pregnant people, including but not limited to the distance from their nearest abortion provider. I argued that telemedicine does not inherently fix the problems underpinning the abortion care crisis but helps individual people navigate extant barriers to abortion within the context of a neoliberalised and anti-abortion health care and political system. The simplified and rational narrative of the travel-to-abortion burden does not sufficiently account for how women imagined and encountered barriers in making their abortion decisions and attempting to

arrange care. In this section, I extend this conversation to consider three levels at which abortion care has been provided and their implications: the individual, the community, and the state. My analysis shows how telemedicine cuts across these three levels in that it is legal and biomedical, but not entirely individualised, and that it seeks to expand access even while it is not physically present in the community.

Abortion access in the US is frequently understood in terms of state and federal law. Federal laws set the parameters of state regulation of abortion, defining what is an acceptable restriction on the procedure and what constitutes an 'undue burden' on the individual seeking care. Abortion restrictions have defined who can access abortion, where, when, why, and how. Although research participants themselves did not always explicitly attribute their difficulty accessing abortion to the law, they understood that there were state-based differences in how easy it was to get an abortion—which are, of course, differences in state law. What particularly affected them were laws requiring the 'physical presence' of physicians to dispense medication abortion, thus prohibiting telemedicine abortion and enforcing travel, either to a clinic or across borders for legal telemedicine. Abortion restrictions have also limited who can *provide* abortion and the facilities which can offer the procedure—a set of restrictions commonly referred to as the targeted regulation of abortion providers. So-called TRAP laws, which require medically unnecessary licensing standards, architectural specifications, and proximity to and agreements with local hospitals, as well as other regulatory requirements for abortion clinics have limited the number of abortion clinics in the US, causing a mismatch in supply and demand. This has meant that abortion clinics are fewer and farther between, have fewer appointments, and may not provide a full spectrum of services.

These practical barriers to abortion care are not only shaped by the law but also by the particularities of the US health care system. As I discussed in Chapters 1 and 6, the US health care system has a combination of publicly- and privately-funded care. However, the law dictates that no federal funds can be used on abortion care. It is thus up to individual states to provide public funds for abortion care, which most do not. The exceptional feature for abortion is that the federal government cannot and *will not* fund abortion—let alone provide it—where it may fund other forms of health

care. Therefore, the burden of providing abortion is on specialised abortion clinics and the burden of paying for abortion is on the individual. While some private insurance may offer abortion coverage, this is not common. Thus, abortion is generally paid for up-front and out-of-pocket, particularly by those on low-income, reinforcing the gendered nature of out-of-pocket expenditure. Because of the dynamics of state regulation and the health care system, abortion is also expensive despite the simplicity of the tools involved in procedural abortion and the low manufacturing cost of medication abortion. These costs increase with gestational age and are, of course, accompanied by logistical costs—travel, accommodation, childcare, time-off—for abortion seekers when accessing the procedure. When people cannot pay, they must rely on not-for-profit entities to support them with funding, forego other bills, or ask friends or family, which may necessitate unwanted disclosure. Cost was an important contributing factor for research participants to choose telemedicine abortion, which is often cheaper than in-clinic abortion.

But telemedicine abortion also enabled study participants to avoid going to a clinic. It was not so much that clinics were far away, although they were, but that clinics meant protestors. The religious right in the US has a strong political influence on the 'issue' of abortion. In practice, this means that they are allowed to create crisis pregnancy centres which aim to discourage abortion and receive state funding to do so. It also means that they have been allowed for decades to set up demonstrations outside of abortion clinics with little to no repercussions. Under the guise of free speech, protestors engage in so-called 'sidewalk counselling' to dissuade and shame women and girls away from abortion. Participants who had previously gone to abortion clinics had visceral memories of encountering protestors, while others feared these encounters. Beyond the imagination of these clinical encounters, participants anticipated and experienced abortion stigma in their communities and amongst their friends or families. Participants did not widely disclose their abortions for fear of backlash from religious or conservative people in their lives. Some did disclose and faced judgement from family members.

In effect, this combination of anti-abortion laws and sentiment and privatised health care mean that abortion is difficult to access in the US. This lack of state provision

raises the question of who should be responsible for providing abortion care? This research speaks to three levels at which abortion care could be provided and how telemedicine is implicated in these levels: the individual, the community, and the state.

