This chapter focuses on abortion as a global issue and the growing body of debates and research examining abortion policies, including from the perspectives of states and non-state actors such as nongovernmental organizations (NGOs) and religious groups. In particular, it reviews what we know about women and pregnant people seeking abortion care across national borders. We take the “global” in this chapter as different forms of mobilities related to abortion, including care seeking, the flows of discourses, and the circulation of political and economic agendas—these mobilities exist across national borders, but are also relevant when crossing regional borders within countries, as we will discuss in relation to abortion travel.

Abortion as a right of women and pregnant people to health and self-determination, and one of women’s fundamental sexual and reproductive rights, lies at the heart of anthropological inquiry, in particular the anthropology of reproduction. Abortion remains perhaps the most fought-over reproductive right across time and geopolitical contexts, and much of these struggles are within the context of the politics of morality. While abortion is extremely common, with one in four pregnancies ending in abortion globally, access to care varies widely from legal and safe to clandestine and/or dangerous. The right to this service is deeply embedded in culturally, historically, and politically specific agendas. As such, anthropological analyses of abortion as reproductive policies, experiences, discourses, and practices offer a versatile theoretical and empirical lens with which to examine broader questions about gender inequities, the role of women and pregnant people, their rights in a society, health as a right, and social justice movements. This lens is especially significant for understanding global processes, including neoliberal economics and governance, the movement of discourses and people across borders, as well as the ongoing efforts of numerous advocacy organizations, including anti- and pro-abortion rights groups. Moreover, while predominately quantitative public health studies of abortion have been substantial, anthropologists can offer deeper, fine-grained analyses of these issues and processes from ethnographic and qualitative research work.

The chapter offers readers guidance on the topic of abortion from the perspectives of anthropology and related disciplines, given that anthropological studies are still limited. We provide a review of the state of knowledge and insights from research on legal and social barriers to access abortion care, their impact on women, and abortion travel. This includes travel for abortion care between countries and in-country travel between regions. We discuss the fragmented abortion
policy landscape when considered from a transnational view, and we engage with the question of the impact of these fragmented policies on women's choices and experiences with legal/illegal abortion and abortion travel across national and regional borders. We also provide an overview of how both restrictive (e.g., Poland, Malta) and ostensibly liberal abortion laws (e.g., France, Italy) fuel travel for health care to distant locations in the European context, where in most countries abortion is legal on request or on broad grounds.

Overall, we hope to convey that the analysis of abortion policy, governance, and practice, taken in a cross-border view, presents a highly complex picture with fragmentation and variability, in particular of policies on the one hand, but also of converging themes showing similarities in obstacles in accessing care as well as clear cause-and-effect events and practices on the other hand, including restrictions on abortion that drive women and pregnant people to travel far from their area of residence to seek abortion care.

Some of the earliest medical texts in the ancient world identify abortion as a practice, as do numerous references during the Roman Empire period (Joffe 2009). Currently, the most common abortion procedures include surgical abortion via vacuum aspiration (a minor operation) and medical abortion (taking medication to terminate a pregnancy). Medical abortion was first developed and distributed in France in 1988 as the RU-486 pill and is on the World Health Organization’s List of Essential Medicines. Women and pregnant people who seek abortion care may receive either a medical or surgical abortion, depending on their preference as well as the national laws and the services offered where they live or at the destination where they might have traveled to obtain an abortion.

Access to abortion services is a phenomenon at the heart of the politics of reproduction as well as politics on the larger national and international scale across many geopolitical settings, as highlighted by anthropologists Faye Ginsburg and Rayna Rapp (1995). A substantial body of literature has since been generated by anthropologists or with anthropological methods about abortion in the form of country studies situated in their specific historical, political, and cultural contexts (e.g., Anton 2016; Aragón Martín 2016; Capelli 2017; De Zordo 2016, 2018; Diniz 2014; Kennedy 2018; Kligman 1998; Luehrmann 2016; Maffi 2018, 2020; Mattalucci 2016, 2018b; Mishtal 2015, 2017; Morgan 2009; Ostrach 2017; Rostagnol 2018; E. Singer 2017). Many of these country studies also engage with articulations of local issues with transnational influences, such as international conventions, discourses, and advocacy strategies that reach across national borders and become locally relevant.

