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Beyond the State: Abortion Care Activism in Peru

It is 2023, and we are currently witnessing the entrenchment of a hyper-restrictive legal environment for abortion in the United States (Murray 2021). However, reproductive justice advocates have contended that the latest interventions are only part of the picture and the state of abortion uncare has been shaped through a range of micro- and macropolitical and legal interventions. Black, Indigenous, and people of color (BIPOC) and socioeconomically disadvantaged communities have witnessed the steady erosion of their pathways to abortion care through disinvestment in public health services and the targeted regulation of abortion providers or TRAP laws (Austin and Harper 2018; Solazzo 2019). That said, the 2022 *Dobbs v. Jackson Women's Health Organization* judgment is a substantial escalation. It effectively overturns *Roe v. Wade*, the 1973 judgment positioned as the fundamental federal protection of abortion care (Hannan 2021). In *Roe*'s absence, state legislatures will be able to criminalize abortion provision and access to care without breaching federal protections (Silberner 2022).

As soon as Justice Samuel Alito's draft decision overturning *Roe* was leaked, feminist pro-choice and reproductive justice activists began to consider how movements in jurisdictions where abortion has been heavily restricted have disrupted barriers to abortion. Within these discussions, Latin America is frequently used as a point of reference. Latin America has historically been, and continues to be, home to some of the most restrictive abortion laws, policies,

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and regulations in the world (Fernández Anderson 2020). In most countries, abortion is only permitted under specific circumstances: when necessary to save the mother's life or health and in cases of rape. Some countries ban it without exception and criminalize those who have "unexplained" miscarriages (Bergallo, Jaramillo Sierra, and Vaggione 2018). Millions of clandestine abortions take place every year in Latin America in contexts where abortion is illegal or where it is heavily restricted, with prosecution and incarceration a very real threat (Dzuba, Winikoff, and Peña 2013). At the same time, the period since the early 2000s has seen significant liberalization of abortion law in Latin America. The achievements of activists in Colombia (González-Vélez, Melo-Arévalo, and Martínez-Londoño 2019) and Argentina (Artazo, Ramia, and Menoyo 2021) in the past decade are particularly significant. Since 2020, for example, coordinated legal challenges by the *Ni Una Menos* campaign in Argentina and the *Causa Justa* campaign in Colombia, part of the *marea verde*, have led to the decriminalization of abortion.[1]

Abortion politics in Latin America is increasingly depicted as emblematic of how feminist movements can reverse seemingly entrenched antiabortion restrictions through the law (González-Vélez, Melo-Arévalo, and Martínez-Londoño 2019). It is unsurprising, then, that at a time when established legal protections for abortion have been dramatically eroded in the United States, feminist activists and commentators question what can be learned and adopted from Latin American feminist legal activism. To us, however, as scholars of feminist abortion activisms in spaces and places where restricted access to abortion is well established, a feminist commitment to defending and protecting abortion access solely through legal frameworks is problematic. It neglects the barriers to abortion entangled with but outside of the law (Díaz Amado et al. 2010; Bloomer, Pierson, and Estrada-Claudio 2018). Activisms targeted at addressing reproductive injustice and expanding abortion access, including the Latin American green wave, have emphasized that the law is only one technology of the uncaring state (Stifani et al. 2018). These activisms have highlighted how the historic and continuing intersection of law, medicine, and policy results in states of *uncare* with regard to abortion (Svallfors and Billingsley 2019; Ramos Jaraba et al. 2020). By "state of uncare" we mean a context where state-led systems of care and care policies are orientated toward restricting abortion and where those who access abortion and those who facilitate it face reprisals. To address abortion uncare, these activists argue, it is important

[1] The *marea verde* (or "green wave" in English) is the collective descriptor for feminist mobilizations for reproductive justice, specifically abortion, that have emerged in the past decade. The label "green" stems from the use of green bandanas by activists, first in Argentina and later across the continent.

to engage with and disrupt the combination of discourses that govern reproductive health.

Using insights from research in Peru, we outline how activists have engaged with and disrupted the state of uncare for abortion. We focus on *acompañamiento*, a feminist political praxis that constructs transformation-orientated "infrastructures of abortion care" (Bercu et al. 2022). These political projects challenge the factors that underpin Peru's restrictive politics of abortion through collective and holistic caring infrastructures outside the state. In doing so, *acompañamiento* underscores the need to address the more complex problem of reproductive governance and the limitation of reproductive autonomy that is reflected in restrictive legislation. It is this project, we argue, that should guide the US feminist response to *Dobbs*.

Overall, this article contributes both to discussions on care generally and on abortion and reproductive justice specifically. For care scholarship, we further the project of relocating care-theory building away from global North/minority world histories and experiences (Raghuram 2012).[2] The analysis of care woven through this article has emerged from global South/majority world praxes shaped by global South/majority world contexts. We thus build on emerging literature addressing what Parvati Raghuram (2016) provocatively refers to as feminist care theory's "unspoken" and "unnamed locatedness in the global North" (517). This literature does not discount care research and feminist writing based on and in the global North. Rather, it argues that feminist care research needs to relocate its analysis to contexts of the global South to enrich our understandings and debates on care.