7.2.1 | Abortion as self-care

Prior to and following the *Dobbs* decision, activists have emphasised that abortion care is 'community care' and that abortion care is 'self-care'. The notion of self-care has increasingly been divorced from its radical origins and has been subsumed into a neoliberal agenda which uncritically necessitates expensive 'self-care' routines to prevent burnout (Michaeli, 2017; Raphael, 2023). 'Self-care' can be empowering but it might also be a necessity given the pressures of an un-caring health care system. In the case of abortion, we know that neoliberalism has shifted the responsibility for care to the community and made individuals responsible for care of themselves and others. Telemedicine can be considered a mechanism through which this responsibilisation occurs, by transforming the home into a site of health care provision that relies on the unpaid labour of both care givers and care receivers. Telemedicine abortion has emerged as a necessity, or a 'sticking plaster' that is addressing the need for abortion care in the US. It calls into question whether true 'choice' is possible if telemedicine is an abortion seeker's best or only viable option for care. Telemedicine abortion may also be a manifestation of the very problems it seeks to address insofar as it does not expressly challenge the lack of locally available care and creates an avenue for venture capital to profit from the abortion care crisis. At the same time, my research has demonstrated that abortion via telemedicine cannot entirely be understood as 'self'-care. Within the telemedical pathways explored in this research, abortion seekers depend on abortion providers, practical support organisations, as well as their social networks to facilitate access to and a caring experience of abortion care; they rely on a 'constellation of actors' (Berro Pizzarossa and Nandagiri, 2021) to facilitate care.

7.2.2 | Abortion as community care

However, we might call into question how large a role health care providers should have in this constellation of actors. Abortion care in the US has largely been the

purview of independent abortion clinics and national abortion providers. Many of these clinics are not-for-profit and therefore rely in part on donations and grants to fund their operations, like Just The Pill (JTP). Telemedicine abortion, on the other hand, has uniquely enabled for-profit entities, including tech companies and venture capital, to enter the abortion care space. Regardless, telemedicine abortion has been presented as a logical alternative to in-person abortion care because clinics are limited in number, disproportionately affecting rural abortion seekers. Because these clinics are also separated from other health care facilities, they are an easy target for anti-abortion protest and violence, which may induce a degree of anxiety in abortion seekers, as my research has shown. Beyond the question of 'virtual' or in-person abortion care, is whether abortion care should be situated within the health care system. In response to the lack of state provision, abortion accompaniment networks in Latin America have offered a necessary alternative to biomedical approaches to abortion care which demonstrate that abortion can be safe, effective, and acceptable even while illegal and facilitated by activists (Moseson et al., 2020; Walsh, 2020; Zurbriggen, Keefe-Oates and Gerdts, 2018). However, my study participants wanted the feelings of safety attendant with talking to a doctor, suggesting that, while the US has a lot to learn from extra-legal models, there may still be a role for legal and clinical provision of abortion, including through telemedicine.

7.2.3 | Abortion as state provision

Beyond biomedicalisation, abortion accompaniment networks also provide an alternative to state care, or legal abortion. Although there has never been state-provided abortion care in the US, we can consider what degree legality matters and whether legality should be a strategic focus of feminist movements. On the one hand, compliance (willing or not) with new abortion bans after the *Dobbs* decision has led to a 'chilling effect' across the health care system—not just in sexual and reproductive health—in which medical providers are unwilling to provide medications or procedures that could any way be perceived by the anti-abortion carceral state as abortifacient. In states where abortion is legally available, abortion providers, funds, and practical support organisations are being pushed to their limit to support out-of-state abortion-seekers who now must pay higher travel costs to access care. The abortion provider-patient ratios in the US immediately skyrocketed (Kirstein et al.,

2022), which means there are less providers and less appointments for everyone regardless of geographical location. On the other hand, abortion legality has never guaranteed access in the US. Telemedicine abortion attempts to facilitate access for people who might otherwise struggle to get an abortion, especially due to distance, but must comply with the law and is therefore limited in what it can practically do. While the US has remote abortion pill provision that operates outside the law, such as Aid Access, Women on Web, and online pharmacies, some abortion seekers may not feel comfortable with this because of perceptions of medical or legal risk.