Literature generated by the discipline of public health has flourished on the topic of anti-abortion rights movements, particularly in the context of the United States because of the restrictive regulations of abortion care that several states have passed over the last decade, forcing women and pregnant people to travel far from where they live, including across state lines (e.g., Barr-Walker et al. 2019; Jones and Jerman 2013). Yet, despite serious limitations imposed on abortion access in a number of states and the fragmentation of abortion legislation, anthropological attention to this problem has been minimal and scholars have called for greater ethnographic research to document and analyze this issue in the US context (Andaya and Mishtal 2016).

Reproductive governance as a theoretical lens

The concept of reproductive governance is arguably one of the key theoretical advancements in the anthropology of reproduction, and therefore the anthropology of abortion, developed by anthropologists Lynn Morgan and Elizabeth Roberts and conceptualized as “the mechanisms through which different historical configurations of actors—such as state institutions, churches,
donor agencies, and NGOs—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and practices” (Browner and Sargent in this volume; Morgan and Roberts 2012: 243). Thinking with reproductive governance inspires us to contemplate how abortion governance—while ultimately directed to shape women’s and pregnant people’s reproductive conduct—is situated in politico-economic processes, how it is useful in the construction of particular political rationalities, and how it is deployed in the service of church, state, and other actor’s agendas. More recently, reproductive governance theory has been further developed in the context of global politics (Morgan 2019).

From a global perspective on abortion, the lens of governance becomes vital. In the edited volume, A Fragmented Landscape: Abortion Governance and Protest Logics in Europe (De Zordo et al. 2016), Lynn Morgan argues that “there are limits to using country studies to understand the global dimensions of abortion,” in particular because “[m]ovements for and against reproductive rights have become globalised” (Morgan 2016: 277). In addition to cross-border politics, Morgan draws attention to cross-border economics, money flows, and profits made related to abortion healthcare, practices, pharmaceutical business, and rights movements, as well as to the many, some as yet unknown, behind-the-scenes processes worth analysis, including policy-making that controls who can cross borders and how. Likewise, justifications of abortion restrictions in global neoliberal discourses are often framed by rationalizing cutbacks in healthcare and social services (Andaya and Mishtal 2016). This highlights the stratification of access to care that is evident in the global analysis of abortion policy, governance, and care. These aspects of abortion will continue to present rich areas for research in the decades to come, even as studies are emerging that take up this call. Studies that specifically engage with these questions beyond national borders have offered analyses of abortion in the context of reproductive governance (e.g., Morgan 2015, 2016; Whitaker and Horgan 2016; Unnithan and De Zordo 2018), supranational policy-making (Mishtal 2014; Suh 2018), and comparative analyses of case studies (e.g., Bloomer and O’Dowd 2014; De Zordo 2018; De Zordo and Mishtal 2011; Linders and Bessett 2016).

Anti-abortion rights backlash

While cross-border reproductive care has become a global phenomenon, as we shall discuss later, far right-wing, anti–sexual and reproductive rights movements have also become increasingly vocal and extended their political influence and advocacy work transnationally (for the US, see Andaya and Mishtal 2016; for Latin America, see Arguedas Ramirez and Morgan 2017; Morgan 2017; for Europe, see Datta 2018; De Zordo et al. 2016; for Eastern Europe, see Mishtal 2015; for Russia, see Rivkin-Fish 2013, 2017).

In the US, for example, a perhaps new anti-abortion strategy is the emergence of so-called TRAP laws (Targeted Regulation of Abortion Providers), which impose arbitrary and unwarranted restrictions on providers—for example, new requirements that providers secure local hospital privileges, which may be impossible to obtain in anti-abortion states, or that clinics be located no more than 30 miles from a hospital, thereby forcing some rural clinics to close (Andaya and Mishtal 2016: 5–6).

