The New York Times | http://nyti.ms/1tOfQff

MAGAZINE

The Dawn of the Post-Clinic Abortion

By EMILY BAZELON AUG. 28, 2014

In June 2001, under a cloud-streaked sky, Rebecca Gomperts set out from the Dutch port of Scheveningen in a rented 110-foot ship bound for Ireland. Lashed to the deck was a shipping container, freshly painted light blue and stocked with packets of mifepristone (which used to be called RU-486) and misoprostol. The pills are given to women in the first trimester to induce a miscarriage. Medical abortion, as this procedure is called, had recently become available in the Netherlands. But use of misoprostol and mifepristone to end a pregnancy was illegal in Ireland, where abortion by any means remains against the law, with few exceptions.

Gomperts is a general-practice physician and activist. She first assisted with an abortion 20 years ago on a trip to Guinea, just before she finished medical school in Amsterdam. Three years later, Gomperts went to work as a ship's doctor on a Greenpeace vessel. Landing in Mexico, she met a girl who was raising her younger siblings because her mother had died during a botched illegal abortion. When the ship traveled to Costa Rica and Panama, women told her about hardships they suffered because they didn't have access to the procedure. "It was not part of my medical training to talk about illegal abortion and the public-health impact it has," Gomperts told me this summer. "In those intense discussions with women, it really hit me."

When she returned to the Netherlands, Gomperts decided she wanted to figure out how to help women like the ones she had met. She did some legal and medical research and concluded that in a Dutch-registered ship governed by Dutch law, she could sail into the harbor of a country where abortion is illegal, take women on board, bring them into international waters, give them the pills at sea and send them home to miscarry. Calling the effort Women on Waves, she chose Dublin as her first destination.

Ten women each gave Gomperts 10,000 Dutch guilders (about $5,500), part of the money needed to rent a boat and pay for a crew. But to comply with Dutch law, she also had to build a mobile abortion clinic. Tapping contacts she made a decade earlier, when she attended art school at night while studying medicine, she got in touch with Joep van Lieshout, a well-known Dutch artist, and persuaded him to design the clinic. They applied for funds from the national arts council and built it together inside the shipping container. When the transport ministry threatened to revoke the ship's authorization because of the container on deck, van Lieshout faxed them a certificate decreeing the clinic a functional work of art, titled "a-portable." The ship was allowed to sail, and van Lieshout later showed a mock-up of the clinic at the Venice Biennale.

As the boat sailed toward Dublin, Gomperts and her shipmates readied their store of pills and fielded calls from the press and emails from hundreds of Irish women seeking appointments. The onslaught of interest took them by surprise. So did a controversy that was starting to brew back home. Conservative politicians in the Netherlands denounced Gomperts for potentially breaking a law that required a special license for any doctor to provide an abortion after six and a half weeks of pregnancy. Gomperts had applied for it a few months earlier and received no reply. She set sail anyway, planning to perform abortions only up to six and a half weeks if the license did not come through.

When Gomperts's ship docked in Dublin, she still didn't have the license. Irish women's groups were divided over what to do. Gomperts decided she couldn't go ahead without their united support and told a group of reporters and protesters that she wouldn't be able to give out a single pill. "This is just the first of many trips that we plan to make," she said from the shore, wrapped in a blanket, a scene that is captured in "Vessel," a documentary about her work that will be released this winter. Gomperts was accused of misleading women. A headline in The Telegraph in London read: "Abortion Boat Admits Dublin Voyage Was a Publicity Sham."

Gomperts set sail again two years later, this time resolving to perform abortions only up to six and a half weeks. She went to Poland first and to Portugal in 2004. The Portuguese minister of defense sent two warships to stop the boat, then just 12 miles offshore, from entering national waters. No local boat could be found to ferry out the women who were waiting

onshore. “In the beginning we were very pissed off, thinking the campaign was failing because the ship couldn’t get in,” one Portuguese activist says in “Vessel.” “But at a certain point, we realized that was the best thing that could ever happen. Because we had media coverage from everywhere.”