7.3 | Abortion access and experiences with telemedicine: where and how should abortion care be provided?

My second research aim was to determine whether telemedicine abortion addresses geographic barriers to abortion care for rural women and pregnant people. In Chapters 5 and 6, I found that telemedicine does address geographic barriers to abortion care for rural women and pregnant people, albeit in an incomplete way. In Chapter 5, I argued that telemedicine abortion is not a panacea for rural health inequalities, but a promising pathway for abortion care. Abortion seekers are often just as likely to cross borders for telemedicine care and therefore the promises of telemedicine are not fully realised. However, despite the travel often involved in accessing telemedicine abortion, in Chapter 6 I argued that the material and time-space dimensions of the abortion pills, the relational practices of abortion care via telemedicine, and the affective and embodied experience of abortion care at home make telemedicine abortion care at home a viable alternative to the clinic-based care. By moving abortion care away from brick-and-mortar clinics, telemedicine abortion opens opportunities for alternative experiences of abortion care. In this section, I extend this conversation to consider two spaces in which abortion care has been provided and their implications: brick-and-mortar clinics and the 'virtual' clinic.

Where care is not available locally, particularly in rural areas, telemedicine is understood to cut across these distances to provide care, thus improving access and reducing inequalities. This research was premised on interrogating whether telemedicine abortion has indeed been a 'game changer' for rural women and

pregnant people who live far away from an abortion clinic. In reality, I found that it was more complex in that it both was and was not a 'game changer'.

JTP offered two telemedical pathways: 1) 'full' telemedicine in states with legal telemedicine abortion, where the abortion pills are delivered straight to patients' doors, and 2) cross-border telemedicine, as I call it here, where the abortion pills must be picked up from a state with legal telemedicine abortion. In the latter, JTP patients mostly travelled as individuals but also in groups to the 'mobile clinic' in Colorado. Although JTP primarily delivers 'full' telemedicine, most of my participants (9/11) lived in states without legal telemedicine abortion and therefore had to cross state borders to access care. Inter-state travel is common to access clinic-based abortion care and my spatial analysis demonstrated, in line with previous research, that rurality was associated with long travel times to the nearest abortion clinic, often to another state. Telemedicine is supposed to resolve the burden of distance with 'virtual' or 'remote' care (WHO, 2019, 2022b). However, this promise has not been realised in the case of abortion care because people are still travelling. The main reason for this is abortion exceptionalism; telemedicine is an accepted pathway for care in all 50 states, *except* for abortion in many of them. Study participants did not always understand why the pills could not just be sent to their door, given that it was telemedicine, underscoring the social construction of state borders and law. It also highlights that telemedicine abortion, though 'virtual', is subject to many of the same infrastructural and political constraints as clinic-based care.

Despite the necessity of travel—two round-trips, sometimes over long distances— participants expressed that cross-border telemedicine was still more convenient for them than in-clinic abortion care. The convenience was in the delivery of affordable and timely care, even though it could not reasonably be considered 'local' care. Telemedicine addressed barriers to accessing brick-and-mortar abortion clinics. Firstly, there are a limited number of abortion clinics and, as such, these clinics have limited availability. Participants initially struggled to find abortion care and had to weigh up travel distances with available appointment times, which were often multiple weeks away. They had to take what was the soonest available, rather than what worked best for them. Telemedicine appointments with JTP were available

sooner and were potentially less resource-intensive for participants, although shipping times for the pills could constrain the ability to terminate the pregnancy as soon as possible. Secondly, telemedicine abortion was generally cheaper than medication abortion or procedural abortion access in a clinical setting. Several study participants were on no or low-income and struggled to pay for the abortion, so cost was an important factor in their decision-making. This financial issue points to the constraints of choice under a neoliberal and anti-abortion health care system. This can also be seen in the way that participants discussed being 'used to' driving long distances to access care. Because rural health inequalities, frequently manifested in the absence of local health care options, are so widespread, distance was not as salient for my participants as issues of time and cost in terms of accessing abortion care.

