To the reader: This piece was written for a Symposium on the book After Dobbs by David Cohen and Carole Joffe. Here is a description of After Dobbs:

> *In June 2022, the Supreme Court overturned Roe v. Wade. However, it did not end abortions; rather, because of the courageous work of people on the ground, as well as the determination of patients who need care, abortion has survived – and even thrived – in ways the no one predicted. [Based on interviews with abortion providers and advocacy communities, the book] uncover[s] how they alongside their allies, prepared for and then responded to this momentous event.*

Lessons Learned from Global Responses to Criminal Abortion Laws

Cynthia Soohoo[1]

After Dobbs chronicles how U.S. abortion providers and activists developed creative new models to provide abortion care in the post-*Dobbs* era. The stories are inspiring, but not surprising. While the U.S. recognized the right to abortion from 1973-2022, other countries struggled under criminal abortion laws. In the 2000s, activists and some medical professionals, supported by regional and global networks, leveraged innovations in medicine and community insights to develop models to enable people to safely end their pregnancies despite criminal laws.

Almost twenty years later, the *Dobbs* decision has ushered in a new era of criminalization in the U.S. As was true in other parts of the world, criminal abortion laws have not decreased abortions. Instead, restrictive laws have catalyzed innovative new models for providing abortion information, care and support. In the U.S., unlike other countries, many of these strategies have been led by abortion providers and funds, who simultaneously inhabit the roles of health care professionals and abortion rights activists.

In many countries, the public's experience with the impact of criminal abortion laws galvanized reform efforts. Scholars have criticized some of these efforts for failing to completely decriminalize abortion and remove gestational or reason-based requirements or requiring that abortions be performed in regulated health care settings, creating "backdoor criminalization" for individuals who self-manage abortions and those who help them. Some countries also have included provisions that address affordability and other barriers to care and ensure that patients receive respectful, nonjudgmental and confidential care.

---

[1] Professor of Law CUNY School of Law. Thanks to Izzy Braham for her research assistance and to Farah Diaz-Tello and Rebecca Reingold for their insightful comments.

I. Global Experience With Criminal Abortion Laws

A. Criminalization and Unsafe Abortion

During the *Roe* Era, the key global takeaways about criminal abortion laws were that they (1) do not decrease abortions,[2] (2) are associated with high maternal mortality rates and unsafe abortions,[3] and (3) disproportionately impact poor or marginalized communities who lack resources to travel to obtain legal care or access to providers willing to provide safe clandestine abortions.[4w]

At the 1994 International Conference on Population and Development, governments made addressing unsafe abortion a global priority.[5] Because criminal abortion laws prevented people from accessing abortion care, even when laws recognized exceptions for obstetric emergencies or rape, human rights bodies called on states to take efforts to prevent unsafe abortion, including by repealing criminal laws and ensuring access to abortion services and post-abortion care.[6] Calls for decriminalization also reflected human rights law's growing recognition of the "inherent antagonism between punitive legal frameworks and the right to health."[7]

B. Medication Abortion Changes the Landscape

The development of medication abortion was a game changer in efforts to prevent unsafe abortion. Medication abortion originated in the 1980s when Brazilian women discovered that misoprostol, a drug sold in drug stores without a prescription to treat

---

[2] Joanna N. Erdman, *Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach,* 34 HARV. J. L. & GENDER 413, 458 (2011); Gilda Sedgh, Jonathan Bearak, Susheela Singh, Akinrinola Bankole, Anna Popinchalk, Bela Ganatra, *Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends,* 388:10041 THE LANCET P258 (2016) (finding no association between abortion rates and the grounds under which abortion is legally permitted).

[3] Erdman, *supra* note 2, 458; Marlene Gerber Fried and Loretta J. Ross, ABORTION AND REPRODUCTIVE JUSTICE 211 (U. Cal. Press 2025); World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd ed. WHO; 2012, 90 ("Evidence increasingly shows . . . that, where abortion is legal . . . and where safe services are accessible, both unsafe abortion and abortion-related mortality and morbidity is reduced.")

[4] *See e.g.* Cassia Roth, *Abortion Access in the Americas: a hemispheric and historical approach*, FRONT. PUBLIC HEALTH 11.1284737, at 3 (discussing findings in Brazil that poor women and women of color, disproportionately experienced higher rates of maternal mortality and morbidity).

[5] United Nations, Programme of Action of the United Nations International Conference on Population and Development 1994, para. 8.25.

[6] See e.g. Human Rights Committee, General comment no. 36, para. 8, U.N. Doc. CCPR/C/GC/36 (2019); Committee on Economic, Social and Cultural Rights, General comment No. 22, para. 28, U.N. Doc. E/C.12/GC/22 (2016).

[7] Mariana Prandini Assis and Joanna N. Erdman, *Abortion rights beyond the medico-legal paradigm*, 17(10) GLOBAL PUB. HEALTH 2235, 2238 (2021).

gastric ulcers, could be used to induce miscarriages.[8] Unlike other clandestine methods, misoprostol use was safe and effective.[9] During the same period, a French pharmaceutical company developed the drug mifepristone to be used with misoprostol for medication abortions.[10] Today, the WHO recognizes two protocols for medication abortion, mifepristone in conjunction with misoprostol or "misoprostol alone."[11]

In the 1990s, abortion was heavily restricted in Latin America, but use of misoprostol to self-manage abortion became widely known.[12] Information spread through activist networks, health providers, social workers, lawyers and academics,[13] and the incidence and severity of post-abortion complications decreased.[14] Indeed, even as countries retained criminal abortion laws, informal use of misoprostol has been credited for the global decline in abortion-related morbidity and mortality since 1990.[15]

C. Health care settings

Globally, in many countries where abortion was criminalized, health care settings have been sites of coercion, racism, and obstetric violence.[16] Abortion criminalization reflects and exacerbates abortion stigma that often is internalized by health care providers. Stigma and paternalism can intertwine, resulting in health providers who

---

[8] Francine Coeytaux, Leila Hessini, and Amy Allina, *Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands,* 25-6 WOMEN'S HEALTH ISSUES 608, 609 (2015); Patty Skuster, Heidi Moseson and Jamila Perritt, *Self-managed abortion: Aligning law and policy with medical evidence,* 160 INT'L. J. GYNECOL. OBSTET. 720, 721(2023); Naomi Braine, ABORTION BEYOND THE LAW 20 (Verso 2023); Mariana Prandini Assis and Joanna N. Erdman, *In the name of public health: misoprostol and the new criminalization of abortion in Brazil,* 8(1) J. OF LAW AND THE BIOSCIENCES at 3 (2021).

[9] Erdman, *supra* note 2, at 418.

[10] Skuster et al., *supra* note *8,* 721. The two drug regimen was introduced in France in the 1980s and spread through Europe. Braine, *supra* note 8, at 19-20. It was not approved in the U.S. until 2000. *Id.* at 20.