Without consulting her local allies, Gomperts changed strategy. She appeared on a Portuguese talk show, held up a pack of pills on-screen and explained exactly how women could induce an abortion at home — specifying the number of pills they needed to take, at intervals, and warning that they might feel pain. A Portuguese anti-abortion campaigner who was also on the show challenged the ship’s operation on legal grounds. “Excuse me,” Gomperts said. “I really think you should not talk about things that you don’t know anything about, O.K. . . . I know what I can do within the law.” Looking directly at him, she added, “Concerning pregnancy, you’re a man, you can walk away when your girlfriend is pregnant. I’m pregnant now, and I had an abortion when I was — a long time ago. And I’m very happy that I have the choice to continue my pregnancy how I want, and that I had the choice to end it when I needed it.” She pointed at the man. “You have never given birth, so you don’t know what it means to do that.”

Two and a half years later, Portugal legalized abortion. As word of Gomperts’s TV appearance spread, activists in other countries saw it as a breakthrough. Gomperts had communicated directly to women what was still, in many places, a well-kept secret: There were pills on the market with the power to end a pregnancy. Emails from women all over the world poured into Women on Waves, asking about the medication and how to get it. Gomperts wanted to help women “give themselves permission” to take the pills, as she puts it, with as little involvement by the government, or the medical profession, as possible. She realized that there was an easier way to do this than showing up in a port. She didn’t need a ship. She just needed the Internet.

Gomperts no longer works from a boat. Eight years ago she started Women on Web, a “telemedicine support service” for women around the world who are seeking medical abortions. She and a small staff share a one-room office in Amsterdam on a residential street, where red-and-pink flowers bloom on the balconies of brick buildings. Early in July, I went to visit the space, which has six workstations with computers, a few shelves and a filing cabinet with the sticker “Trust Women.” A large window opens onto a courtyard, where a Cupid fountain bubbles.

On the morning I arrived, Gomperts — who is 48 but looks younger, with freckles and black hightop sneakers — was talking with one of her help-desk staff members, Renata, about an email she recently received from a 22-year-old woman who lives in Brazil, where abortion is legal only in cases of rape and to save the life of the mother. “I need help please,” the woman wrote. “I’ve tried to get other information” about how to get an abortion, she added in another message later that day. “But I could not. I’m desperate.”

Almost 40 percent of the world’s population lives in countries, primarily in Latin America, Africa, Asia and the Persian Gulf, where abortion is either banned or severely restricted. The World Health Organization estimated in 2008 that 21.6 million unsafe abortions took place that year worldwide, leading to about 47,000 deaths. To reduce that number, W.H.O. put mifepristone and misoprostol on its Essential Medicines list. The cost of the combination dose used to end a pregnancy varies from less than $5 in India to about $120 in Europe. (Misoprostol is also used during labor and delivery to prevent postpartum hemorrhage, and global health groups have focused on making it more available in countries with high rates of maternal mortality, including Kenya, Tanzania, India, Nepal, Cambodia, and South Africa.) Gomperts told me that Women on Web receives 2,000 queries each month from women asking for help with medical abortions. (The drugs are widely advertised on the Internet, but it is difficult to tell which sites are scams.)

Responding to the 22-year-old woman in Brazil, Renata — a 54-year-old artist who moved to Amsterdam from South America 26 years ago and who asked me to use only her first name because of the controversial nature of her work — wrote to ask how far along she was in her pregnancy. Women on Web will open a new case only if a woman is less than nine weeks pregnant, to ensure time for delivery of the medication before the end of the first trimester. In filling out the online consultation Women on Web provides, the woman in Brazil dated her pregnancy at seven weeks. She reported no signs of an ectopic pregnancy — a condition that, while rare, can be fatal and cannot be treated with a medical abortion.