In terms of experiencing abortion care, drawing on my findings from Chapter 6, telemedicine was further positioned as a preferred alternative to the abortion clinic. Even though they had to travel to have their appointment and pick up the abortion pills, research participants never had to go to the abortion clinic. Participants anticipated barriers to 'good' abortion care, particularly in the presence of anti-abortion protestors outside of the clinic. Moreover, although abortion clinics can provide medication abortion, in some participants there was a sense of the clinic being a sterile, biomedicalised place and the prospect of an 'invasive' procedural abortion was part of that. Telemedicine abortion allowed participants to have their abortions at home, thereby avoiding the threat of anti-abortion protests and enabling a more 'natural' abortion in the comfort of their home. However, home-based abortion did not represent a total evasion of these barriers to good care. Abortion stigma still shaped their experience in terms of who they disclosed the abortion to and who they allowed in the space of their abortion. This underscores the point that the home is not always a caring place, but it is a potential site of holistic abortion care when people are able to 'create' the space in terms of human and non-human things. In addition, the home was not entirely dichotomous to the clinic, because JTP still offers a biomedical model of abortion care, even though it is remotely provided. As such, telemedicine provided a 'compromise' between the perceived comfort and convenience of the home and the perceived safety of clinical spaces.

This research has demonstrated that telemedicine abortion is not entirely virtual, both in its requirement of travel for some states, its vulnerability to place-based infrastructure and abortion restrictions, and its emplacement in the home and acts of care. Telemedicine has been positioned in opposition to the abortion clinic in its potential to solve rural health inequalities, particularly distance, but it does not entirely deliver on this promise. Nevertheless, it has begun to change the spatial configuration of abortion care through displacing care away from the clinical setting and towards the home. This shift raises the question of where and how should abortion care be provided? This research speaks to two spaces through which abortion care could be provided.

7.3.1 | Abortion in brick-and-mortar clinics

Although research demonstrates that medication abortion has overtaken procedural abortion as the most common abortion method in 2020 (Jones et al., 2022), we do not yet know what proportion of this has been delivered by telemedicine versus in an abortion clinic. Until 2020, all abortion care was delivered in brick-and-mortar clinics, even where it engaged in 'partial' telemedicine. Independent abortion clinics provide the majority of abortion care in the US, and they have continued to do so in spite of increasing restrictions at the state-level and the everyday threat of anti-abortion violence, although in some cases they have had no choice but to shut down operations. The provision of abortion in abortion clinics has a number of spatial implications for care. Abortion is siloed away from other forms of sexual and reproductive health and the abortion clinic is a physical manifestation of this. Although they may provide other forms of SRH themselves, the fact of abortion provision makes them spatially vulnerable to city ordinances as well as to anti-abortion laws and protest, which have adopted many spatial strategies to shame abortion seekers, prevent abortion, or shut down clinics. The physical presence of 'sidewalk counsellors' and the intangible presence of the state in the clinical encounter can make the abortion clinic a daunting place to seek care, even as the clinicians and clinic escorts seek to create a caring experience. Telemedicine can offer a person-centred approach to care without patients needing to encounter the 'sonic' or visual patriarchy of protest outside the clinic, something my participants

valued, but this does not necessarily represent a true choice. Moreover, some people prefer going to the clinic and prefer or need a procedural abortion.

7.3.2 | Abortion in the 'virtual' clinic

Most telemedicine abortion providers in the US do not have a physical presence but are entirely online and offer telemedicine across multiple states. My research aligns with previous work demonstrating that telemedicine abortion is safe, effective, and acceptable to both patients and providers (Aiken et al., 2021b; Upadhyay and Grossman, 2019). However, I have challenged the notion that telemedicine abortion is necessarily a 'game changer' for people who live far away from an abortion clinic as well as the notion that telemedicine more broadly is a solution to rural health inequalities. This is because, in practice, many people live far away from a state in which telemedicine abortion is legal and therefore the burden of distance which telemedicine purports to solve remains. It is therefore not necessarily the burden of distance through we can differentiate between telemedical and in-person care pathways, but rather how telemedicine changes the space and place of care. In the shift away from clinical provision, I have explored the promises and pitfalls of telemedicine as a neoliberal care 'fix' which both relies on and obscures unpaid and self-care. In this, and beyond the notion of distance, I have called into question that telemedicine is truly a 'virtual' form of care. Even where telemedicine abortion is being delivered to its full potential, abortion care still has a place. Most of the time that place is the home. My analysis demonstrated that telemedicine abortion had temporal and material dimensions as well as affects that were facilitated by the space of the home, as opposed to the clinic, as well as the provision of person-centred and clinical care 'at a distance' by JTP. Therefore, telemedicine represents just as much a shift in the space of abortion care as it does the mechanism through which abortion care is delivered, but true reproductive 'choice' in abortion care may only be possible when the full spectrum of pathways is available.