[11] World Health Organization, Abortion Care Guidance, 3.4.2: Medical management of induced abortion (2022) [hereinafter WHO Abortion Care Guidance]

[12] Sara Larrea, Laia Palencia and Carme Borrell, *Medical abortion provision and quality care: What can be learned from feminist activists,* 45(1) HEALTH CARE FOR WOMEN INT'L 47, 48 (2024); Erdman, *supra* note 2, at 418.

[13] Marta Martinez and Liana Simstrom, *How a network of women in Latin America transformed safe, self-managed abortions,* OPB.org (June 8, 2025)

[14] Larrea et al. *supra* note 12, at 48; Erdman, *supra* note 2, at 418; Fried and Ross, *supra* note 3, at 237; Raquel Irene Drovetta, *Safe Abortion Information Hotlines: An Effective Strategy for Increasing Women's Access to Safe Abortions in Latin America,* 23(45) REPRO. HEALTH MATTERS 47, 48 (2015). Lucia Berro Pizzarosa and Patty Skuster, *Toward Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform,* 23(1) HEALTH AND HUMAN RIGHTS J. 199, 204 (2021) (discussing decrease in septic abortions in Chile).

[15] Assis and Erdman, *supra* note 8*,* at 12*;* Pizzarosa and Skuster, *supra* note 14 at 200; Joanna N. Erdman, Kinga Jelinska and Susan Yanow, *Understandings of self-managed abortion as health equity, harm reduction and social change,* 26:54 REPRODUCTIVE HEALTH MATTERS 13, 13 (2018).

[16] Erdman, *supra* note 2, at 440 (noting that "mistreatment in public health care facilities of women who terminate their pregnancies is widespread").

"believe that they have the right to accuse, judge and condemn [people seeking abortion-related care]."[17] In many countries, criminal laws included exceptions for abortions in cases of rape, or endangerment of the pregnant person's life or health. But often it was unclear when the exceptions applied.[18] Provider fear and stigma led to the practical inability to access abortion, even if a person was legally entitled to one, and discouraged individuals from seeking post-abortion care for fear that health care providers would judge or report them to legal authorities.[19] In countries that liberalized abortion laws, provider attitudes continued to prevent or delay care in areas with high rates of conscientious objection.[20]

II. Global Strategies in Criminalized Contexts

This section describes the models that developed in the 2000s to disseminate information about medication abortion in countries with criminal abortion laws.

A. Health Care Provider Models

In the 2000s, health care providers working in criminalized contexts developed harm reduction strategies to provide information about safe self-management.[21] In 2001, Uruguay criminalized abortion except in cases of rape, threat to the pregnant person's life or health and extreme poverty.[22] Even if these conditions were met, as a practical matter, it was very difficult to obtain an abortion because there were no implementing regulations

[17] *Id.* at 440-41.
[18] Kim Ricardo, *Was Justice Ginsburg Roe-ght? Reimagining U.S. Abortion Discourse in the Wake of Argentina's Marea Verde,* 48 MITCHELL HAMLINE L. REV. 128, 151 (2022).
[19] Brianna Keefe-Oates, Chelsea G. Tejada, Ruth Zurbriggen, Belén Grosso, and Caitlin Gerdts, *Abortion Beyond 13 Weeks in Argentina: Healthcare-Seeking Experiences During Self-Managed Abortion Accompanied by the Socorristas en Red*, 19:185 REPRODUCTIVE HEALTH, at 3-4 (2022), https://doi.org/10.1186/s12978-022-01488-6 *at* 4; Braine, *supra* note 8, at 81.
[20] U.N. Working Group on Discrimination Against Women and Girls, Conscientious Objection to Abortion: Key Considerations, U.N. Doc. A/HRC/WG.11/41/1, para. 21 (2024) See e.g. Bianca M. Stifani, Martin Couto and Alejandra Lopez Gomez, *From harm reduction to legalization: The Uruguayan model for safe abortion*, 143(S4) INT'L J. GYNECOLOGY & OBSTETRICS 45, 49 (2018).
[21] Roopan K. Gill, Amanda Cleeve and Antonella F. Lavelanet, *Abortion hotlines around the world: A mixed-methods systematic and descriptive review,* 29:1 SEXUAL AND REPRODUCTIVE HEALTH MATTERS, 75, 76 (2021).
[22] Erdman, *supra* note 2, at 420.

and abortion was highly stigmatized.[23] As a result, Uruguay suffered high rates of maternal mortality associated with unsafe abortion that disproportionately impacted poor women.[24]

Pereira Rossell Hospital Center, Uruguay's main public maternity hospital was particularly hard hit.[25] From 1996-2001, unsafe abortion caused 47% of maternal deaths.[26] In response, a group of doctors (who later formed "Iniciativas Sanitarias") developed the Uruguay harm reduction model. [27] Under the model, pregnant patients were informed of their options including the limited circumstances for legal abortions. If patients indicated they wanted to terminate their pregnancy, a trained team provided "information on the risks associated with the different means used to induce abortion" including information about how to use misoprostol safely and effectively.[28] The team did not prescribe or provide information about how to obtain the drug.[29] The model included "before and after care" composed of testing to confirm the pregnancy and a follow up appointment to treat complications and provide contraceptive counseling.[30]

The model brought abortion seekers into the health system and reduced abortion-related morbidity and mortality.[31] The Ministry of Health supported the program, issuing regulations (that were later codified) implementing harm reduction services in public sector facilities.[32] In 2012, Uruguay liberalized its abortion law, decriminalizing abortion up to twelve weeks (described below).

Health care providers in other countries developed programs based on the Uruguay model.[33] In 2006, International Planned Parenthood/Western Hemisphere Region[34]

---

[23] *Id.* at 420; Giselle Carino, Jennifer Friedman, Marcela Rueda Gomez, Carrie Tatum and Leonel Briozzo, *A Rights-Based Model: Perspectives from Health Service Providers*, 39(3) IDS BULLETIN 78 (2008); Ana Labandera, Monica Gorgoroso and Leonel Briozzo., *Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country,* 134 INT'L JOURNAL OF GYNECOLOGY AND OBSTETRICS S7, S7 (2016). Ines Pousadela, *From feminist extravagances to citizen demand: the movement for abortion legalization in Uruguay*, in WOMEN'S EMANCIPATION AND CIVIL SOCIETY ORGANIZATIONS: CHALLENGING THE STATUS QUO? 141, 140 (Christina Schwabenland ed 2019).

[24] Erdman, *supra* note 2, at 424. From 1995-1999, unsafe abortion was the leading cause of maternal mortality, accounting for 28% of maternal deaths. Labandera et al. *supra* note 23,at S7.

[25] Carino at al., *supra* note 23, at 78.

[26] Labandera et al., *supra* note 23, at S7.