On July 5, three days after the Brazilian woman’s initial query, her consultation was sent to a doctor to review. Five physicians work for Women on Web part time; some of them also have jobs in abortion clinics doing surgical procedures. Gomperts wouldn’t tell me where the doctors were based, only that she consulted with a law professor to determine that “everyone is operating in a legal setting.” Despite her earlier defiance on the ship, she decided on this front not to court controversy. “We are trying to demedicalize abortion, but the reality is the doctors are liable,” she said.

At the Amsterdam office, Renata followed the Brazilian case. After reviewing and approving the woman’s consultation, the doctor wrote a prescription for mifepristone and misoprostol and sent it electronically to a drug exporter in India. The exporter would fill the prescription and send the medication to the woman, in a package with a tracking number, so she and the help desk could follow its progress. Renata sent the Brazilian woman an email telling her how to take the pills, once they were delivered, in a series of doses over 24 hours. The instructions explained what to expect when the medication takes effect — bleeding, cramping and discomfort. When taken together, the pills are 95 to 98 percent effective.

Gomperts designed her program — based on the radical idea of providing abortions without direct contact with a doctor — for women in countries where abortion clinics are nonexistent or highly restricted. But her model is invigorating abortion rights activists in the United States, where the procedure is simultaneously legal and increasingly hard to access. In their eyes, medical abortion, delivered through a known, if faraway, source, could be a transformative response: a means of access that remains open even when clinics shut.

Medical abortions take place over hours instead of minutes and can be more painful than surgical abortions. One Dutch woman I spoke with who had an abortion through Women on Web while she was living abroad in 2012 told me about her experience. “When the cramps started, I felt horrible,” she said. At the time, she was 40 and living in Burkina Faso in West Africa. She hadn’t meant to get pregnant; she wasn’t in a serious relationship, and she had a 7-year-old son she was raising on her own. During the abortion, she sent him to a friend’s house for the weekend and “cocooned” herself, making tea and putting on music. “I’d vomit, take a warm bath, feel the cramps, get into bed, have diarrhea, go back to the bath,” she said. “I was in pain. It really hurt. But I knew what was happening.”

When women take the pills and feel uncertain — worried, for example, about whether they are bleeding too much or not enough — they can write to Women on Web with questions. The help-desk staff is trained to send a standardized list of warning signs but not to weigh in about the severity of anyone’s particular symptoms. “We cannot judge your situation over a distance, so we advise you to visit your doctor,” Gomperts said. “This is the limitation of the service.” She argues that it’s not a constraint that puts women at risk. “If you think something is wrong, what’s crucial is to be able to recognize it. Women can do that. The help desk makes sure they’ll go to a doctor if there is an indication that they might have a problem.”

When women do seek medical attention, Women on Web also counsels them about how to avoid criminal charges if they live in countries where they have reason to fear prosecution. To ingest the mifepristone and misoprostol they are told to place the drugs in their cheek or under their tongue, where the medicine cannot be detected in the body. (If they are inserted vaginally, they may leave fragments.) Gomperts says there is no medical reason for women to tell anyone that they’ve used pills. Treatment, if needed, is the same as it would be for a spontaneous miscarriage. “Women shouldn’t be afraid to look for care when they need it, and at the same time they shouldn’t do anything to incriminate themselves,” Gomperts said.

In Brazil, the legal risk is acute. This summer, some women who were sent drugs through Women on Web reported that custom officials were confiscating their packages. Gomperts and her staff started telling Brazilian women to look for help elsewhere, sending links to resources in other places, like public clinics in Mexico City that provide abortions inexpensively. The 22-year-old in Brazil told Renata she couldn’t travel. Renata warned that the delivery wasn’t guaranteed, saying, “You understand the situation: You need to keep looking for help because there is a chance the package won’t arrive.”

“I’m trying,” the woman wrote back. “But everyone here is misusing women. They are selling four pills” — an incomplete dose — “for three times my monthly salary. Thank you very much for what you’re doing. It is very important for many people.”