7.4 | Discussion

In this thesis, I have argued that telemedicine abortion can reduce geographic barriers to abortion care for rural women and pregnant people. I proposed a more expansive understanding of geographic barriers to abortion care, which includes but

is not limited to the burden of distance to the nearest abortion clinic. I found that the burden of distance in fact remains through cross-border telemedicine abortion, due to the legal factors constraining abortion provision in the US, meaning that the promises of 'virtual' care have not realised. As such, I have found that what differentiates telemedicine abortion from in-clinic provision is the space and place in which care takes place. My discussion in this chapter has considered the ways in which telemedicine abortion is shaped by the landscape of abortion law and provision as well as the broader neoliberal and anti-abortion health care and political systems. While noting that telemedicine may be problematic, I suggested that telemedicine abortion is in practice more than a 'sticking plaster'. Likewise, while suggesting that telemedicine abortion may be a preference, I have observed that true reproductive 'choice' has not been available for many under *Roe*, given the gap in abortion provision and 'undue burdens' created by abortion restrictions at the state-level. These gaps and burdens are not solved by telemedicine abortion and as such it cannot be considered a panacea for rural health. Nevertheless, within the material conditions in which abortion seekers are making their decisions, it remains an important pathway for provision.

Notwithstanding the efforts of abortion providers throughout the country, there is no denying that there is an abortion care crisis in the US, which loomed before *Dobbs* and has only been intensified in its aftermath. It is widely acknowledged that neither the executive nor the legislative branch made sufficient efforts to address the crisis instigated by the judicial branch in the *Dobbs* decision. They couched their response to the crisis in terms of reproductive 'choice' rather than abortion and therefore reinforced abortion stigma. Although the federal government response was wanting, individual states made efforts to protect, or even advance, abortion rights, including through protecting abortion seekers and providers from prosecution. Individual municipalities have also sought to become 'safe havens' for abortion and even provide abortion funding. At the same time, we know that these progressive efforts have been matched by regressive efforts elsewhere. Moreover, there has been a growing recognition that the state and the legal status of abortion should not be the arbiters of abortion rights. Groups like Shout Your Abortion, in the vein of abortion

accompaniment and feminist networks throughout the world, emphasised that they would 'aid and abet' abortion.

At the individual level, there were some not so useful responses to *Dobbs* which laid bare tensions within the US feminist movement, such as suggesting that abortion provision be moved onto Native American reservations which are not subject to US federal law or suggesting that women get long-acting reversible contraceptives as soon as possible. Alongside racist and imperialist comparisons with other countries as well as *The Handmaid's Tale*, some unproblematically suggested an 'abortion underground' or otherwise reinventing the wheel of abortion funds and practical support. These propositions contrasted with the efforts of abortion providers and activists who have been attempting to meet demand. There has been increasing public attention to case studies from the so-called global South, especially Mexico, which demonstrate how abortion can be provided outside the confines of the law. Mexican feminists have already been helping US abortion seekers, but US feminists may have a lot to learn from extra-legal provision in Latin America and beyond. My research has shown, however, that there is still an important role for legal abortion provision via telemedicine. Whilst complying with unjust laws, telemedicine abortion enables person-centred, at-home abortion care with medical supervision which may be preferable and more convenient for many abortion seekers in the US. Abortion infrastructure must be shored up to ensure continued access in the face of an un-caring state.

7.4.1 | Further research

As part of the effort to consider how abortion infrastructure is being shored up to advance abortion access and care in the US after *Dobbs*, research could further develop the notion of cross-border telemedicine into new empirical areas. My discussion of cross-border telemedicine focused on rural women who travelled across state lines to have their telemedicine appointment and pick up the pills. I did not knowingly interview patients who opted not to do this, even though telemedicine abortion was not legal in their state. Moreover, it would be useful to understand when people decide that cross-border telemedicine is in fact too burdensome and either go to a brick-and-mortar clinic, order pills online, or use mail-forwarding or virtual

mailboxes. In short, more research is needed to understand the decision-making around telemedicine abortion, given both the changing abortion landscape and the potentially elusive promises of telemedicine. Related to this, it would be useful for research to consider the role of tech companies and venture capital in abortion care provision. Research should also explore how activists are attempting to fill gaps in provision outside of legal or biomedical frameworks, without jeopardising the safety or security of those activists.