Central to Raghuram's contention, which is arguably intentionally polemical, is that robust conceptualizations of care produced through analysis of global North contexts may be ill suited to the diverse histories, geographies, and relationalities of care beyond the global North. Raghuram points to two components of the problem. First, how and by whom care is practiced differs between the minority and majority worlds. This is overtly recognized in decolonialist, majority world–focused writing on kinship and familial relations, including the burgeoning literature on African and South Asian aunties (Khubchandani 2021). Aunties occupy a particularly important but, according to Kareem Khubchandani, ambivalent role in South Asian and African culture

[2] We recognize both "North-South" and "minority-majority world" categorizations in this article. "Minority-majority world" is used in sociology and political geography to underline that such categorizations do not refer solely to territory but to international political economies whereby a minority of the world's population control and profit from the world's resources at the expense of the majority. This minority population is more "Westernized" and occupies a hegemonic status as a result of colonialism.

and society. Resonant with Patricia Hill Collins's (1987) figure of the "othermother," aunties engage in caring practices either directly, through giving care, or through supporting "bloodmothers" (5). However, critical auntie studies (Khubchandani 2021) present the South Asian/African auntie as engaging in both disruptive and restrictive care relating to gendered positionalities and social relations. Aunties take care of social norms but can also provide care considered subversive. While still relatively nascent in feminist care theory, writing on aunties, derived from cultures outside the global North, both displaces maternal relations, the center of early care ethics literature, and presents care practices as complex political entanglements that govern and disrupt.

Second, care in the global South is shaped by markedly different histories than in the global North. The origins of some of these histories lie in the minority world, most obviously colonization and the spread of colonial capitalism through imperial projects (Lutz 2018). Scholars writing in, on, and to minority world contexts have noted this relationship through, for example, recognition of global care chains (Lutz 2018).

Here we will follow Raghuram's recommendation and relocate the discussion of reproduction and care to the majority world, exploring how this can help move feminist care forward. The majority world phenomenon of *acompañamiento* is useful for feminist care scholars, as it illustrates how care politics can draw attention to larger questions regarding the effects of macro and micro interventions on the forms of care supported, under what circumstances, and with what contingencies (Robinson 2013). By exploring the perspectives and engagements of *acompañante* activism, we can center intersecting questions regarding how bodies are governed by care frameworks, how particular forms of care become marginalized, and how infrastructures of care can transform how we imagine care. This use of care as an entry point for larger discussions about marginalization and governing resonates with Joan Tronto's (2010, 2015) and Fiona Robinson's (2011, 2013) arguments about how we need to further our understanding of the politics of care. This includes the stratification of who cares and who can receive care along classed, raced, and gendered lines.

We contend that, in terms of the contribution to abortion and reproductive justice, through detailing the care politics of *acompañantes* (those who accompany people through their abortions), these Latin American care politics show that the riposte to a state project of abolishing abortion care should be to generate infrastructures of abortion care beyond the state. This is a particularly timely intervention that will be of use outside of Latin America. Countries such as the United States and Poland have of late become more actively uncaring regarding abortion access. By taking care scholarship beyond the global North, we can open up spaces for connection and solidarity.

The article is organized in four sections. First, we provide a brief overview of our methodology, locating our analytic frames and detailing data used to advance our arguments. Second, we outline the politics of abortion care in Peru. Third, we present the feminist care activisms that have emerged within and as a result of this political context, underlining how *acompañantes* have constructed an infrastructure of abortion care by bringing together actors, technologies, and strategies. The fourth section explores the ethic of care than underpins and shapes this infrastructure of abortion care. We show how *acompañantes* provide abortion care that differs from minority world care models in three key ways: care as beyond the state, care as holistic, and care as collective. The article concludes by arguing that *acompañante* care work is instructive both in terms of expanding how we understand feminist care activism and in relation to the potential direction of abortion care activism in the global North/minority world.

Methodology

In this article, we have attempted to adopt key aspects of feminist and decolonial approaches. Our analysis begins within the Latin American historical context, specifically that of Peru. Theoretically, this constitutes a relocation of care consistent with still-nascent critiques of care theory as dominated by minority world perspectives. We have selected Peru as representative of a state that is actively uncaring with respect to abortion.

As a general principle, the arguments advanced in this article, the underpinning data, and its theoretical approach reflect a commitment to feminist and decolonial methodologies. That said, it is important to recognize our positionalities. Two of the authors are from universities in the United Kingdom, and, while we have tried to maintain dialogue with the types of political movements we discuss here, we are not members of those movements. One of the authors has tried to support feminist abortion activism in Ireland but does not claim an activist identity. One of the authors is based in a Peruvian university and has participated in feminist abortion activism, though she does not currently recognize herself as an activist. We have not used data collected through participatory or coproductionist approaches. We cannot therefore claim that our methodological approach is unequivocally a decolonial feminist one.

That said, the fact that the article is written in English for an academic publication based in the global North resonates with a critical component of decolonial theory. Our intention is not to tell the story of the global South but to center the global South as a site of learning for a global North audience (Vázquez 2009; Motta 2019). Through our analysis here, we aim to challenge and address the progressive logics of reproductive health that dominate the

political landscape in the global North. First, we disrupt the positioning of majority world/global South abortion activism that works outside the state, as the Peruvian activists we center here do, as participating in acts of desperation. This conceptual disruption echoes the arguments relating to self-managed abortion, a practice that has itself been driven forward by activists in Latin America. Abortion outside the state, within literature on self-managed abortion, is a reclamation of bodily autonomy (Erdman, Jelinska, and Yanow 2018). Second, we contend that policy interventions financed and celebrated by the global North as mechanisms for enabling greater reproductive decision making have not facilitated reproductive autonomy. We highlight the promotion of family planning and the expansion of a medicalized, clinician-led model of abortion care as particularly problematic. The former, following Rishita Nandagiri (2021) and others (see Svallfors and Billingsley 2019), has marginalized abortion care; the latter has displaced abortion from the community to the clinic.