[27] Carino et al., *supra* note 23, at 77; Labandera et al., *supra* note 23, at S8; Erdman, *supra* note 2, at 414.

[28] Erdman, *supra* note 2, at 421; Carino et al., *supra* note 23, at 78; Labandera et al. *supra* note 23, at S8.

[29] Erdman, *supra* note 2, at 414.

[30] Carino et al., *supra* note 23, at 78. *See* Labandera et al., *supra* note 23, at S8 (providing detailed description).

[31] Stifani, *supra* note 20, at 46.

[32] Carino et al., *supra* note 23, at 78; Labandera et al., *supra* note 23, at S8; Erdman, *supra* note 2, at 421.

[33] Erdman, Jelinska & Yanow, *supra* note 15, at 13,15.

[34] IPPF/WHR was a major provider of sexual and reproductive health care in Latin America and the Caribbean and in 2012 had 40 member associations in the region. IPPF/WHR, Iniciativias Sanitaras, Women's Link

("IPPF/WHR") and Iniciativas Sanitarias partnered to bring harm reduction models to countries in the region.[35] Working with IPPF/WHR member associations, country specific models were developed, followed by efforts to encourage public health clinics to adopt the models.[36]

In addition to harm reduction programs, in Argentina, some health care professionals provided abortions under the legal exceptions despite the lack of legal clarity about when the exceptions applied and a hostile professional environment.[37] Some also provided before and after-care sometimes in coordination with activists who accompanied self-managed abortions.[38]

B. Activist Self-Management Models

Professors Mariana Prandini Assis and Joanna N. Erdman describe how "beginning in the 2000s, feminist activists organized in local collectives, nationwide networks, and global telehealth organisations . . . innovated upon the informal use of abortion pills, seeking to make the practice safer through the provision of information and support, and eventually the supply of pills too."[39] Activists combined feminist self-help strategies with advocacy to decriminalize abortion and reform health care systems.[40] Strategies included hotlines, accompaniment, web-based communication, community work and combinations of these activities.[41]

1. Hotlines

In the 2000s, grassroots feminist organizations working in restrictive settings launched hotlines to provide "information by telephone about how to terminate a pregnancy using medications based on evidence based protocols."[42] Collectives also shared information through blogs, chats, Facebook, Twitter, and published manuals and reports.[43] Hotlines discussed symptoms and side effects, when to seek medical help and

---

Worldwide, *The Foundation for a Comprehensive Sexual and Reproductive Health Counseling Service* 2 (2012).

[35] Carino et al., *supra* note 23, at 77.

[36] *Id.* at 80.

[37] Alicia Ely Yamin & Agustina Ramon Michel, *Using Rights to Deepen Democracy: Making Sense of the Road to Legal Abortion in Argentina,* 46:3 FORDHAM INT'L L. J. 377, 402-3, 411 (2023); Ricardo, *supra* note 18, at 150-51, 157-58. In 2015, the environment improved when the Ministry of Public Health issued administrative guidelines interpreting the health exception to the criminal abortion. *Id*. at 151-53, 157-58.

[38] Drovetta, *supra* note 14, at 50.

[39] Assis and Erdman, *supra* note 7, at 2236.

[40] Ruth Zurbriggen, Brianna Keefe-Oates and Caitlin Gerdts, *Accompaniment of second-trimester abortions: the model of the feminist Socorrista network of Argentina,* 97 CONTRACEPTION 108,109 (2018).

[41] Braine, *supra* note 8, at 76.

[42] Gill et al., *supra* note 21, at 76 79.

[43] Drovetta, *supra* note 14, at 49, 50, 51.

how to avoid legal risk when communicating with health care providers,[44] as well as information about how to self-source medicines.[45]

The first hotline developed from a collaboration between the Dutch non-profit Women on Waves ("Waves") and Portuguese activists. At the time, Waves provided abortion care on a ship that docked in international waters off the coast of countries with restrictive abortion laws.[46] In 2004, when Portuguese authorities prevented the ship from entering the port, Waves published the medical protocol for using misoprostol online, and Portuguese activists began sharing the protocols on the temporary hotline set up to schedule appointments.[47] When the boat left, the hotline continued.[48]

In 2005, the founder of Waves created Women on Web to train activists in the protocols for medication abortion and to develop a telemedicine abortion platform (discussed below).[49] In 2008, Women on Web worked with Ecuadoran activists, who hung a banner on a statue overlooking Quito that read "SAFE ABORTION" with a phone number, and the first hotline in Latin America was born.[50] The Ecuadorian feminists were well networked, and information about the hotline spread among feminists in South America.[51] "Within two to three years, there were hotlines in Argentina, Chile, and Peru."[52] In Chile, the availability of misoprostol on the informal market combined with the dissemination of information through hotlines has been credited in the reduction of septic abortions which plagued Chile in the 1980s.[53]

2. Accompaniment

Accompaniment is a longstanding feminist practice in Latin America, combining "witness and physical and emotional presence" to support "individuals and families through the medical and legal aftermath of different forms of violence against women."[54] In countries where abortion was legal for limited grounds or in certain regions,

[44] Gill et al., *supra* note 21, at 82; Drovetta, *supra* note 14, at 53.
[45] Erdman et al, *supra* note 15, at 15.
[46] Braine, *supra* note 8, at 66.
[47] *Id.* at 22-23, 66.
[48] *Id.* at 23, 66.
[49] *Id.* at 27; https://www.womenonweb.org/en/women-on-web/#Our_story
[50] Martinez and Simstrom, *supra* note 13; Braine, *supra* note 8, 23-24, 66-68.
[51] Braine, *supra* note 8, at 24.
[52] *Id.* at 25, 68; Fried and Ross, *supra* note 3, at 206.
[53] Pizzarosa and Skuster, *supra* note 14, at 204.
[54] Braine, *supra* note 8, at 25, 75.

accompaniment networks helped people obtain abortions within the health system and travel to hospitals that provided care.[55]

In the early 2000s rape was the only legal ground for abortion in Guanajuato, Mexico.[56] To ensure rape survivors could access services, a feminist human rights organization began accompanying them to appointments with gynecologists.[57] Over time, activists learned the protocol for medication abortion and began sharing the information and accompanying self-managed abortions.[58] According to Professor Naomi Braine, over the next ten years, abortion accompaniment strategies spread throughout South America.[59]

Argentina's Socorristas en Red ("the Socorristas") are the largest accompaniment network. Formed in 2010 when Argentine law only permitted abortion in cases of rape or health endangerment,[60] the Socorristas support and accompany people who self-manage all or part of their abortions at any stage of pregnancy regardless of legality. [61] Their model includes intake over a telephone hotline, an in person meeting on how to safely use abortion pills and accompaniment during the abortion process in the form of ongoing communication and assistance, which can be in person or over the phone.[62] The model emphasizes compassionate support without judgment or mistreatment.[63]