7.5 | Conclusion

Based on my findings presented in this thesis and this discussion, I argue that telemedicine abortion does not entirely eliminate geographic barriers to abortion care. With respect to distance—the primary justification for telemedicine interventions—state-level restrictions meant that individuals still travelled long distances to access care. Nevertheless, telemedicine emerged as a mechanism through which responsive and necessary abortion care is provided during an enduring crisis in abortion care. This crisis has been created by the neoliberalisation of health care in the US, including through the promulgation of telemedicine, and a wider anti-gender agenda that has restricted, banned, and criminalised abortion at different scales. Given this context, telemedicine abortion may place the onus of responsibility of abortion care on the individual and may represent constrained choices. However, my research suggests that it is too simplistic to paint telemedicine abortion as a 'care fix' for this crisis. Telemedicine abortion is not exclusively chosen because travel distance to an abortion clinic is too burdensome or the cost of an in-person abortion too high. Telemedicine abortion is also quality abortion care, which is chosen for reasons of convenience, privacy, and comfort, which brick-and-mortar abortion clinics may not offer. Rather than enabling self-care per se, I suggest instead that telemedicine abortion enables the decentring of self-care towards a relational experience of abortion care in an uncaring state. Telemedicine abortion offers potential insights into the radical potential of abortion care, such as taking abortion care out of clinical settings and putting it into individual and community hands. These questions encompass but extend beyond recent innovations in abortion care pathways to interrogate how abortion is bound up in issues of social, economic, and reproductive justice which cannot be resolved simply be reinstating

Roe. We need to consider how to build a sufficient abortion care infrastructure within and outside of the formal health care system.

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Appendixes

Appendix 1 | Recruitment text messages

Hi! We're writing to ask whether you would be willing to be interviewed for a PhD research project on telemedicine abortion access for rural folks. We're reaching out because you live in a rural county! Interviews will last approx. one hour and you will be paid a $15 gift card for your time. This project is run by Olivia Engle at Birkbeck, University of London. If you are interested, please send Olivia a text at 952-641-7338 or an email at oengle01@mail.bbk.ac.uk. Thank you!

¡Hola! Le escribimos para preguntarle si estaría dispuesta a ser entrevistada para un proyecto de investigación doctorado sobre el acceso al aborto por telemedicina para la población rural. ¡Nos comunicamos consigo porque vive en un condado rural! Las entrevistas durarán aproximadamente una hora y se le pagará una tarjeta de regalo de $15 por su tiempo. Este proyecto está dirigido por Olivia Engle en Birkbeck, Universidad de Londres. Si usted está interesada, envíe un mensaje de texto a Olivia al 952-641-7338 o un correo electrónico a oengle01@mail.bbk.ac.uk. ¡Gracias!

Hi! We're writing to ask whether you would be willing to be interviewed for a PhD research project on our mobile abortion clinics. The anonymous interviews will last approx. one hour and you will be paid a $15 gift card for your time. This project is run by Olivia Engle at Birkbeck, University of London. If you are interested, please send Olivia a text at 952-641-7338 or an email at oengle01@mail.bbk.ac.uk. Thank you!

¡Hola! Le escribimos para preguntarle si estaría dispuesta a ser entrevistada para un proyecto de **investigación** doctorado sobre nuestras clínicas móviles. Las entrevistas anónimas durarán aproximadamente una hora y se le pagará una tarjeta de regalo de $15 por su tiempo. Este proyecto está dirigido por Olivia Engle en Birkbeck, Universidad de Londres. Si usted está interesada, envíe un mensaje de texto a Olivia al 952-641-7338 o un correo electrónico a oengle01@mail.bbk.ac.uk. ¡Gracias!