In terms of data used, the article primarily draws on empirical research in Peru, conducted between November 2020 and March 2021. This consisted of twenty-five in-depth, open-ended interviews with people involved in abortion access and activism, particularly *acompañante* care work. We employed purposive sampling to select a group of experts on the topic of abortion provision in Peru, and we contacted participants through already existing research relationships or by cold-contacting email addresses that we found online. The interviews took place on the videoconferencing software Zoom due to the social distancing restrictions enforced during the initial outbreak of the COVID-19 pandemic; they covered abortion access in Peru, barriers to provision, routes to informal access, and much more, depending on the interviewee.

This research project received ethical approval from University of Exeter, and participants were always given the option of full anonymity.[3] All data is stored securely and accessible only by the research team. The interviews all took place in Spanish and were then transcribed and coded by the researchers. Quotes used here were translated into English by the authors.

Peru and the politics of abortion

Clandestinity and unsafety define most people's experience of abortion in Peru. Although first-trimester abortion is considered one of the safest medical procedures when performed in appropriate settings, clandestine conditions increase the chance of associated hospitalizations and maternal deaths. Furthermore, the health burdens of unsafe abortions unfold along sharp

[3] Ethical approval reference eCLESGeo000794.

class and ethnic cleavages. Poor and Indigenous women disproportionately suffer the potentially fatal consequences of the combination of severe abortion restrictions and lack of provision for abortion care in health settings even where it is legally permissible and clinically necessary, including in circumstances where there is a risk to maternal mortality (Wurtz 2012; Singer 2019). In addition to these health burdens, it is the women who suffer complications from unsafe abortions and are hospitalized as a result who face the greater risk of judicial punishment, as the legal chain of prosecution often starts when the public hospital staff turn women in to the authorities, as figure 1 illustrates (Salazar Vega 2019). The Peruvian state not only denies abortion as an essential form of care but actively punishes and prosecutes women and pregnant people who attempt to interrupt their pregnancies.

Peru is thus reflective of a state of abortion uncare. Antiabortion legislation is the most visible representation of this uncare and the most obvious explanation for abortion's clandestinity in Peru. Peruvian abortion law constitutes a hyperrestrictive environment (de Londras 2020). The criminal code criminalizes abortion—a woman can be sentenced to up to two years in prison for accessing an abortion, and anyone who performs an abortion can be sentenced to one to five years (Cámara-Reyes, Obregón-Gavilán, and Tipiani-Mallma 2018). While "therapeutic abortions" have been permitted since 1924 and are currently allowed if the pregnancy poses a high risk to the mother's health and well-being, guidelines are poor, and such abortions are difficult to access in practice, meaning Peru has one of the most restrictive abortion frameworks in Latin America (Motta Ochoa and Salazar Lostaunau 2019). As in other jurisdictions in Latin America, those suspected of procuring abortion services illegally, including patients presenting with miscarriage and pregnancy loss, have been pursued through the courts. As the image in the figure illustrates, practitioners in clinics have been co-opted by the legal project restricting abortion. Such legal frameworks and examples of antiabortion lawfare (Enright, McNeilly, and de Londras 2020) are visible across Latin America and the Caribbean. In Uruguay, Honduras, and El Salvador, for example, patients presenting with miscarriage have faced criminal charges and have even been imprisoned under antiabortion legislation.

However, the antiabortion legal framework is only one way the Peruvian state has constrained abortion access. To understand fully the state of abortion uncare, it is essential to take the broader context of reproductive politics into account. Peru represents a country where successive, persistent political discourses and interventions have made abortion inaccessible even when it is legally permissible (Rousseau 2007). The clandestinity of abortion is as much the result of this inaccessibility as the legal prohibitions, a phenomenon discussed by Lynn Morgan and Elizabeth Roberts (2012) through their

Figure 1 A poster at a public hospital in the Abancay region of Peru warns that "every patient diagnosed with an incomplete abortion must present themselves to the police on duty." In 2017, the poster was removed after public outrage on social media.

model of reproductive governance. In Peru, the individual experience of abortion uncare is rooted in coexistent state projects, national and transnational, relating to family planning, maternal health, and the medicalization of abortion.

The use of family-planning initiatives to minimize abortion has particular relevance to Peru, where a combination of Catholic church–led natalist

concerns about "the improvement of families as Catholic communities" (Necochea López 2008, 58) and reliance on international donors such as USAID (Ewig 2006) worked to orient reproductive health provision toward contraception and to reduce "unsafe" abortion rates (Rousseau 2007). Doctrines of fertility control are embedded within reproductive health policy and investment in Peru, and discourses from the 1970s onward have actively connected good motherhood with fertility control, the continuation of pregnancy, and the provision of material support for children (Rousseau 2007; Necochea López 2008). The target populations of these programs and discussions were predominantly already marginalized communities—rural, poor, and Andean—and there is extensive evidence of the escalation from reversible family planning to coerced and nonconsensual mass sterilization by state-backed agencies (Boesten 2014). This escalation is reflected most overtly by the state-run sterilization campaign under the Fujimori administration in the mid-1990s. The combined result of these state projects is the reduction of investment in abortion care, the stigmatization of those who seek abortion as failed reproductive citizens, and the formation of a political ideology that favors reproductive control above reproductive autonomy.