While the Socorristas support self-management, one of the movement's goals is to reinstate accessible, empathetic, and non-discriminatory abortion care in the health system,[64] and their services include helping individuals who qualify for legal abortions and choose clinical care navigate the healthcare system.[65] In many regions, the Socarristas

---

[55] *Id.* at 26. *See e.g.*, Alexandra Wollum, Sofía Garduno Huerta, Oriana Lopez Uribe, Camille Garnsey,S. Michael Gaddis, Sarah E. Baum Brianna Keefe-Oates, *The influence of feminist abortion accompaniment on emotions related to abortion: A longitudinal study in Mexico,* SSM POPULATION HEALTH 19 (2022) 101259 at 2.
[56] Braine, *supra* note 8, 26, 76.
[57] *Id.* at 26.
[58] *Id.* at 26; Martinez and Simstrom, *supra* note 13.
[59] Braine, *supra* note 8, at 76; Martinez and Simstrom, *supra* note 13.
[60] Prior to a 2012 Supreme Court case and the issuance of Guidance from the Public Health Ministry there was a lack of clarity about when these exceptions applied. Ricardo, *supra* note 18, at 148, 150-51, 153, 154-56.
[61] Keefe-Oates et al, *supra* note 19, at 4; Zurbriggen et al, *supra* note 40, at 109.
[62] Keefe-Oates et al, *supra* note 19, at 4*;* Zubriggen et al, *supra* note 40, at 110.
[63] Zubriggen et al, *supra* note 40, at 109.
[64] *Id*. at 109.
[65] *Id*. at 109; Brianna Keefe-Oates, Sofia Filippa, Elizabeth Janiak, Ruth Zurbriggen, Belen Grosso, Jarvis T Chen and Caitlin Gerdts, *Seeking abortion accompaniment: experiences and self-managed abortion preferences of hotline callers after abortion legalisation in Argentina* 51 BMJ SEX REPROD HEALTH 152, at 2 (2024); Silvina Ramos, Brianna Keefe-Oates, Mariana Ramero, Agustina Ramon Michel, Mercedes Krause, Caitlin Gerdts and Alicia Ely Yamin, *Step by Step in Argentina: Putting Abortion Rights into Practice*, 15 INT'L J. OF WOMEN'S HEALTH 1003, 1010 (2023).

developed relationships with health care professionals, who refer patients they cannot treat to the Socorristas.[66] Identifying supportive providers also allows the Socarristas to send people for pre- and post-abortion care without risking their legal safety.[67]

3. Telehealth and digital platforms

The harm reduction, hotline and accompaniment strategies provided information about how to safely self-manage an abortion, but individuals still needed to obtain abortion pills. In some countries, misoprostol was and is available in pharmacies or through informal networks.[68] In 2006, Women on Web created the first telemedicine platform designed to directly mail abortion pills to women anywhere in the world.[69] The platform maximizes the strengths of different legal systems.[70] Doctors are licensed in countries with liberal laws around online prescriptions, and medications are shipped from India.[71] People in need of an abortion fill out an online consultation form and communicate by email with a helpdesk. Emails are answered by staff in 18 countries who speak multiple languages, and unless there are medical contraindications, pills are sent by mail.[72] Although some jurisdictions challenge the legality of international telehealth, it operates within a medical model. Doctors are involved in the process and write prescriptions, although their direct interaction with users is limited.[73]

Digital platforms continue to evolve. In 2022, two Canadian doctors founded Aya Contigo, a digital abortion companion initially launched in Venezuela. The app functions like a hotline and accompaniment collective, providing evidence based information about self-managed abortion as well as real time virtual accompaniment through the app's chat function.[74] Virtual accompaniment includes technical and psychoemotional support and referrals to trusted service providers for access to medication and post-abortion care.[75] The app's founders hope that in addition to facilitating access and support for self-managed abortions, it can "improve the quality of the experience for the person seeking an abortion, and empower people to have autonomy over their reproductive choices."[76]

---

[66] Keefe-Oates et al., *supra* note 19, at 6,10; Martinez and Simstrom, *supra* note 13.
[67] Zurbriggen *et al*. *supra* note 40, at 109, 110; Keefe-Oates et al, *supra* note 19, at 3, 4.
[68] Erdman et al, *supra* note 15, at 14. Braine, *supra* note 8, at 106-08.
[69] Braine, *supra* note 8, at 21, 55.
[70] David S. Cohen and Carole Joffe, OBSTACLE COURSE 226 (U. Cal. Press 2020) [hereinafter "OBSTACLE COURSE"].
[71] Braine, *supra* note 8, at 20-21, 92-93.
[72] *Id.* at 92-93 (describing the platforms as offering "slightly medicalized approaches to [self-managed abortion]"); womenonweb.org.
[73] Braine, *supra* note 8, at 92.
[74] Vitala Impact Report 2020-22 at 7; Vitala 2023 Impact Report at 9.
[75] Vitala Impact Report 2020-22 at 8. Vitala 2023 Impact Report at 9-10, 12-13.
[76] Vitala Impact Report 2020-22 at 2.

C. Evaluating Global Models

1. Provider Based Strategies

Harm reduction models bring abortion seekers into the formal health care system. However, because patients obtain abortion pills on their own, medical staff are legally distanced from "providing an abortion,"[77] and can take the position that they are merely sharing evidence-based information and providing before and after care.

In less politicized contexts, harm reduction provides a vehicle to address unsafe abortion as a health issue even though abortion remains criminalized.[78] Indeed, Professor Erdman argues that countries that recognize the right to health have an affirmative obligation to ensure that individuals have information to prevent unsafe abortion.[79] This may explain why the Uruguayan Ministry of Health supported harm reduction in public health clinics.

Harm reduction also can help to destigmatize abortion and disrupt paternalistic patient/provider roles. IPPF/WHR described harm reduction training as means to "expand a rights-based approach to sexual and reproductive health [and] to transform the inequality currently present in the provider-client relationship."[80] The model emphasizes providers' responsibility to prevent unsafe abortion and support patients' right to information, health and autonomy. It stresses that even if abortion is criminalized, providers' primary ethical obligation is to "protect the health and human rights of their clients."[81] The model "focuses on women as the primary decision-makers" placing medical professionals in a supporting role.[82] In Argentina, health professionals who provided abortions under the legal exceptions also began to use rights language to legitimize their work and destigmatize the provision of abortion care.[83]

Harm reduction programs can also "inspire health professionals to see themselves as important advocates for legal and social change."[84] Health care providers can be an important voice in efforts to repeal restrictive laws and expand access to care.[85] In

---

[77] Erdman et al., *supra* note 15, at 15; Erdman, *supra* note 2, at 434.
[78] Erdman, *supra* note 2, at 424-45.
[79] *Id.* at 436-37.
[80] Iniciativas Sanitarias, Orientame and IPPF, *Ensuring A Rights-Based Approach to Sexual and Reproductive Health Services: A Quality Monitoring Tool for the Harm Reduction Model*, 6 [Hereinafter "*Ensuring A Rights Based Approach*"]
[81] *Id.* at 4.
[82] *Id.* at 5.
[83] Yamin and Michel, *supra* note 37, at 411.
[84] *Ensuring A Rights-Based Approach*, *supra* note 80, at 6.
[85] Erdman, *supra* note 2, at 462.