Appendix 2 | Information sheet and consent form

Information Sheet

Researcher: Olivia Engle, oengle01@mail.bbk.ac.uk

Supervisors: Jasmine Gideon, j.gideon@bbk.ac.uk, Kalpana Wilson, k.wilson@bbk.ac.uk

Department of Geography

Birkbeck, University of London

Malet Street,

London WC1E 7HX

020 7631 6000

Title of Study: Abortion at home: the potential of medication abortion to address geographic and spatial barriers to abortion care

Name of researcher: Olivia Engle

The study is being done as part of my PhD degree in the Department of Geography, Birkbeck, University of London. The study has received ethical approval.

This study investigates the extent to which medication abortion (the 'abortion pill') provided by telemedicine can address barriers to abortion care for rural women and pregnant people.

You will be asked to participate in a recorded interview via video conferencing or telephone about your experience in the provision of abortion care. This information will help the researcher to assess whether telemedicine medication abortion services are useful to rural women and pregnant people.

Data will be transcribed analysed by the researcher by drawing out key themes as they relate to the research question.

If you agree to participate, you will agree a convenient time and place for me to interview you for about an hour to an hour and a half. You are free to not answer any question and to stop the interview at any time. You can withdraw from the study up until the data you have provided has been anonymised and aggregated into a larger dataset from which it is impossible to extract, which is a process that takes approximately 4 weeks.

Your data will be stored in a secure university repository for three years. If requested, this data will be anonymised.

The analysis of your participation in this study will be written up in the PhD thesis and publications that may arise from it. If you choose anonymity, you will not be identifiable in any publication which might ensue.

Anonymised data will be made available to other researchers in a safeguarded format with the UK Data Service.

The study is supervised by Drs Jasmine Gideon and Kalpana Wilson who may be contacted at the above address and telephone number.

For information about Birkbeck's data protection policies, please visit:
http://www.bbk.ac.uk/about-us/policies/privacy

If you have concerns about this study, please contact the School's Ethics Officer
sshpethics@bbk.ac.uk

You also have the right to submit a complaint to the Information Commissioner's Office
https://ico.org.uk/

Consent form

Title of Study: Abortion at home: the potential of medication abortion to address geographic and spatial barriers to abortion care
Name of researcher: Olivia Engle

I have been informed about the nature of this study and willingly consent to take part in it.

I agree to the following data collection and processing approaches being used for my data:
- Recorded interview (60-90 minutes)

I understand that I will not be identifiable in any presentation of this research without my further, written, consent.

I understand that I may withdraw my data at any time before it has been anonymised and combined with other data.

I understand that the anonymised form of the data I have provided will be made available to other researchers through publications and by being deposited in a data repository.

I am over 18 years of age.

Name

_____

Signed

_____

Date

_____

There should be two signed copies, one for participant, one for researcher.

Appendix 3 | Date and length of interviews

Patients

Name (pseudonyms)	Interview Date	Interview Length
Beth	21 January 2022	1 hour 1 minute
Erin	21 January 2022	1 hour 4 minutes
Claire	26 January 2022	59 minutes
Morgan	26 January 2022	1 hour 10 minutes
Lucy	9 March 2022	1 hour 30 minutes
Laura	17 March 2022	53 minutes
Alice	30 March 2022	1 hour 11 minutes
Helen	31 March 2022	40 minutes
Jenny	29 June 2022	1 hour 40 minutes
Elena	13 December 2022	1 hour 23 minutes
Diana	14 December 2022	1 hour

Key informant participants

Name	Title	Organisation	Interview Date	Interview Length
Anonymous	Executive Director	JTP	16 and 25 May 2022	1 hour 16 minutes
Dr Julie Amaon	Medical Director	JTP	9 June 2022	1 hour 18 minutes
Anonymous	Clinic Director	JTP	23 June 2022	1 hour 14 minutes
Anonymous	Patient Educator	JTP	8 June 2022	57 minutes
Susan Schumacher	Director of Board	JTP	13 May 2022	1 hour 6 minutes
Shayla Walker	Executive Director	Our Justice	6 June 2022	1 hour 15 minutes
Marie Khan	Director of Programs	Midwest Access Coalition	11 May 2022	2 hours 2 minutes

Appendix 4 | Interview questions

For patients:

- As the text message from JTP mentioned, you were contacted as a potential interviewee because of living in a rural county. So I am hoping we might start by you telling me a bit about where you live…

- Is life for women in X different than life for men?