The genealogy of abortion uncare and clandestinity in Peru resonates with global histories of reproductive justice. In the United States and globally, the emerging restrictions on abortion have been preceded by conservative emphases on contraception and good mothering. National and global reproductive health projects have prioritized pregnancy prevention and maternal health support (Nandagiri 2021). These have facilitated the marginalization of abortion within the spectrum of reproductive care provision, a phenomenon that Rene Almeling (2015) and Siri Suh term "stratified reproduction" (Suh 2018, 664). As Suh (2018, 2019) and Nandagiri (2021) note, despite substantial investment in reproductive health by transnational organizations, and despite statements on the importance of reproductive health, such as the 1992 Cairo Declaration, clandestinity and uncare remain a common experience for abortion seekers. The provision and availability of abortion services nationally and locally is often unequal, creating insurmountable cost burdens and resulting in abortion travel (Bloomer, Pierson, and Estrada-Claudio 2018). These inequalities intersect with other social determinants of poor health access and compound uneven political economies and geographies of abortion. Encounters with stigmatizing attitudes from health professionals are frequently reported in research (Suh 2018). These attitudes are worsened by reproductive health interventions focused on fertility control, as abortion seekers are cast as irresponsible (Morgan and Roberts 2012).

What is distinct about Peru, and Latin America more broadly, is the response of feminist activism. Although Latin American feminist activists, like

minority-world activists, have responded to abortion uncare by demanding that the state guarantee abortion rights and by highlighting the uneven political economies of reproductive (in)justice, a prominent strand of feminist activism—*acompañante*—foregrounds the provision abortion care in a way that challenges the discourses underpinning uncare. This involves *acompañantes* engaging in practical support activities that are visible in minority-world movements, including providing information, supporting abortion travel, and advocating for the recognition of nonlegal barriers to abortion. Yet, as Naomi Braine (2022) notes, the totality of *acompañante* activism is not comparable to feminist abortion care activism in the minority world. *Acompañantes* not only demand the minimization of legal barriers to abortion care, they also engage in the formation of new infrastructures of abortion care. These infrastructures disrupt minority-world concepts of safe abortion care as medicalized and provided via state institutions, producing a collective and holistic infrastructure of care beyond the state (Bercu et al. 2022).

The emergence of this activist pursuit is intertwined with the genealogy of abortion uncare outlined above. The family-planning "revolutions" and the reliance on conservative international investment indicate that the Peruvian state cannot be fully trusted to protect, and is at times demonstrably hostile to, the exercise of reproductive autonomy.[4] Moreover, the history of abortion law in Peru, as in other Latin American countries such as Venezuela and Colombia, indicates that the liberalization of reproductive health has frequently been underpinned by antiabortion projects (Ewig 2006). Peruvian contraception law was increasingly liberalized throughout the 1970s and 1980s; by comparison, Peru's draconian abortion laws have remained largely untouched (Rousseau 2007). Investment in maternal health and contraception, including coercive contraception, dominates the policy landscape. The state emphasizes the need to address abortion as a public health and safety problem, an approach that Suh (2018) argues reinforces the reproductive stratification outlined above.

The Peruvian activist response also problematizes the medicalization of abortion as exemplary of colonialist projects intent on establishing and reinforcing medical hegemony. Toward the end of the nineteenth century,

[4] The period from the 1960s to the 1990s was marked by a rapid international expansion of family-planning programs. While family-planning advocates and services had been available in some countries since the early twentieth century, the family-planning movement expanded incrementally, with significant political resistance, until the mid-twentieth century. Family-planning policies from the 1960s onward are termed "revolutionary" due to their scale and pace but also because the programs were antithetical to the dominant conservative religious ethos. This was particularly the case in Latin American countries such as Colombia and Peru (Robinson and Ross 2007).

abortion became medicalized in minority-world contexts in that it was only to be performed by medical professionals, and with this came the implementation of laws prohibiting traditional and community-based abortion care (Bloomer, Pierson, and Estrada-Claudio 2018). Medicalized abortion care models emphasize individual safety, with the implication that care outside of clinical frameworks is potentially riskier and less safe. The abortion experience itself is reduced to an individual reproductive event that should be managed by clinicians (Sheldon 1997).

Decolonial theorists such as Rolando Vázquez (2009) argue that the ascendancy of medical models reflects a hegemonic project of obliviating traditional forms of care and knowledge in the majority world. Global investment in safe abortion initiatives, including postabortion care, reinforces the hegemonic position of medical, clinic-based professionals (Erdman, Jelinska, and Yanow 2018; Suh 2018). Even policies such as Peruvian task-sharing programs with Andean community birthing care, which present themselves as interested in expanding care (Gabrysch et al. 2009), have been critiqued for this reason. Analysis of this initiative indicates that, during implementation, care is decentered in favor of medicalization (Guerra-Reyes 2016, 2019). Those who opt to access care outside clinics are stigmatized and discriminated against by health professionals. Literature on bodily and reproductive autonomy regards such experiences as manifestations of obstetric violence, since decision making is denied. For Indigenous communities and activists working toward individual reproductive control, this results in a sense that the state's intention is to erase their reproductive autonomy.

Having contextualized the situation of clandestinity and state harm in Peru, we now explore how a diverse range of feminist groups and collectives have constructed what we term an "infrastructure of abortion care" against the backdrop of this history of reproductive control and state uncare.