Uruguay, medical support for decriminalization gave legitimacy to the demands of the feminist movement and helped shift public opinion about abortion.[86]

IPPF/WHR's training also emphasized access to safe abortion as a social justice issue. Recognizing that wealthier individuals were more likely to have access to safe abortion information, the training asked medical professionals to "examine their role in promoting the democratization of information" and ensuring "that all women – not just those with greater social capital – are ensured access to life-saving information and the support of health services [to help them safely deal with unwanted pregnancies]."[87]

2. Activist based strategies

Feminist activists combined support for self-management with work to decriminalize abortion. But for many activists, self-managed abortion is more than a stop gap measure to ensure abortion access until legal reform enables provision in health care settings. Activist self-management strategies have created new models of abortion care, both within and outside of health care settings, and for some activists are part of a broader fight for women's self-determination.

After Argentina partly decriminalized abortion in 2020, many abortion seekers continued to choose self-management with accompaniment.[88] Respondents in a 2024 study reported negative experiences with healthcare systems and a preference for accompaniment's socioemotional support and "continuous, comprehensive, person-centered approach."[89] This is consistent with studies of people who self-managed in the U.S. during the *Roe* era, who self-managed abortions because of privacy, logistical issues, and prior negative experiences with health care systems.[90]

Today, the Socorristas continue to accompany self-managed abortions, but they also are working to implement Argentina's legal reforms and transform the health system.[91] Their work includes "train[ing] providers in high-quality, person-centered abortion provision,"[92] and developing new models of care that "integrate[] self-management of abortion with provider-supported abortion."[93] This mixed care model,

---

[86] Pousadela, *supra* note 23, at 146; Stifani, *supra* note 20, at 46.
[87] Carino et al. *supra* note 23, at 77, 79, 80.
[88] Keefe-Oates et al., *supra* note 65, at []; Martinez and Simstrom, *supra* note 13.
[89] Keefe-Oates et al., *supra* note 65, at 6; Martinez and Simstrom, *supra* note 13.
[90] Keefe-Oates et al., *supra* note 65, at 2, 5.
[91] Sarah C. Keogh, Georgina Binstock, Mailen Perez Tort and Susheela Singh, *Progress in providing legal abortion services after law reform: A quantitative study in three provinces of Argentina,* 5(2) PLOS GLOBAL PUB. HEALTH e003526, 12/20.
[92] Ramos et al., *supra* note 65, at 1010.
[93] *Id*. at 1010.

where people seek services and support in a range of settings at different stages of a single abortion, has been recognized by the WHO and may better reflect people's actual experiences and preferences.[94]

Some activists see self-managed abortion as an opportunity to challenge rather than transform health care settings. They argue that requiring that abortions occur within a regulated medical system is a "form of social control" that transfers surveillance and discipline from the state to health care authorities."[95] For them, the ability to self-manage abortion is not just a health issue, but a political act and a form of self-determination. Thus, hotlines have been described as empowering women to appropriate, share, demystify and democratize information.[96] Similarly, activists use the term "accompaniment" rather than provision to emphasize that they are not providing a service, but supporting self-management as an act of solidarity.[97]

III. Comparisons to the U.S.

The U.S. response to criminal abortion laws has differed from global responses in the 2000s in three ways. First, in the immediate aftermath of Dobbs, there was a significant increase in the number of people traveling out of state to access clinical care.[98] *After Dobbs* describes the creativity, heroic efforts, and resources invested to help people get to states where care remained legal. Second, the U.S., like other countries, has experienced a significant increase in medication abortion, but perhaps reflecting advances in technology over the last twenty years, in the U.S. efforts to support medication abortion have relied more heavily on digital platforms. Third, for the most part, the strategies chronicled in *After Dobbs* work within or expand existing legal and health care frameworks rather than working outside of them.

---

[94] Keefe-Oates et al., *supra* note 65, at 2; WHO Safe Abortion Guideline, 3.6.2, Self-management approaches in whole or in part.
[95] Erdman, *supra* note 2, at 443; Assis and Erdman, *supra* note 7, at 2238.
[96] Erdman, *supra* note 2, at 448.
[97] Braine, *supra* note 8, at 80; Erdman et al, *supra* note 15, at 17.
[98] Six months after *Dobbs*, the proportion of patients traveling to other states for abortion care doubled. Kimya Forouzan, Amy Friedrich-Karnik and Isaac Maddow-Zimet, *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care* (Guttmacher Dec. 2023). https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care; Recently, out-of-state travel has declined, possibly due to expanded access to medication abortion, resource strains on support networks, and new restrictions, eliminating some travel options. Guttmacher, *New Release: Preliminary Guttmacher Data Shows a Decline in Abortions and Cross-Border Care in States Without Total Abortion Bans* (September 30, 2025), https://www.guttmacher.org/news-release/2025/preliminary-guttmacher-data-show-decline-abortions-and-cross-border-care-states

These differences reflect historical factors, timing, differences in legal structures and political context as well as the unique role of abortion providers in the U.S.

A. Historical Context

The U.S. has gone from a period where abortion was legal for almost 50 years to a period of criminalization. Global strategies developed in the 2000s arose in countries that had labored under criminal abortion laws for a long period of time. As a result, there was no infrastructure of trained abortion providers and abortion care was heavily stigmatized in health care settings.

Experiences with high rates of maternal mortality associated with unsafe abortion resulting from criminal laws helped build recognition that abortion access is a public health, human rights and social justice issue in other countries.[99] In contrast, *Roe* shielded two generations of Americans, who are only beginning to understand the full impact of criminal abortion laws.

B. Federalism

After the Supreme Court dismantled federal constitutional protections for abortion, federalism allowed some states to criminalize abortion and others to maintain or expand protections. Differences in state laws made it possible for people to travel within the U.S. to access legal clinical care (albeit often for great distances and at great cost) that was not possible in other countries.[100] Providers also were able to move, opening new clinics or operating mobile clinics in supportive states on the border of hostile states.[101] This type of travel generally was not possible in countries that lacked variation in state laws and an existing infrastructure of abortion providers.

Ironically, even as telehealth technology and medication abortion enabled providers to care for patients anywhere in the country, federalism and geography continued to complicate access as telehealth providers tackled legal questions about where care is rendered and medication abortions occur.[102] (discussed below).