On July 13, the woman reported a new problem: The tracking number for her package had disappeared from the online system for international mail. “I wonder if the order was made,” she wrote. “Please help me! I am very worried!”

Gomperts took that plea to the person who is the last crucial link in the Women on Web delivery chain: Mohan Kale, a 44-year-old businessman in India who exports the pills.

Kale and Gomperts met two years ago when she went to India in search of a new supplier. His was one name on a long list, but when Gomperts went to his office, Kale’s relaxed way with his workers put her at ease. When they sat down to talk, Kale told Gomperts that his wife was a social worker and that he was involved with local charities. “He wasn’t showing off,” she said. “It was the opposite of that. He just felt a lot of responsibility for the suffering in his country.”

When I spoke to him over Skype last month, Kale told me that his company, Kale Impex, supplies 1,500 drug compounds, including mifepristone and misoprostol, and has $4.5 million in annual revenue. He said he understood why it was important to Gomperts to partner with a drug exporter. “It’s a simple pill and still not freely available,” he told me. At one point over Skype, he asked me to turn on my camera. “Can you see this?” he said, holding up a sheaf of papers that Gomperts gave him. “These are notes from women we sent the packages to.” I asked him to read one, and he chose a message from Malaysia. “Me and my boyfriend are not really fluent in English, but you guys at Women on Web really did a great job,” it read. “We are grateful for the help and support and thank you for all that you do.” I had seen other notes like this in Gomperts’s office. One message from Kenya read: “I retrieved the medicine from the post in Nairobi yesterday. I kissed the pills when they fell into my hand.” Another from Northern Ireland read: “I used your service a few months ago. Today I finally found out I was back to normal, whatever that really means, seems strange to say really, but I wanted to say a HUGE thank you.” Kale paged through more notes, reading off a list of the places they came from: Costa Rica, Malta, Pakistan, New Zealand, Chile, India, Uganda, Ireland, Brazil, South Korea, Saudi Arabia, the United Arab Emirates,

Poland, Algeria. “So many countries,” he said, with a note of awe.

Kale ships the mifepristone and misoprostol at cost; this helps Women on Web remain in the black. Women who request medical abortions are asked for a standard donation of 90 euros, which goes toward staff salaries and overhead. If women say they can’t afford this — the 22-year-old from Brazil said she couldn’t — they are still sent the medication. Last year, about two-thirds of the women made the suggested contribution; the others gave a small donation or none at all.

After working smoothly with Kale for two and a half years, Gomperts started running into delivery and tracking problems last spring. Last year, the United States began an investigation into the export of generic drugs by Indian companies, claiming patent violations. Though the Indian government denied the allegations, Kale said the regional authorities in Mumbai forced companies like his to reroute their deliveries. Since then, tracking numbers and deliveries were getting lost.

Kale knew this was causing heartache for women who were waiting for their pills. “The anxiety level of the women goes up,” he said. “It’s painful.” He and Gomperts agreed to send a second shipment to anyone whose package appeared to be lost. Like any web-based small business concerned with customer satisfaction, the Women on Web help-desk staff was trying to trace the packages as they traveled from India to their global destinations. It was time-consuming work, and it underscored the tenuous nature of sending abortion pills around the world in an effort to circumvent the law. In the office, Gomperts sat with a staff member who was trying to track down a shipment that Kale Impex sent 10 days earlier to Nicaragua. She found a record of the tracking number on the Indian post-office website, but it wasn’t clear how to plug it into the Nicaraguan system. Gomperts emailed one of Kale’s assistants asking if the company could send the shipment again.

Next, they looked for another package that had been mailed to Chile on June 6 and found that it had arrived at a Chilean airport on June 30. The staff member looked at the recipient’s records to find out how many weeks pregnant she now was. “O.K., she’ll get this by 11 weeks,” she said with relief. Gomperts said, “Send her the details — the tracking number and that it’s at the airport.” The staff member typed the note in Spanish. “Please let us know when you receive the package,” she wrote at the end.