At the supranational level, the Vatican began to use human rights language to oppose abortion, with human rights understood to be the “rights of the family” or women’s “right to motherhood,” and its representatives have been vocal at the Council of Europe on reproductive rights policy-making (Mishtal 2014). This re-definition of human rights from the distinct vantage point of Catholic ideology was enshrined in the 1999 Vatican statement, “The Family and Human Rights,” written specifically to respond to and take advantage of the 50th anniversary
of the Universal Declaration of Human Rights. Arguably, global statements such as this provide important entry points for anthropological research, given their reproductive governance at the supranational level, which in turn may (or may not) be taken up in a variety of national contexts, as well as generate cross-border activist campaigns aiming to influence power structures at a variety of levels. In fact, anti-abortion groups have been networking internationally in order to exert political pressure not only on their own governments, but also on supranational entities such as the European Union (Korolczuk 2019; Mattalucci 2018a, 2018b), and scholars, including Neil Datta (2018), are documenting the rise of a systematic transnational anti-gender campaign. Datta’s 2018 exposé released by the European Parliamentary Forum on Population and Development documents the work of the international organization Agenda Europe and their strategic program titled, “Restoring the Natural Order: An Agenda for Europe.” Agenda Europe is a Vatican-inspired global professional advocacy network linking groups from over 30 countries. The document reveals the group’s agenda: To roll back existing laws on human rights related to sexuality, reproduction, and LGBT rights, defining the family in traditional patriarchal terms as Christian, White, and heterosexual.

Such a political environment has produced reproductive policies that neglect and actively suppress the family-making processes and reproductive rights of non-heterosexuals and migrants and has led to increasing restrictions on abortion rights, including in countries where abortion has been legal for decades, leading people to seek reproductive care cross-border.

**Mobilities of discourses**

Debates, discourses, and specific imageries related to abortion have been circulating across national and continental boundaries, and are mobilized by anti-abortion activists collaborating globally. Much of this opposition draws on tactics developed in the United States by “pro-life” campaigns over the last several decades to advance what has become known as fetal/embryonic personhood; in addition, they make claims that abortion harms women’s health (Arguedas Ramirez and Morgan 2017; Lowe 2019; Mattalucci 2018b: 81; Morgan 2017). These tactics capitalized on medical advances in prenatal imaging techniques to propose new subject positions such as “embryonic rights” or “fetal rights” and the embryo/fetus as a “patient” entitled to health care (Morgan 1997, 2009) and have even resulted in the imposition of scripts on providers to inform women and pregnant people about the gestational age of the “unborn child” (Buchbinder 2016).

Likewise, abortion rights activists often call upon transnational discourses of human rights or women’s rights to oppose restrictions on abortion and, similarly, women themselves may engage such discourses when conceptualizing abortion access (Andaya 2014; Mishtal 2015; Morgan 2015). Although human rights discourse has been criticized for its universalist Eurocentric underpinnings, human rights as an advocacy tool have been extremely important for reproductive rights activists in their struggles to protect and advance abortion rights, including through such mechanisms as the European Court of Human Rights (Chavkin and Chesler 2005). In Poland, abortion rights activists sought to align their movement with transnational causes, employing human rights arguments as held by the EU (Mishtal 2015, 85; Nowicka 2011). In Argentina, feminists used reproductive rights arguments (instead of the more inclusive concept of reproductive justice) as a proven advocacy tool owing to the post-dictatorship receptivity of the state to the language of human rights (Morgan 2015). Anthropologists and feminist scholars therefore have advocated for versions of rights discourses that are vernacularized to suit local political and social contexts (Levitt and Merry 2012). Likewise, feminist communities, be they within a country or internationally, may identify with shared interests, rather than a shared...
definition of rights. Indeed, coordinated international feminist campaigns using rights-based discourses across Latin America have also led to the expansion of abortion rights in Uruguay and Mexico City (Morgan and Roberts 2012: 248). In this sense, rights discourses and associated policies are important for anthropological inquiries that examine abortion from a global perspective.

**Mobilities of abortion pills**

Abortion practices themselves have been undergoing a significant expansion in recent years into international flows of abortion pills and telemedicine services, facilitated to a significant extent by feminist collectives like Women Help Women or Women on Web. The growing cross-border shipments of abortion medication are allowing an increasing number of women and pregnant people to safely self-manage abortions at home, with some advocates calling for a wider shift of abortion away from healthcare settings as a form of social change (Endler et al. 2019; Erdman et al. 2018; Gerdts et al. 2018). Abortion via telemedicine has been especially important for women and pregnant people in countries with very restrictive laws across the world, including the few European countries with very restrictive laws—Poland, Ireland (before 2018), and Malta. However, women and pregnant people may need and want a surgical termination (i.e., aspiration in the first trimester or a dilation and evacuation [D&E] later in pregnancy, a technique that is neither taught to obstetricians-gynecologists nor provided in many countries where abortion is legal) and should be entitled to obtain these procedures if they wish (including during global pandemics, discussed later) at least in those countries where abortion is legal on request or on broad grounds. Access to some medical techniques, and abortion care in general, is increasingly difficult, which is why self-managed abortion is becoming appealing also in “liberal” contexts. Additionally, medical abortion via pills is much less expensive and easier to provide than instrumental abortion, raising questions about the financial benefits from this shift derived by states during times when they may be looking to further relinquish responsibilities to provide comprehensive reproductive healthcare under the pressures of the global neoliberal economy. The travel of abortion pills thus also poses questions about the extent of policy effectiveness and the nature of transnational reproductive governance (Sheldon 2014). Further anthropological studies investigating women’s and pregnant people’s needs and experiences with different techniques in different social, cultural, and legal contexts are needed.