C. Role of Abortion Providers

---

[99] Roth, *supra* note 3, at 2, 3. Professor Roth argues that rather than focusing on privacy rights or when life begins Argentine activists emphasized "social equality and economic justice," emphasizing that "women from all classes have abortions, but only poor women die from them."

[100] Mexico is also a federalist country, and in 2000s, the District Federal partially decriminalized abortion, allowing some people to travel there for care. Cynthia Soohoo, *Turning Away from Criminal Abortion Laws and Towards Support for Pregnant People and Their Families,* 104 B.U. LAW REVIEW ONLINE 109, 113 (2024).

[101] David S. Cohen and Carole Joffe, AFTER DOBBS 71, 154-56 (Beacon Press 2025) [hereinafter "AFTER DOBBS"]

[102] *Id.* at 110, 158; Katie Corwin, *Telehealth in Reproductive Health Care: A New Frontier in the Fight for Abortion Access,* 27 CUNY L. REV. 304, 331-32 (2024).

Outside of the U.S., harm reduction programs helped train and change doctors' attitudes towards abortion, but feminist activists emerged as leaders in efforts to respond to criminalization. The strategies they developed responded both to the critical need to prevent unsafe abortion and the historic mistreatment of patients within health care settings.[103]

In the U.S., decades of legal attacks and harassment from anti-abortion activists made providing quality abortion care a professional and political commitment for abortion providers. The free standing clinic model developed in the 1970s as a more affordable and patient supportive alternative to hospital care.[104] The Supreme Court accelerated the separation of abortion from mainstream medical care by allowing Congress to prohibit federal Medicaid coverage and permitting states to prohibit abortions in state hospitals.[105] Prior to *Dobbs,* 95% of abortions took place in free standing clinics.[106] While abortion should be part of mainstream medical care, the segregation of care led to the creation of abortion clinics staffed by medical professionals who specifically identify as abortion providers and are deeply committed to patient centered care, women's rights, and self-determination for pregnant people.

Further, the anti-abortion strategy of targeted overregulation of abortion clinics forced providers to navigate a gauntlet of unnecessary restrictions, implemented by hostile and biased regulators.[107] Providers also regularly dealt with harassment and threats from anti-abortion protesters.[108] This weeded out the faint of heart. So it is not surprising that abortion providers led efforts to maintain care post-*Dobbs* or that they have been incredibly creative, nimble, and effective.[109] Similarly, because attacks on abortion providers had forced many clinics to close, creating abortion care deserts even when abortion was constitutionally protected*,* abortion funds and patient navigators already existed. And through careful planning and hard work*,* they were able to expand and innovate to support the huge influx of patients and the complexities and expense of navigating interstate travel.[110]

---

[103] AFTER DOBBS, *supra* note 101, at 61, 65, 80, 86-87.
[104] OBSTACLE COURSE, *supra* note 70, at 66.
[105] Harris v. McRae, 448 U.S. 297 (1980); Webster v. Repro. Health Servs., 492 U.S. 490, 501 (1989); OBSTACLE COURSE at 66.
[106] OBSTACLE COURSE, *supra* note 70, at 16.
[107] *Id.* at 60-63 (describing TRAP laws that target abortion clinics and regulate them in "minute, overbearing and very expensive detail").
[108] AFTER DOBBS, *supra* note 101, at 71-92.
[109] *Id.* at 92, 127-28, Chapter 2-5.
[110] *Id.* at 55, 122-3, 173-76.

Faced with tremendous legal uncertainty and a politically hostile environment, providers and abortion funds have worked closely with attorneys to assess and navigate legal risk.[111] Sometimes this results in a conservative approach.[112] Based on her research on global strategies to support self-managed abortion, Professor Braine notes that activist collectives are able to take greater risks than professional and legally recognized entities, like NGOs, or in the U.S. case, abortion clinics and funds. Because activist collectives exist outside legal and medical systems it is easier for them to take risks in restrictive legal and social environments.[113]

D. Timing and Technology

In the 2000s, criminal abortion laws had been on the books in many countries for years, resulting in high rates of maternal mortality. The discovery of medication abortion as a means to terminate pregnancy outside of a clinical setting provided an opportunity to mitigate the impact of criminal laws, and abortion hotlines and accompaniment networks proliferated to help people safely self-manage abortions.

In the U.S., Plan C and the Miscarriage and Abortion (M+A) hotline can be viewed as the 2025 online version of telephone hotlines and accompaniment. Both sites provide detailed information about how to use abortion pills.[114] The M+A hotline provides a form of accompaniment, though with medical professionals rather than activists, who answer questions from people by phone or text as they use abortion pills.[115] Plan C also provides information about where to access pills sorted by state.

Globally, Women on Web created the first telehealth platform in 2008, mailing pills to users around the world.[116] In 2018, Women on Web founded Aid Access to provide similar services in the U.S., initially relying on non-U.S. doctors to write prescriptions and sending pills from overseas.[117] Politics and overregulation of medication abortion delayed the development of U.S. based telehealth platforms until 2021.[118] Post-*Dobbs*, telehealth has rapidly expanded. In the first half of 2025, 27% of abortions in the U.S. were provided

[111] *Id.* at 52, 55, 63, 128, 176.
[112] See e.g. *id.* at 111,158 (describing providers who only provide procedural abortions to out of state patients and prohibit the use of post office boxes or mail forwarding).
[113] Braine, *supra* note 8, at 57-58.
[114] AFTER DOBBS at 157, 161.
[115] *Id.* at 157, 202.
[116] Braine, *supra* note 8, at 21-22.
[117] In 2019, the FDA sent a warning letter to Aid Access questioning the legality of importing mifepristone from abroad. OBSTACLE COURSE, *supra* note 70, at 227; Braine, *supra* note 8, at 22.
[118] AFTER DOBBS, *supra* note 101, at 148

through telehealth appointments compared to 2% in spring 2022.[119] However, legal concerns initially limited the reach of telehealth platforms with some U.S. based platforms restricting or declining to provide services to patients who reside in states where abortion is criminalized or telehealth abortion is prohibited.[120]

E. Political Context

Professor Braine notes that for activists risk is "based not just on the letter of the law" but also on political calculations, reflecting local context that can change over time.[121] In Latin America, many countries had the same laws, but political factors influenced the threats activists and abortion seekers experienced.[122] In the 2000s, many hotlines and accompaniment networks developed in contexts where abortion was criminalized but not necessarily highly politicized.[123] This has changed.[124] By 2019, Ecuadorian activists reported feeling less secure engaging in direct action because of changes in the political environment, including recent prosecutions of women for abortion which had been unheard of in 2008.[125] Government actors also can act to decrease risk. For instance, in Argentina prior to law reform, the Ministry of Health issued regulations broadly interpreting the law's health exception, providing clarity and legal support for providers,[126] and in Uruguay, the Health Ministry made harm reduction an official policy. However, in a highly politicized environment, it is much more difficult for government officials to use their discretion to support access or to turn a blind eye to what Professor Braine describes as "en tierra gris" (a grey area).[127]