That evening after work, Gomperts and I bought rotis for a picnic she was having with her family. We walked to a park and met her children, a son who is 8 and a daughter who is 9, Gomperts’s sister Miriam, who is also a doctor, and Renata, who is Miriam’s wife. They all live in a communal house with a couple of other families. At one point, Gomperts’s children ran up to show her the pink-and-blue bracelets they had woven at school, then spotted friends wearing face paint and went off with them.

Surrounded by other families who brought food, music and soccer balls, Gomperts lay on her back and told me about an organizational struggle that exploded in the spring when most of the staff — about 20 people, many of whom worked remotely — as well as a majority of the board quit over her management style. I talked to one former staff member, who said that for years Gomperts trusted her and other longtime workers to give women comprehensive counseling, including medical advice, in response to questions about possible complications. But, she said, several months earlier Gomperts had abruptly put a stop to this to make the system more efficient and assert her own control.

Gomperts said she has been accused of having founder’s syndrome: being good at starting organizations but bad at running them. She was worrying about managing the new staff she hired. “If someone is working for you, can’t you just tell them what to do?” she asked. “Am I being too bossy?”

I asked Gomperts why, as a Greenpeace activist, she chose abortion as her cause. She thought for a minute. Her philosophy, she said, was about the “reduction of suffering” but also about self-determination. She said she was “interested in finding the blind spots of the law.” She liked upending the system. “I enjoy that,” she said. “If I was interested in money, I’d have a company in the Cayman Islands, getting all the tax deductions I could to get rich.”

Of the thousands of emails that come to Women on Web, 40 to 60 a month now originate in the United States, Gomperts said, double the number from two years ago. On the first day I was in the office, she showed me a recent email from Florida. “Please tell me where I can get miso without a prescription,” the email read. “I live in the United States and have no health insurance. I have two children and I am currently out of work, there’s no way I can afford another child. Please help. I’m desperate.”

Gomperts is sympathetic but firm in her refusal to get involved in the United States. “We’re sorry, the doctors of Women on Web cannot provide the service in any country with safe abortion services,” reads the response American women receive from the help desk. She told me: “I know that it’s difficult, because abortion is not accessible to them. But this is not our work. I think this is a problem the U.S. has to solve itself. There are so many resources, so much money available there for abortion rights groups, I think they should be able to work on this. Starting on paper, with changing the laws.”

The laws regarding access to medical abortion have been contested in the United States since the drugs became available in the 1980s. Mifepristone was initially licensed in France in 1988. Abortion opponents lobbied to keep the drug out of the United States, and in 1990, the administration of George H. W. Bush made it illegal to bring the drug into the

country for personal use. In 2000, however, after a long Clinton-era fight, the Food and Drug Administration approved mifepristone under the name RU-486. Doctors could dispense the drug, but the F.D.A. imposed restrictions that persist to this day. Before doctors can order the medication, they must provide information about their qualifications. Patients have to be given the medication at a doctor's office instead of picking it up at a pharmacy. Mifepristone also carries a black-box label, the F.D.A.'s strongest alert for life-threatening effects. It has been used in 2.3 million procedures resulting in 11 reported deaths of women. Misoprostol, which is 85 percent effective on its own, is available in the United States by prescription.

The F.D.A. approved mifepristone through the seventh week of pregnancy. Many doctors, though, prescribe the medication off label through 10 weeks, based on recent research showing it remains effective. Medical abortion now accounts for approximately a third of all abortion through that period in this country. Ohio and Texas require abortion providers to follow the more restrictive F.D.A. protocol; a similar law will go into effect in Oklahoma in November.