**Mobilities of global infections affecting abortion**

Re-emerging and emerging infections such as Zika and COVID-19 are de facto global in nature and raise questions about access to abortion care, and reproductive rights and healthcare more broadly. Viruses freely traverse national borders; women and pregnant people are differentially affected by these global infections and are dependent on local abortion laws. The high rates of microcephaly and other congenital complications in infants born to Zika-infected women and pregnant people prompted discussions about the role of the state in ensuring abortion access. Yet, while the Pan American Health Organization advocated for safe termination of pregnancy as an ethical duty during the Zika outbreaks (PAHO 2016), the restrictive abortion laws in Belize and Brazil stood unchanged. The state called on women to “postpone” pregnancies in Belize (Gray, Deven, and Mishtal 2018: 11) and to abstain from sex for six months in Brazil (Diniz 2017: 114). These tactics exemplify how states use neoliberal governance logic to shift responsibility (and blame) onto the individual rather than accepting the obligation of ensuring fundamental healthcare provision and welfare of its citizens.
During the global pandemic of COVID-19, states instituted restrictions on residents’ mobility and closed borders. Meanwhile, healthcare systems became overloaded. These measures raised immediate alarms about women’s and pregnant people’s access to abortion care as an essential service, as designated by the World Health Organization. The Republic of Ireland became a contrasting model for other countries when, on April 7, 2020, Minister of Health Simon Harris allowed remote consultation with medical practitioners (rather than two face-to-face visits) and home administration of abortion pills to ensure that Irish women and pregnant people retained access to abortion care during the COVID-19 pandemic. Two days later, the UK government followed the Irish example and allowed the home use of abortion pills for early terminations—a highly significant move given that the 1967 UK abortion law specifically forbids abortions outside of the clinical setting. These examples show that responsive political action to safeguard women’s and pregnant people’s rights and health is needed and indeed possible when states consider evidence-based information and listen to the voices of reproductive health advocates and the medical community (Mishtal et al. 2020). However, gestational age limits on abortion remain a major barrier in access to care, especially during health crises like COVID-19 (De Zordo et al. 2020a).

While anthropologist Merrill Singer highlights the syndemic potential of global infections as these intersect with and potentiate other health problems (M. Singer 2017), abortion experiences and governance in times of global pandemics due to emerging or re-emerging microbes is a rich and as yet uncharted research field for anthropological and feminist researchers in the years to come.

In the remaining sections of this chapter, we particularly focus on abortion travel as a phenomenon that reflects a multitude of layers when thinking about the global elements of abortion. We focus mainly on North America and Europe, where significant and ongoing studies on abortion travel have been conducted, with some attention to South America and Africa. Thematically, we focus on the effects of abortion laws that are restrictive and those which may appear liberal, but still drive women and pregnant people to travel for abortion; the underlying socioeconomic and political conditions which fuel abortion travel; and the governance of abortion access.

**Abortion travel as a major international phenomenon**

**Reproductive travel**

Over the last 15 years, studies on medical travel, or “medical tourism” as it has also been defined in the literature, have proliferated in anthropology, sociology, health studies, migration studies, women’s and gender studies, and bioethics. As Sobo (2009) noted, this phenomenon went unnoticed until the mid-2000s, when it grew exponentially as a result of the increasing spread of information and tourism on a global scale and of the growing cooperation between the public and the private health sectors. While initially medical travel mainly involved flows of people from poorer to wealthier nations, in the 2000s this pattern started to change as people from wealthier nations began to travel to poorer countries or other neighboring wealthy countries for medical treatments including organ transplants, infertility treatments, and gender confirmation. Anthropologists started to explore different kinds of “biomedical mobilities” (Beck 2012) by investigating the cross-border movements not only of people seeking medical treatments, but also of health professionals, knowledge, technologies, and substances.