Consideration of U.S. strategies must factor in decades of right-wing organizing, the extreme politicization of abortion, and the weaponization of the law.[128] In the U.S., abortion providers are overregulated, intensely scrutinized by licensing boards and the media, and constantly on the lookout for anti-abortion plants posing as patients.[129] Criminal abortion laws impose extreme sentences, and politically motivated prosecutors aggressively over

---

[119] Society of Family Planning, *WeCount report,* April 2022 to June 2025, 6 (Dec. 9, 2025), https://societyfp.org/wp-content/uploads/2025/12/WeCount-Report-10-June-2025-data.pdf.
[120] AFTER DOBBS, *supra* note 101, at 150.
[121] Braine, *supra* note 8, at 97-98.
[122] *Id.* at 105.
[123] *Id.* at 208.
[124] Professor Braine notes that the politicization of abortion by evangelical churches have increased the incentives for prosecutors to file charges against women for abortion in many parts of the world. *Id.* at 103, 111-112.
[125] *Id.* at 97-98,100, 109-10, 209.
[126] Yamin and Michel, *supra* note 37, at 407-09; Ricardo, *supra* note 18, at 145.
[127] Braine, *supra* note 8, at 98-100, 110.
[128] *Id.* at 104, 208.
[129] AFTER DOBBS, *supra* note 101, at 55, 64,131.

interpret their authority to prosecute abortion seekers and helpers.[130] In addition to protecting their organizations, abortion clinics and funds must also consider the risks to staff and patients, given the onslaught of new criminal abortion laws and hostile prosecutors.[131]

For the most part, *After Dobbs* describes the work of licensed abortion providers and non-profit organizations working within, and sometimes pushing legal boundaries, to maintain abortion access.[132] Some of the individuals profiled in *After Dobbs* are taking risks, not by actively violating the law, but by taking legally justified, but untested positions, and by creatively expanding legal protections. For instance, some providers are mailing abortion pills to patients in ban states[133] relying on new state telehealth abortion shield laws. States with shield laws seek to protect medical professionals who provide telehealth abortion care to out of state patients by prohibiting extradition to, or co-operation with legal actions in, states where abortion is illegal.[134] These laws are just beginning to be tested in courts, and providers risk arrest and prosecution if they travel to ban states where they have sent pills.[135] But their decision to take the risk has greatly expanded the reach of telehealth. In 2025, 55% of telehealth abortions and almost all abortions in states with total bans were provided under telehealth shield laws.[136]

Plan C seeks to ensure that people have information about how to obtain and use abortion pills irrespective of the legality abortion where they live. In addition to providing information about nearby clinics and telehealth services, it provides information about where to get pills without a prescription from websites and community networks. Critical to Plan C's goal of providing safe use information, all sources are vetted by Plan C,[137] and the site prominently features links to the M+A Hotline as a resource for people who have medical questions about using abortion pills.[138] Plan C consults with attorneys to

[130] See e.g. Ala. Code §§ 26-23H-6(a),13A-5-6 (imposing class A felony subject to life imprisonment or a sentence up to 99 years); Laura Huss, Farah Diaz-Tello and Goleen Samari, *Self-Care Criminalized: The Criminalization of Self-Managed Abortion from 2000 to 2020,* If/When/How: Lawyering for Reproductive Justice 38-40 (2023).
[131] AFTER DOBBS, *supra* note 101, at 174, 176.
[132] *Id. at* 155-6,163.
[133] Rachel Cohen Booth, *Access to abortion pills has grown since Dobbs,* VOX, Dec. 27, 2023, https://www.vox.com/policy/2023/12/27/24015092/abortion-pills-mifepristone-roe-reproductive-misoprostol.
[134] AFTER DOBBS, *supra* note 101, at 158.
[135] *Id.* at 158; Booth, *supra* note 133.
[136] Society of Family Planning, *supra* note 119, at 10,11.
[137] AFTER DOBBS, *supra* note 101, at 161-62.
[138] *Id.* at 162.

understand legal risks, but takes the position that it has a First Amendment right to share evidence-based information.[139]

IV. Lessons for Legal Reform

As discussed above, other countries' experience with criminalization led to the development of new models of abortion care, both within, outside, and in concert with health care settings. But how can global experiences responding to criminal laws help U.S. lawyers as we develop a vision for the post post-*Dobbs* world?

A. Reforming Criminal Laws

Self-management strategies have had a mixed impact on the law. In some countries, experience with and resistance to criminal abortions laws helped catalyze liberalization efforts. In other countries, dissemination of information about medication abortion outside of medical and legal systems led to increased regulation of the drugs used.[140] In the 1980s, misoprostol was available without a prescription in Brazil.[141] By 1998, misoprostol required a double copy prescription and was listed as a controlled substance.[142] In 2024, Louisiana took a similar approach, classifying mifepristone and misoprostol as Schedule IV controlled substances.[143]

Over the last 15 years, several countries have responded to the efforts to decriminalize and liberalized abortion laws.[144] However, scholars have critiqued reforms that fail to fully decriminalize abortion and incorporate unnecessary regulatory requirements, creating backdoor pathways for criminalization.[145] Human rights bodies and the WHO also have called for full decriminalization, removing abortion from penal codes, not applying other criminal offenses to abortion and ensuring there are no criminal penalties for having, providing, assisting with, providing information about abortion.[146]

To date, countries reforming their laws have not fully decriminalized. Instead of removing abortion from the penal code, some drafters create exceptions for "legal

---

[139] *Id.* at 163.
[140] Assis & Erdman, *supra* note 8, at *7*: Braine, *supra* note 8, at 24, 143.
[141] Assis & Erdman, *supra* note 8, at 3.
[142] *Id.* at 3-4. Double copy prescriptions require that the pharmacists retain a copy of the prescription which is subject to regulatory inspection. *Id.* at 3, n. 17.
[143] Rosemary Westwood, *Louisiana Reclassifies Drugs Used in Abortions as Controlled Dangerous Substances*, KFF HEALTH NEWS (July 24, 2024), https://kffhealthnews.org/news/article/louisiana-mifepristone-misoprostol-abortion-pills-reclassified-dangerous-controlled-substances/.
[144] Pizzarosa and Skuster, *supra* note 14, at 203-207 (describing statutory amendments to abortion laws in Uruguay, Chile, Ireland, Isle of Man, New Zealand, Thailand, Argentina). The high courts of Mexico and Colombia have also struck down criminal abortion laws. Soohoo, *supra* note at 100, at 110.
[145] Pizzarosa and Skuster, *supra* note 14, at 200, 208.
[146] *Id.* at 208.