A medical abortion in the United States usually involves two office visits. At the first, a woman often has an ultrasound, to date the pregnancy. She is given mifepristone in the office and misoprostol to take at home 24 hours later. Then, at a follow-up visit, the woman has an examination to make sure the abortion is complete. (The F.D.A. protocol, however, calls for three visits and recommends that the misoprostol be taken under medical supervision; Texas requires four visits.) Some clinics in the United States and abroad are experimenting with cutting the number of office visits by making the follow-up visit optional — if the woman isn't sure whether an abortion is complete, she can either take a home pregnancy test or return for an examination.

A number of clinics have explored the option of allowing women, particularly those who live in remote areas, to receive the drugs without seeing a doctor in person. In one program set up by Planned Parenthood in 2008 in Iowa, doctors in Des Moines have used videoconferencing to treat more than 6,500 patients in rural clinics, talking with them on-screen and viewing test results. By pushing a button on their computers, the doctors can remotely open a drawer that holds the needed dose of pills. The patient takes the mifepristone with the doctor watching and a nurse or medical assistant supervising on site, and then the patient leaves, with the misoprostol, to miscarry at home. A study of the program found that the telemedicine patients had the same outcomes — high rates of successful abortion and low rates of complications — as women who saw their doctors in person. In 2010, the Iowa Medical Board found that the telemedicine program was safe and met the prevailing standard of care. After complaints from Iowa Right to Life, however, Terry Branstad, the Republican governor, replaced the board last year. The new members voted to halt the telemedicine. Planned Parenthood challenged the board's decision, but a judge upheld it earlier this month.

Just as abortion rights supporters have come to appreciate the potential of mifepristone and misoprostol to increase access to abortion, anti-abortion activists have come to grasp the threat it poses. In the last four years, 15 states have blocked medical abortion via telemedicine, requiring doctors to be physically present when patients take their pills. Advocates for laws that limit access to medical abortion, which they call "chemical abortion," say that the procedure should be restricted to protect the safety of women.

Monique Chireau, a professor of obstetrics and gynecology at the Duke University School of Medicine and a board member of Americans United for Life, says the number of women who die or suffer serious complications from abortions may be higher than reported. "The truth is we have no idea what the rates of morbidity and mortality for abortions are in the United States, because the data system is flawed," she told me. Some states don't accurately report, she said, and the numbers may not be dependable, because women who go to the doctor or emergency room with complications may be reluctant to say that they've had a medical abortion. "Despite all we may hear about abortion being a benign procedure, it's really not," Chireau said of the pills. "And it's important to remember it's elective. This is not lifesaving surgery or surgery for cancer."

Chireau pointed me toward a 2009 study in Finland that found a far higher rate of hemorrhage than previous studies had. The authors of the Finnish study, however, say that the method of data collection by health officials may have inadvertently inflated the numbers. They conclude that "serious, 'real' complications" are rare.

Most studies show that two or three women out of 1,000 need follow-up care for serious complications after a medical abortion, with a death rate of 0.5 out of 100,000. (The death rate for childbirth is 14 times as high.) A 2013 study tracked more than 230,000 women in the United States who went to a Planned Parenthood-affiliated clinic, took mifepristone there and then took misoprostol at home. Only 0.65 percent had serious problems like bleeding or infection.

In the United States, the idea of terminating a pregnancy without much or any medical assistance can sound troubling, reminiscent of the sorts of procedures women were forced into before abortion was legal. Yet in March, the American Congress of Obstetricians and Gynecologists reviewed the medical literature and concluded that women can "safely and effectively" use telemedicine to have a medical abortion, including taking misoprostol at home. Daniel Grossman, a clinical professor of obstetrics and gynecology at the University of California, San Francisco, and a researcher at the abortion rights group IBIS Reproductive Health, agrees with this assessment. "Self-induction with mife and miso is not your mother or

your grandmother's self-induction. Provided that women have good knowledge about using the medication properly, it's a great option."