Building feminist infrastructures of abortion care in Peru

Peru's hyperrestrictive environment means that most abortions are performed clandestinely, beyond the eyes of the state. Clandestine abortions include those supported by health providers working outside clinics or formal medical settings (e.g., hospitals). However, this does not mean that all abortions accessed in Peru, or Latin America generally, are unsafe or uncaring. As Joana Erdman, Kinga Jelinska, and Susan Yanow (2018) note, while clandestine abortion is frequently positioned as dangerous, empirical health research challenges reading clandestinity as synonymous with unsafety. The problem with clandestinity is that it is challenging to know where and how to access an abortion in a safe, cared-for way if one cannot use formalized routes (e.g., hospitals

or medical clinics). In response to this challenge, a series of actors, including health workers, mobilize to facilitate access to caring abortions. In the remaining part of this section, we show how individuals, groups, and organizations, alongside technologies and strategies, are woven together to forge—and continually recreate—infrastructures of abortion care.

"Infrastructure" has become a fashionable term in recent years. While it has been defined in many different ways, within and outside academia, and has defied any fixed definition (Fourie 2006; Wilson 2016), there is a growing body of scholarship within what has been termed the "infrastructural turn" (Amin 2014, 138). Early work on infrastructures considered them to be "by definition invisible, part of the background for other types of work" (Star 1999, 377) and "frequently mundane to the point of boredom" (Di Nunzio 2018, 1). Susan Leigh Star's important contribution here is to call attention to how overlooked infrastructures, whether sewers, power supplies, or bureaucratic forms, help us interrogate questions of power and justice. This work also focuses on how infrastructure is not a discrete thing in and of itself but is always a relation (Star and Ruhleder 1994). Such scholarship led to an understanding that infrastructures are not the background of life upon which things run; rather, they are political, and we need to understand how they are brought into being and continually remade (Bowker and Star 2000). As Lauren Berlant (2016, 393) has argued, "infrastructure is defined by the movement or patterning of social form. It is the living mediation of what organizes life: the lifeworld of structure." Dynamism and the potential for restructuring, then, are the common threads that run through current conceptualizations of infrastructure.

A very recent development in scholarship on infrastructure has been the coining of the term "infrastructure of care" (Alam and Houston 2020; Power and Mee 2020; Odendaal 2021). Drawing on the work of Star (1999), Emma Power and Kathleen Mee (2020, 485) "conceptualize infrastructures not as pre-figured objects or necessarily public, capital goods, but as dynamic patterns that are the foundation of social organization" in their work on housing as an infrastructure of care. In her work on South Africa's COVID-19 response, Nancy Odendaal (2021, 391–92) uses "infrastructures of care" to refer to "the data, technology and human agency that contribute to the care landscape emerging from the virus response." Ashraful Alam and Donna Houston (2020), meanwhile, consider care as an "alternate" infrastructure to focus on the ordinary and the intimate, and the role of everyday, noninstitutional care spaces. This nascent work is providing a framework for understanding an organization of care that includes people but also takes into account materialities, technologies, systems, and governance. These all shape what kind of care is possible, if at all. Importantly,

Power and Mee (2020) highlight how values become coded into infrastructures, which then (re)produce social difference.

If current conceptions of infrastructures of care provide a framework that includes people but also takes into account materialities and technologies, we define infrastructures of abortion care as a set of relations between actors, technologies, and strategies that are brought into being by an interest in the embodied and emotional well-being of the people seeking to have an abortion. These infrastructures of care create possibilities for abortion in restricted contexts by expanding the paths of action available to people, providing a level of regularity and predictability of the abortion experience, and serving as a source for practical and emotional support throughout the abortion trajectory. This infrastructural work, following Alam and Houston (2020), also reimagines the possible shape of abortion care. The next section will outline how the infrastructures generated by *acompañamiento*, at the margins of an uncaring state, reimagine abortion care. As a preface to this, here we explain the actors, technologies, and strategies that generate this infrastructure of abortion care.

The actors who constitute the infrastructures of abortion care are not uniform and are mainly differentiated by their level of organization, the technologies and knowledge they deploy, and the strategies they use to interact and respond to clandestinity. Although the limits between them are blurry and overlapping, we can broadly identify three type of actors who build infrastructures of care in Latin America: family and friends, health care practitioners, and *acompañantes.*

First, family and/or friends who accompany people seeking to terminate their pregnancies are often the only source of help and support in Latin America (Erviti 2005). While social networks can reduce physical, mental, or emotional burdens and facilitate access to timely medical care in cases of an emergency, their help can also be experienced with ambiguity or, at worst, can represent an additional source of stress, for instance, in cases where they oppose the pregnant person's decision.

Second, there is an extensive network of health care practitioners who provide safe surgical abortions in Latin America. Throughout the 1990s, a growing network of health care providers were trained to effectively perform abortions using manual vacuum aspiration. These providers included not only physicians but also registered midwives, nurses, nurse technicians, and even traditional midwives—a cadre of health professionals who provide the bulk of reproductive health care in Latin America, as in other developing regions, especially in small cities and rural areas (Berer 2009). Once trained, these same professionals could implement projects to train others in even more remote areas, expanding the network much further. This has had a big impact on

the enlargement and decentralization of care sites, increasing access to safe abortion services.