The development of new assisted reproductive technologies and their increasing global demand generated a transnational flow of people, techniques, and gametes, which attracted the
attention of anthropologists working in the domain of reproduction in different world jurisdictions (Deomampo 2016; Gurtin and Inhorn 2011; Inhorn 2015; Salama 2018; Smietana 2019; Whittaker and Speier 2013; see also chapters by Inhorn, Whittaker, and Deomampo in this volume). This growing literature has shown that the main reasons for seeking reproductive care across borders are that some treatments are not available or legal in people’s local area or country, or they are cheaper or considered of better quality abroad. However, not all people have access to citizenship status, information, financial resources, support, and social networks that make reproductive travel possible. Reproductive travel thus makes evident and reinforces existing gender, social, and racial/ethnic inequalities, while leading to self-arranged practices that may be illegal, but challenge the discriminating reproductive policies that force people to travel far from where they live, including abroad.

For all of these reasons, the term “medical tourism” has been strongly criticized over the last decade and the term cross-border reproductive care has been adopted instead by researchers studying the phenomenon of reproductive travel (Inhorn and Patrizio 2012). As scholars have highlighted, the experiences of people traveling to access reproductive technologies, in fact, are more similar to exile than to a vacation (Inhorn and Patrizio 2009). At the same time, some locations have developed into global “hubs” for reproductive services (Inhorn and Patrizio 2012). In Europe, for instance, Spain is one of the main destinations for reproductive services (in vitro fertilization, ICSI) and treatments with donor eggs (Bergmann 2011; Marre et al. 2018; Zanini 2011).

Abortion travel across national and regional borders

Spain, along with England and the Netherlands, is also one of the main European destinations for cross-border abortion travel, as the results of a European Research Council (ERC)–funded, European study on barriers to legal abortion and abortion travel are showing (De Zordo et al. 2020a). Abortion travel is a very relevant but understudied phenomenon, particularly but not only in Europe. The historians Christabelle Sethna and Gayle Davis (2019) have illustrated how in the US, Canada, and Europe women have traveled to seek abortion care within the borders of their own country or across borders both before and after abortion’s legalization. Thus, abortion travel is not only about illegality, but other forms of restrictions imposed on women and pregnant people.

In spite of the widespread nature of abortion travel, this phenomenon has remained at the margins of the interest of researchers investigating medical mobilities and cross-border reproductive care in particular. This lack of interest, as Sethna points out, is “odd, given that individuals who cross borders for many kinds of medical services encounter very similar legal and extralegal obstacles in their health jurisdictions as do women seeking abortion services” (Sethna and Davis 2019: 8). It may be due to the challenging nature of abortion travel research wherein the researchers must capture experiences of women and pregnant people during a single visit in a foreign clinic, and secure ethics approvals from multiple countries, in addition to other methodological and logistical challenges. Even in works devoted to the topic of abortion, Sethna notices, abortion travel is barely mentioned. A recent review of studies on women who travel for abortion care (Barr-Walker et al. 2019) shows an increasing social scientific interest in this phenomenon.

Only a few studies of abortion travel have been carried out in countries and continents outside of the US (Australia, Canada, South Africa, Mexico, the UK, Ireland, Norway, and the Netherlands) and examined not only in-country but also cross-border abortion travel. Moreover, most existing studies have been undertaken with quantitative instruments and public
health metrics in mind, such as measuring the distance of people’s residences from abortion providers, and, in some cases, the burdens related to travel (including financial costs and childcare needs). The few mixed-method and qualitative studies have explored the emotional impact of the experience of traveling, which can be difficult and disruptive to women’s and pregnant people’s lives as well as their experiences with the forced disclosure of their decision to have an abortion due to their need to organize their travel (e.g., Baum et al. 2016; Jones et al. 2013). Anthropological studies would excel in capturing the complexity of factors leading women and pregnant people to travel for abortion care and their experiences with that process; these studies are sorely needed.