- What are some of the attitudes or ideas about sex, pregnancy, birth control or abortion in X?

- What is sexual and reproductive health care like in X?

- Would you be willing to share some of your reasons for having an abortion?

- How did you come to decide to have a medication abortion at home through telemedicine?

- And then, if you're willing to share, how was the actual experience of having your abortion at home?

- Thank you so much for sharing your experience. I am hoping to conclude by talking a bit about what you choices you might have made if you had not found JTP.

For JTP staff:

- Can you walk me through the process through which an abortion seeker has an abortion with JTP?

- How is this different for:
    - Rural women and pregnant people
    - Service areas/out-of-state
    - English/non-English speaking

- If someone reaches out from a state farther away, what do you suggest to them?

- Can you tell me about how JTP has adapted to the various U-turns on telemedicine abortion from the FDA and Supreme Court?

- Have you encountered any legal action? Do you have concerns about any potential legal action or ramifications?

- Plans/progression

For staff of partner organisations:

- What is your organisation?

- How does your organisation fit within abortion care provision in the region?

- How does your organisation serve rural women and pregnant people? What are the particular challenges facing rural women and pregnant people in accessing abortion care?
  - What proportion of your clients are those from rural places, either of the Midwest or elsewhere?
  - Are there any challenges specific to the rural Midwest?
  - What are the potential solutions?
  - Intersectionality?
- Can you tell me about the relationship between your organisation and JTP?

For both staff of JTP and partner organisations:
- What is your position in the organisation and what do you do?
- What brought you to the work you are doing today?
- What does reproductive justice mean to you? To what extent is your work guided by reproductive justice? Intersectionality?
- How would you define self-managed abortion? Does self-managed abortion differ from telemedicine abortion?
- How would the overturning *Roe v. Wade* and *Planned Parenthood v. Casey* affect abortion seekers in the region? Why do you think Minnesota and Illinois will be hubs for abortion care? How do you see your role if/when that happens?

Appendix 5 | Demographic questionnaire

What is your zip code?

- Don't know

- Other (please specify)_____

- Prefer not to answer

How old were you at the time of your abortion?

- Don't know

- Other (please specify)_____

- Prefer not to answer

With which ethnic or racial group do you most identify? Select all that apply.

- African American/Black

- American Indian or Alaskan Native

- South Asian (e.g. Indian, Pakistani, Bangladeshi, etc.)

- Southeast Asian (e.g. Vietnamese, Laotian, Cambodian, etc.)

- East African (e.g. Somali, Ethiopian, Kenyan, etc.)

- Hispanic or Latino, Latina or Latinx

- Native Hawaiian or other Pacific Islander

- White

- Don't know

- Other (please specify)_____

- Prefer not to answer

What is the primary language spoken in your home? Select all that apply.

- English

- Spanish

- Hmong

- Cushite (e.g. Somali, Oromo, Sidamo)

- Other (please specify)_____

- Prefer not to answer

What best describes your current gender? Select all that apply.

- Man

- Woman
- Gender non-conforming or non-binary
- Don't know
- Other (please specify)_____
- Prefer not to answer

Do you identify as trans?
- Yes
- No
- Prefer not to answer

What best describes your sexuality?
- Heterosexual or straight
- Homosexual, gay, or lesbian
- Pansexual
- Asexual
- Other (please specify)_____
- Prefer not to answer

What best describes your marital status?
- Married
- Separated or divorced
- Relationship, not living together
- Living together
- Single
- Widowed
- Other (please specify)_____
- Prefer not to answer

Do you have any children? If so, how many?
- Yes, _____
- No
- Prefer not to answer

What best describes your highest level of education?

- Some high school
- High school or GED
- Some college or Associate's degree
- College or Bachelor's degree
- Graduate or Master's degree
- Doctorate
- Other (please specify)_____
- Prefer not to answer

What best describes your current employment status? Select all that apply.
- Unemployed (no benefits)
- Unemployed (with benefits)
- Full-time
- Part-time
- Full-time student
- Part-time student
- Don't know
- Other (please specify)_____
- Prefer not to answer

What best describes your household level of yearly income before taxes?

- _____
- Don't know
- Other (please specify)_____
- Prefer not to answer