Third, and centrally, given the focus of this article, a growing number of feminist networks of activists and *acompañantes* facilitate access to self-managed abortions in Peru. The first *acompañante* network emerged in Lima, Peru's capital, in 2009. Since 2015, after the expansion of feminist mobilizations under the banner of *Ni Una Menos* (a movement, initially based in Argentina, against gender-based violence, including reproductive harms), *acompañante* networks have spread within and outside Lima. *Acompañantes* are groups or individuals who provide accurate information and support in self-managing an abortion alongside emotional support, legal guidance, practical resources, and postabortion care (Veldhuis, Sánchez-Ramírez, and Darney 2021). *Acompañantes*, who sometimes offer in-person accompaniment, are typically more involved in the process than other groups, which just provide information about abortion. In recent years, *acompañantes* in Latin America have become pivotal actors in establishing infrastructures of abortion care. Furthermore, as we outline later, in creating infrastructures of care, *acompañantes* foreground a transformative imagining of abortion care as a holistic and collective experience that can exist beyond institutionalized, state-governed spaces.

Self-managed abortions, as supported by *acompañantes*, consist of taking abortion pills, commonly referred to as a medical abortion. The dose may consist of a combination of mifepristone and misoprostol, or just misoprostol. Misoprostol is a medication that was designed to treat stomach ulcers, but women in Brazil realized its abortifacient properties and developed a safe and effective protocol to use it to end pregnancies. It is most effective when used in combination with the medication mifepristone, but this is harder to access in Latin America because it is only used for abortions. With the correct information on how to use the pills, medical abortions are safe and effective and may be preferred by some abortion seekers as they are more affordable and less invasive (Moseson et al. 2020). They also afford greater reproductive autonomy and allow abortion seekers to avoid domains where they may have to defend their decision making or that they have historically experienced as sites of reproductive injustice and control (Erdman, Jelinska, and Yanow 2018). Yet the existence of this pill does not guarantee easy access, and, without accurate information on how to use it, it can be not only ineffective but in extreme cases, risky. As one interviewee explained, "So it [misoprostol] seems great to me when it's used properly, with good information, with good medical support for women, but when all that is not there, then it is also putting them at risk." The role of *acompañante* groups is therefore to build an infrastructure that provides access to the pills themselves as well as access to information on how to use them safely.

Acompañante abortion care involves whatever technologies make abortion care possible. In terms of providing access to abortion medications, this might be the postal system or public transport. Information about using the pills is provided through a range of technologies such as hotlines, where callers can access accurate and up-to-date guidance on how to safely seek an abortion, or handbooks that explain how to self-manage an abortion using text and visual guidance (Drovetta 2015). Social media and instant messaging services have also become crucial technologies, and our interviewees reported using encrypted secure platforms such as Signal and Telegram to avoid surveillance. These allow *acompañantes* to remain anonymous and offer a range of communication, including text-based messaging, voice calls, video calls, and the sharing of images. This latter has been particularly important during the COVID-19 pandemic, when *presencial* (in-person) accompaniment became challenging or impossible and *acompañantes* shifted their care work to be virtual. These technologies enabled the sharing of photos and videos so that *acompañantes* could share their expertise on whether the amount of blood looked excessive or whether the gestational sac had passed.

These technologies are enabled by strategies that facilitate the movement of abortion pills and information on how to use them. For example, one group explained how they created "heat maps" that listed different pharmacies and provided information on which sold misoprostol, how much they charged, and whether they required a prescription. Another strategy is to use code words for misoprostol, and many groups have their own preferred terminology, from sweets to cupcakes, communion wafers to ingredients. A third strategy is the building of strategic relationships. Some groups will work closely with or be part of broader coalitions involving medical professionals, legal advocates, health researchers, and community leaders. This means they can access support but also material resources, as some international organizations are able to donate mifepristone and misoprostol directly to activists in Peru and Latin America more broadly. A final strategy is to provide information about what to do if an abortion seeker is questioned by the authorities, perhaps if they experience complications and need medical attention. If misoprostol is administered buccally—placed between the inside cheek and gums—it is impossible for a medical professional to know that an abortion was intentionally provoked, so *acompañantes* provide training and "scripts" on what to say so it appears to have been an unprovoked miscarriage. In all, a range of strategies are employed to provide safe and effective abortion care that protects those having the abortion as well as those who support them.

In this context, a diverse range of feminist groups and collectives, formal and informal, have constructed an infrastructure of abortion care to minimize these risks and to provide caring abortions. These actors work to distribute the

pills, disseminate information about how to safely administer them, and provide care for those undergoing an abortion. Through these strategies, relationships, and processes, these actors pull together an infrastructure of pills, information, and support to provide abortion care in an uncaring state. We next turn to the ethic of care that drives and shapes this infrastructure of abortion care.

Developing abortion care through *acompañante* care work

Within an uncaring context, *acompañantes* prioritize abortion care as their central activist project. Feminist infrastructures of care offer radically different forms of abortion provision through rejecting assumptions that safe abortion can only be provided by the state, through clinical frameworks (Erdman, Jelinska, and Yanow 2018). *Acompañantes* generate infrastructures of safe abortion care that are beyond the state, holistic rather than just medical, and collective. Here, we use these three elements, first to outline what distinguishes *acompañante* care work as a political project, and second, to suggest what care theory and feminist activists can draw from the *acompañantes*' politics.