abortions" that occur within a gestational period or fall within statutory exceptions. Some laws require consultations or counseling and, in the case of exceptions for life, health, fatal fetal condition or rape, verification by medical professionals or law enforcement. Abortions that do not satisfy these legal requirements remain subject to criminal penalties.[147] Uruguay illustrates this approach. Rather than removing abortion from the penal code, in 2012, it waived criminal penalties for abortions that meet a combination of gestational and reason based requirements.[148] The law also requires counseling and a waiting period for legal abortions.[149] After expanding grounds for legal abortions within the health care system, the Ministry of Health removed misoprostol from retail pharmacies, decreasing people's ability to self-manage.[150]

When Argentina liberalized its law in 2020, it also did not fully decriminalize abortion but it explicitly legalized and recognized a right to abortion until the 14th week of pregnancy and after 14 weeks in cases of rape or life or health endangerment.[151] The law does not require the involvement of a doctor. However, criminal provisions remain, and pregnant people and those who help them can still be prosecuted for abortions outside the specified time frames and grounds.[152] Other countries have adopted laws that make it clear that criminal penalties do not apply to pregnant people, but family, friends or others who help them obtain an abortion outside the medical system still can be prosecuted.[153]

B. Other Legal Reforms

In Latin American countries, social and economic justice arguments played a key role in organizing efforts to decriminalize abortion, emphasizing that people from poor and vulnerable communities disproportionately bear the impact of criminal laws.[154] As a result, reform efforts went beyond repealing or limiting criminal provisions and included measures to expand access to abortion and protect patients' right to non-coercive, respectful care. Both Uruguay and Argentina require that the public health system provide abortions free of charge.[155] Argentina guarantees a right to access free care within (or with

[147] *Id.*at 203-204, 208 (describing regulatory frameworks in Uruguay and Chile after liberalization).
[148] Lucia Berro Pizzarosa, "*Women are not in the Best Position to Make These Decisions by Themselves:" Gender Stereotypes in the Uruguayan Abortion Law,* 1 U. OF OXFORD H.R. HUB J. 25, 28 (2019).
[149] *Id.* at 28-29; Stifani, *supra* note 20, at 47, 49.
[150] Pizzarosa and Skuster, *supra* note 14, at 204.
[151] Ricardo, *supra* note 18, at 187.
[152] *Id.* at 193.
[153] Pizzarosa and Skuster, *supra* note 14, at 205-06, 208 (describing laws in Ireland and New Zealand).
[154] Roth, *supra* note 4, at 03, Soohoo, *supra* note 100, at 123-24.
[155] Stifani, *supra* note 20, at 47.

the assistance of) the health care system within 10 days,[156] and coverage under the national compulsory health plan.[157]

Argentina also limits to scope of provider conscientious objection claims to prevent the accommodations from subverting patient access.[158] Objecting providers must refer patients and may not refuse to perform an abortion in medical emergencies or provide post-abortion care.[159] Failure to comply can give rise to disciplinary, criminal or civil sanctions.[160] Private health care facilities that do not have sufficient personnel to provide abortions must make advanced arrangements for referrals and bear transfer costs.[161]

Argentine law also strives to improve the quality of abortion care within health systems, recognizing patients' rights to dignified treatment, privacy, confidentiality, autonomy and accurate and accessible information.[162] Patients must be protected from third party interference and the prejudices of the health care staff.[163] The law makes it a criminal offense to unjustifiably delay, obstruct or refuse to perform a legal abortion with enhanced penalties for public officials, individuals with authority over health care facilities or health care workers.[164]

Conclusion

After Dobbs reminds us that regardless of the law, people will continue to get abortions, and in the U.S. and around the world there are people dedicated to helping people get the care that they need. The specific responses to criminal abortion laws in the U.S. post-*Dobbs* and global strategies from the 2000s reflect the different time, legal structures and political contexts in which they developed. In both contexts, the responses catalyzed new models for care and helped (or are helping) to spur law reform.

In the U.S., strategies led by abortion providers and activists have pushed the limits but have mostly operated within the boundaries of legal and healthcare systems, leveraging differences in state laws and building and expanding infrastructure to help people travel or to bring services closer to them. Post *Dobbs*, telehealth also has rapidly

---

[156] Ricardo, *supra* note 18, at 187, 191.
[157] *Id.* at 160.
[158] Uruguay also has imposed regulations limiting the invocation of conscientious objection. Luisa Cabal, Monica Arango Olaya, Valentina Montoya Robledo, *Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombia Perspective,* 16(2) HEALTH AND HUMAN RIGHTS JOURNAL 73, 80 (2014).
[159] Ricardo, *supra* note 18, at 190-91.
[160] *Id.*
[161] *Id.* at 191.
[162] Id.; Keogh et al, *supra* note 91, at 2/20.
[163] Ricardo, *supra* note 18, at 187-88.
[164] *Id.* at 191.

expanded. Initially, concerns about providing services to people residing in states where abortion is illegal limited telehealth's reach. In 2023, a number of states passed telehealth shield laws that created a measure of legal protection for providers, and by June 2025, more than half of telehealth abortions were provided under shield laws.[165]

Globally, strategies developed in the 2000s to share information and expand access to abortion pills often operated wholly, or in the case of harm reduction models partially, outside of health systems to support self-managed abortion. As countries have liberalized their laws, innovations and insights from communities and activists – from the discovery of the use of misoprostol for medication abortion to the development of accompaniment models – have inspired new models of care. And activists' work with health care professionals and harm reduction models have helped to destigmatize abortion in health care settings.

In the U.S., abortion providers have played a unique and leading role in responses to criminal abortion laws functioning simultaneously as committed activists and health care professionals. Their leadership role in part explains a greater hesitancy to act fully outside of the bounds of the law and the formal health care system, but the extreme politicization of abortion and the weaponization of criminal law in the U.S. must also be factored in. It should also be noted that self-management outside of health care systems has undoubtedly increased post-Dobbs, but precise numbers are difficult to pinpoint because researchers only track abortion data from licensed clinicians.[166]

As we consider what the law's relationship to abortion should be in a "post post-Dobbs" world, some important lessons emerge from global law reform efforts. First when laws are liberalized, it matters how they are drafted. Rather than creating exceptions for "legal abortions" abortion should be completely removed from penal codes, and laws should prohibit prosecution of pregnant people and those who help them for self-managing abortions or for adverse pregnancy outcomes.

At the same time, people's ability to access respectful abortion care within formal health care settings should be guaranteed. Efforts in Latin America requiring that abortions be provided without charge in the public health system, dismantling power imbalances between providers and patients, and recognizing patients' rights to dignified treatment, confidentiality, accurate information and autonomy are steps in the right direction.

[165] AFTER DOBBS, *supra* note 101, at 159; Society of Family Planning, *supra* note 119, at 11.
[166] *Id.* at 19.