It might be reasonable to assume that women and pregnant people in countries with severely restricted reproductive rights would travel abroad for healthcare. In Europe, most studies on abortion travel have focused on countries with restrictive laws, such as Ireland (e.g., Best 2005; Bloomer and O’Dowd 2014; Francome 1992; Rossiter 2009) or Poland (e.g., Mishtal 2015; Nowicka 2001). Yet, people who ostensibly have access to legal abortion in their countries of residence, such as in France or Germany, also find it necessary to travel abroad for treatment. Women and pregnant people may confirm their pregnancy or decide to have an abortion beyond the first trimester of pregnancy, when most abortion legislations allow access to legal abortion only under very limited and specific circumstances, like serious health problems of the woman or severe fetal malformations (Ingham et al. 2008; Loeber and Wijsen 2008). As recent studies show (De Zordo et al. 2020a; Gerdts et al. 2016) gestational limits for legal abortion can lead women and pregnant people to seek alternatives, including traveling to other countries with less restrictive limits, such as the UK or the Netherlands.

According to publicly available data from the Netherlands (Ministerie van Volksgezondheid Welzijn en Sport, Inspectie Gezondheidszorg en Jeugd 2019), in 2017, more than 3,000 non-Dutch-resident women and pregnant people traveled there to seek abortion care; the majority of them were from Germany, France, and Belgium. In 2018, more than 3,000 non-British-resident women and pregnant people traveled to England and Wales seeking abortion services (Department of Health and Social Care 2019). Approximately 95% of those individuals traveled from the Republic of Ireland, where abortion was highly restricted prior to December 2018, when the law changed and abortion access was significantly expanded (legalizing it up to 12 weeks and under certain circumstances). The rest traveled from Italy, France, Germany, and Denmark—nations with ostensibly liberal laws where abortion is lawful in the first trimester with additional allowances beyond that. Quantitative data collected in the UK also showed that women and pregnant people travel there for abortion care from Malta, where abortion is severely restricted, but also from more distant locations with restrictive laws such as Bahrain, Oman, and the United Arab Emirates (Gerdts et al. 2016). This pilot study showed that the main reason why women and pregnant people travel abroad to the UK from other European countries where abortion is legal was the gestational age limits in their country of residence; in addition, traveling abroad represented a considerable burden for many of them (Gerdts et al. 2016). These data are confirmed by the main findings of the first phase of the ERC research project on cross-border abortion travels in Europe mentioned earlier (De Zordo et al. 2020a, 2020b). Taken together, these studies show that despite relatively liberal abortion laws, a number of legal, procedural, and social barriers (including gestational age limits, mandatory waiting periods/counseling, and conscientious refusal of care) make access to legal abortion difficult for women and pregnant people, leading them to seek illegal abortion and/or travel far from where they live, including abroad. The ERC’s pioneering mixed-method study, which combines an epidemiological and an anthropological component, allows a deeper understanding of women’s and pregnant people’s experiences with different kinds of barriers to legal abortion in their country of origin, as
well as with abortion travel; it also allows investigating whether abortion stigmatization (e.g., Norris et al. 2011; Hanschmidt et al. 2016) may additionally influence access to abortion care in countries where abortion is legal, leading individuals to travel far from where they live.

The preliminary findings from the second phase of this study on in-country abortion travel illustrate that women and pregnant people travel in Europe not only across borders, but also within the borders of their own countries of residence to seek abortion care, including in countries where abortion is legal on request or on broad grounds. In Spain, for instance, thousands travel to Madrid from Castilla-La Mancha (nearly two hours by car) to seek abortion care every year. Access to second-trimester abortion is difficult in Galicia, while in other regions, like La Rioja, covert forms of conscientious objection (when a healthcare professional refuses to provide care citing objections based on conscience) make referral longer or more difficult (Colavolpe et al. 2019). Conscientious refusal of care can actually make access to legal abortion difficult in some regions of countries like Spain and Italy (De Zordo 2018) and lead women and pregnant people to travel far from where they live. In Italy, particularly in the south, rates of conscientious refusal of care among physicians are estimated at around 70% (Italia, Ministero della Salute 2020). The increasing rates of conscientious objection have triggered an intense scientific and political debate at both the national and EU level (especially well documented in Italy) on health professionals’ rights to refuse to provide abortion care versus patients’ rights to obtain a legal, safe abortion where they live (Autorino et al. 2020; Campbell 2011; Chavkin et al. 2017; De Zordo 2016–2018; Heino et al. 2013; Triviño Caballero 2014).