First, *acompañante* care work shows that it is possible to provide safe and effective abortions outside the purview of the state. While there are feminist organizations and activists who argue for the state to step in and provide abortion care, the urgent need for safe abortions in the present means that *acompañantes* recognize the need to provide abortion care outside of state frameworks. Indeed, our interviews with *acompañantes* in Peru showed some frustration over what one called the "liberal approach" to fighting to change the abortion law. As an interviewee emphatically stated, self-managed medical abortion is necessary now because "women continue to die . . . I'm not going to wait . . . for Congress [to legalize abortion]." Another explained: "*Sé que aquí no va a ser legal no sé en cuántos años, pero creo que si acompañamos a una o a dos estamos ayudando un granito en que no pase algo terrible, ¿no?*" (I know it's not going to be legal here, I don't know in how many years, but I think that if we accompany one or two we're helping a bit so that something terrible doesn't happen, right?). However, these actions have bred recognition among activists that the Peruvian state has been a harmful actor in relation to reproductive autonomy (Rousseau 2007). As a response, *acompañantes* have actively created alternative pathways for empathetic feminist abortion care. One interviewee explained that she had previously thought the best strategy was to fight for "legal and safe" abortion in Peru until a friend asked her what that meant in the meantime. From there she began to confront her emotions of shame and fear around accompanying abortions. As these examples show,

claims that care should be the responsibility of institutions and the state do not work in Peru, where abortions are urgently needed in the present and where the state has so often been harmful. *Acompañante* groups create alternative infrastructures beyond the state to address an immediate need and to disrupt the view that abortion should only be provided by the state.

Second, *acompañante* groups are further distinguished by their rejection of the clinic-based, medicalized model as the only safe form of abortion care. These groups do not wholly reject medical practitioners; many have medical professionals inside the group who are able to offer knowledge and support. Nevertheless, *acompañantes* come from a more expansive place of care, underscoring the holistic, relational qualities of positive abortion care that encompass but go beyond the medical interruption of pregnancy. One *acompañante* described her abortion care work as both practical and emotional, which together form the *nivel holístico* [holistic level]. Another called it *acompañamiento integral* [comprehensive accompaniment] because they would sit down and talk and ask, "What do you feel? What do you want?" This form of tailored care takes into account the full lives of those seeking accompaniment in what one *acompañante* group call *acompañamiento diferenciado* [differentiated accompaniment], "which is to understand that we do not all live in the same way, nor do we see the world in the same way." This changes what a "good" or "safe" abortion consists of. For example, one interviewee defined "safe abortions" as "*No solo en el sentido médico, del cuerpo, sino seguros en el aspecto de la salud mental y de las emociones*" (not only in the medical sense, of the body, but safe in the aspect of mental health and emotions). In order to provide this type of holistic care, *acompañante* groups build their infrastructure of care differently. This might be a question of who they have within their collective, as groups often have psychologists or therapists to provide support. It also dictates their protocol and what they offer abortion seekers. As one interviewee explained: "*Sí, el saber más técnico, pero también el acompañamiento humano, acompañar el duelo, la toma de decisiones, lo que implica esto, hacer que la mujer no esté sola. Entonces, básicamente información, acompañamiento en todas sus dimensiones, ¿no?*" (yes, the more technical knowledge, but also the human aspect of accompaniment: accompanying the grief, the decision making, what it all means, making sure that the woman is not alone. So, basically information, accompaniment in all its dimensions, right?). Therefore, *acompañantes'* care work is formulated differently from that of the majority of medicalized abortion providers. Medical knowledge and expertise are important, but emotional support is embedded in the process from the beginning, and the whole health, mental and physical, of the abortion seeker is considered at all stages to create a holistic model of care that can extend beyond the procedure itself.

Third, *acompañante* groups construct an infrastructure of care where abortion is embedded within communal and community relationships. Again, this stems from a recognition of the negative impacts of medicalizing abortion. Medicalization can reinforce social stigma and marginalization by moving abortion out of community and collective relationships (Suh 2019). It can also overlook the problematic attitudes of clinic providers (Halfmann 2012) and decenter the importance of creating atmospheres of trust and dialogue between caregivers and the cared-for (Fisher and Tronto 1990). While the expansion of self-managed abortion, driven by activists in Brazil (Bloomer, Pierson, and Estrada-Claudio 2018; Baum et al. 2020; Diniz, Ambrogi, and Carino 2021), has led to the expansion of telemedicine and abortion "at home" in the minority world, an expansion that escalated rapidly during the COVID-19 pandemic (Lohr 2022), medical models have not been displaced. "At home" abortion care, "community models," and telemedicine in countries such as the United Kingdom, the United States, and Australia remain clinician-led, underscored by concerns of risk and safety. These forms of community care are still medicalized.

By contrast, ideas around mutuality, trust, and the collective underpin *acompañantes*' approach to community-based care (Braine 2022). The collective is an important way to challenge the traumatic, harmful violence of clandestine abortion in Peru. This includes feelings of isolation and shame. For example, an *acompañante* recalled one of her friends who had an "abortion shower," surrounded and supported by friends, and this, despite the physical pain of the process, "meant that it was not a traumatic experience." Engaging the collective in abortion care can have transformative effects on how *acompañantes* understand the problem of clandestine abortion as more than an issue of safety. Hearing about this friend's experience was what convinced our interviewee that it is possible to have an abortion free of guilt and feelings of sin. Another interviewee explained, "The worst thing [about having an abortion in Peru] is the clandestinity and the fear of not knowing who to turn to." A different interviewee, reflecting on her own abortion in Peru and others whom she had accompanied, said "*Como colectividad entendamos que el aborto no es un proceso traumático en sí mismo sino que todo el ontext lo hace traumático*" (As a collective we understand that abortion is not a traumatic process in itself but that the whole context makes it traumatic). Creating this nontraumatic collective space often entails *acompañantes* bringing their own personal experiences into the caring process. One *acompañante* explained that in her group, all the accompaniers have had an abortion themselves so they can explain to those they accompany that they know how they feel. Another explained:

> Dependiendo también de la mujer y cómo se muestre ella, también salen las experiencias personales como 'mira, por ejemplo, en mi caso fue así, y todo salió bien, que no sé qué'; esto nos acerca, nos acerca un montón. Lo cual no quita que todas las experiencias sean gratas.
>
> [Also depending on the woman and how she presents herself, personal experiences also come out, like "look, for example, in my case it was like that, and everything went well, I don't know what"; this brings us closer, brings us a lot closer. Which does not mean that all experiences are pleasant.]

This collective nature of care is facilitated through group sharing sessions where people who are seeking an abortion or who have had one can vocalize their experience and hear the experiences of others. This is done with the clear purpose of combating stigma, raising consciousness, and making abortion care a collective rather than an isolated experience.

Acompañante care work in Peru, as in other Latin American jurisdictions, thus does more than provide a route to an effective abortion through challenging legal barriers or by expanding state provision in clinical settings (Baum et al. 2020; Bercu et al. 2022). It necessitates creating a supportive environment. While minority world discourses have predominantly focused on asking the state to assume responsibility for abortion provision, situating our analysis in Peru shows that this conversation needs to appreciate the fact that, even when the state assumes care, care is not always facilitated in beneficial ways. Access to abortion can been stratified along racialized, classed, and moral lines, and already-marginalized communities are particularly vulnerable to this. *Acompañante* groups' focus on abortion care as holistic challenges medicalized frameworks of abortion care that posit an abortion procedure as isolated and detached from the rest of the person's health and life. An important exception to note here is the emotional and social care work performed by abortion doulas in contexts such as North America and Northern Ireland (Chor et al. 2016; Campbell et al. 2021). Finally, by making abortion care work a collective endeavor, *acompañantes* challenge assumptions that abortions that take place in clandestinity are necessarily traumatic and isolating. Through sharing their experiences and learning from the experiences of others, those who have abortions can be well supported and find the process personally and politically transformative. This model refutes care as a transactional, one-way process, an understanding reflected in the term *acompañar* (accompany), which activists use instead of "help" to highlight that the relationship is one of learning and reciprocity (Vivaldi and Stutzin 2021). This alternative ethic of care provides important lessons for minority world contexts of uncare.

Conclusion

We began this article by asking what the global North could learn from the global South. On one level, Latin America presents a set of strategic tools. These include forms of feminist lawfare that work through rights-based legal tools and technologies such as abortion pills. At another level, one more interesting to us, activisms in the global South present an opportunity for pro-choice feminists in the global North to unlearn assumptions about what their demands should be. *Acompañante* presents a different set of objectives for feminist activists in the United States facing the reversal of *Roe*. Pro-choice activism in the United States has emphasized legally protecting abortion, increasing contraceptive use, minimizing "unsafe" abortion, and expanding provision by medical professionals through clinical frameworks. Within these minority world models of good abortion care, barriers to abortion, unsafe abortion, and clandestine abortion are addressed through a combination of liberalization; investment in health services including telemedicine, telehealth, and postabortion care; and ensuring that voluntary contraception, including long-acting reversible contraceptives, is widely available.

Majority world countries such as Peru have a distinctly different history with regard to abortion. As a result of legal frameworks that have been relatively unchallenged since the 1980s, abortion is almost always a crime in Peru. This means that women and pregnant people wanting to end their pregnancies must find alternative strategies and conceal their abortion from a state that actively prosecutes abortion seekers and providers. Legal pro-choice advocacy is slow and does not address these immediate concerns. Furthermore, as in the United States, the barriers to abortion extend beyond the law, with uneven effects. Indigenous and poorer communities experience the greatest difficulties. These barriers have been worsened by other reproductive health policies. The emphasis on family-planning investment and the medicalization of abortion have marginalized abortion within the spectrum of reproductive health, and this has positioned the decision to have an abortion outside a clinic as an act of desperation and as unsafe. Communities that either have accessed or prefer to access abortion outside state institutions are faced with the problem of navigating clandestine abortion trajectories in isolation. This isolation reinforces abortion stigma and creates safety concerns.

In the face of a state that refuses to respect either the normalcy of abortion care or the decision to access abortion outside of clinical spaces, groups and individuals have developed forms of caring that provide safe, effective, respectful, and empathetic abortions. These activists—*acompañantes*—do not just address the limitations on state-provided or state-sanctioned abortions but have put forward a new vision of abortion care, one where the person having the abortion feels empowered and has autonomy. To appreciate

the complexity of this activism, we have proposed *acompañantes* as generating an infrastructure of abortion care. The term "infrastructure" allows us to think beyond just the people involved in care work to include the materialities and technologies that facilitate that care. Recent scholarship on infrastructures of care (Alam and Houston 2020; Power and Mee 2020; Odendaal 2021) has conceptualized such infrastructures as dynamic patterns that are underpinned by values. Effective abortion care beyond the Peruvian state, in clandestinity, is constituted by technologies and strategies as well as the by people facilitating the relationships between them. And it is a vision of empathetic, autonomous abortion futures, not just legal abortion provided through clinical frameworks, that drives this infrastructure of abortion care. *Acompañante* abortion care work is beyond the state, holistic, and collective. As we have shown through this article, *acompañante* care work is, for many carers, a process filled with love. A post-*Roe* future, through learning from *acompañantes*, could potentially bear witness to a similar process.

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