At the same time, in Italy, the Ministry of Health estimates between 10,000 and 13,000 illegal abortions annually (Italia et al. 2020), but no studies have investigated this phenomenon or that of abortion travel prior to the current, ongoing ERC study mentioned earlier. Spain and Italy are interesting case studies to investigate the effects of various barriers to abortion care, illegal abortion, and in-country and international abortion travel at the same time. In fact, as the ERC study is showing, women and pregnant people coming from even more restrictive areas seek care in places with fewer restrictions; for example, some travel from France and Andorra to seek abortion care in Spain, and Maltese individuals seek abortion care in Italy.

In Europe as well as in other geo-political contexts, including North Africa, abortion providers are often concentrated in cities or more populous regions, making access to abortion limited by geographic residence, which negatively impacts low-income and rural women and pregnant people in particular, and more so in restrictive legal contexts, where some may self-induce an abortion, putting their health and life at risk (Ganatra et al. 2017). In North Africa, from where many women and pregnant people migrate to Europe, abortion is illegal in most countries (Hessini 2007), and there are high mortality-morbidity rates related to illegal and unsafe abortion. At the same time, inter-country and in-country abortion travel are also relevant but understudied phenomena. As abortion is criminalized in Algeria and Libya, many women and pregnant people travel from these countries to Tunisia seeking abortion care, the only country in North Africa where abortion is legal and offered for free. In her work on abortion in post-revolutionary Tunisia, Irene Maffi (2017, 2018, 2020) demonstrates the complicated relationships between changing moralities, contested medical practices, and barriers to accessing abortion in post-revolutionary Tunisia, which has been a model, in the past, for activists and practitioners in countries in the region with restrictive abortion laws, like Morocco (Capelli 2017). As Maffi highlights, many aspects of the current denial of abortion care in Tunisia and/or of the failed access to it still deserve in-depth attention, for instance, by researching the dimension of in-country mobility and its connection with broader health inequalities. Tunisia is an interesting case to compare with other European national contexts because cross-border reproductive
care and domestic abortion travels co-exist and reveal that socioeconomic and legal barriers to women's and pregnant people's reproductive rights perpetuate in North Africa.

Abortion travel occurs also in other parts of the world, including the Caribbean (Pheterson and Azize 2005), Mexico (E. Singer 2017, 23), and India (Deonandan 2013), but has not been the object of extensive, in-depth investigations. More studies are needed to understand this phenomenon, which is relevant from social sciences as well as from public health and human rights perspectives.

**Future directions**

For anthropologists and other feminist researchers, Morgan’s call (2016) for global analysis of abortion presents challenges and opportunities about how exactly these studies can be conducted, since many of the questions span multiple countries and may not be answerable using traditional ethnographic methods. For anthropologists, gender studies scholars, historians, legal scholars, and others interested in this rich and complex topic, it may be necessary to look for innovative methods beyond ethnography, including through collaborations with scholars in public health, law, and other fields. This is not to say that research about global aspects of abortion cannot be situated in a specific context. On the contrary, a local lens is important as an entry point for an inquiry; however, we hope scholars may capitalize on the global aspects of abortion and link their local analyses with the larger mobilities of political strategies, practices, and discourses we present in this chapter as well as with networks of power relationships that underpin and govern abortion. The continued prominence of abortion as a topic of ongoing struggles in the realms of politics, healthcare, global economics, and questions of rights and gender equality in many countries around the world highlights that abortion remains highly significant for the anthropology of reproduction scholarship and future research in this area.

**Notes**

1. See Han in this volume for discussion of the use of “women and pregnant people.”
3. We primarily review anthropological scholarship; however, we also reference a few selected publications from other social sciences or public health when these texts offer important insights that fill some of the gaps in anthropological studies, and therefore help us paint a more holistic picture of the analysis of abortion from a global perspective.
7. For anthropological texts on abortion in Asia see, for example, Maya Unnithan’s study on India (2019) and Andrea Whittaker’s analysis of abortion in the context of global politics of reproductive rights and health with cases from Thailand, Cambodia, Burma, Vietnam, Bangladesh, Indonesia, and India (2010).
8. This project (BAR.2LEGALAB, 680004: https://europeabortionaccessproject.org/) is hosted by the University of Barcelona, funded by the European Research Council, and led by Silvia De Zordo.

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