Most states have a law, often dating from the 19th century, that can be used to prosecute a woman who induces an abortion on her own. Last December, a woman named Jennifer Whalen, in Washingtonville, Pa., was criminally charged for ordering mifepristone and misoprostol online. Whalen said she got the drugs for a 16-year-old pregnant girl who didn't have health insurance and that she didn't know she needed a prescription. She was arrested after the girl went to the emergency room with stomach pains. In August, Whalen pleaded guilty to violating Pennsylvania's law that only doctors can perform abortions, a felony. She awaits sentencing.

Self-administered abortion is increasingly getting attention in states where clinics are closing, especially in Texas. Three years ago, there were 44 abortion clinics in the state. This summer, the number fell to 19. On Sept. 1, a new law is scheduled to go into effect that will require all abortion clinics to be held to the regulatory standards for ambulatory surgical centers, which require widening corridors and providing fully equipped recovery rooms. (The law is being challenged in court as medically unnecessary.) Because of the expense involved in complying with the law, only six clinics are expected to remain open (with two more under construction) in a state of 270,000 square miles. Along the border, in the Rio Grande Valley, the last clinic closed in March. For a time, women bought misoprostol at flea markets in the valley. Then a year ago, police raids for counterfeit drugs drove the trade further underground. Women now cross the border to buy misoprostol in Mexico, where it is legally sold over the counter.

Last summer, some young abortion rights activists in Texas started a group called Rise Up Texas, during protests over the state's new abortion law. Much like Women on Web, they told me, they wanted to be more independent and nimble than the larger mainstream abortion rights organizations in helping women deal with restricted access to abortion. "Since we are very grass roots and not connected to funding, we have flexibility they don't have," Rocío Villalobos, a 29-year-old Rise Up member, said.

Another Rise Up member, Yatzel Sabat, was working on a website called the Texas Abortion Access Project. (She was creating it on her own, she told me, so that Rise Up would bear no legal risk.) Sabat is a 31-year-old veterinary technician, with a shaved head and black-rimmed glasses. When I went to meet her in Austin in June, Sabat showed me a draft version of the site. The home page read "Abortion Without Apology." Other pages showed a map of providers stretching into states beyond Texas and links to groups that will help women pay for travel, lodging or the abortion procedure. On a page called "What Else Can I Do?" was information about misoprostol. Sabat was careful to craft every sentence with an eye to the law. "I can't do anything that could be seen as inciting or advocating," she said. "You can't say, 'Here's where you can get these pills.' But you can say, 'If you have them, here's how you take care of yourself.' All that information is here: the World Health Organization standards on how to use them, with links to Women on Web."

It seemed like a basic exercise of free speech. But going even this far made some more traditional advocates nervous. "The bigger groups are so accustomed to being the target here that we don't really have a culture of resistance to power," said Kathy Miller, president of the Texas Freedom Network, which monitors the activities of far-right organizations.

In Austin, Sabat took me to a training session that she helped arrange with a volunteer doula group called the Cicada Collective, which describes itself as an organization of queer and transgender people of color. A couple of dozen people, mostly in their 20s, gathered for the weekend in the basement of a community center, learning to be "abortion doulas." Doulas usually help pregnant women through labor and delivery, offering physical and emotional comfort. Abortion doulas would embrace the same model to support women through an abortion. They might provide practical help, like housing and transportation for women who were coming from far away or stay with women as they went through medical abortions.

The training included a session on the basics of how misoprostol and mifepristone are administered in clinics and how to help ease the discomfort of miscarriage. (The group brainstormed ideas: Breathing. Tea. Aromatherapy. Coconut water. Heating pads. Peppermint oil.) But Sabat and the other trainers steered clear of any mention of how to get misoprostol and mifepristone online or anywhere else outside a clinic.

Sabat talked about the possibility of creating a hotline for Texas women, a number they could call to discuss their remaining options, especially if more clinics closed in the fall. She had been in touch with Mexican activists who set up hotlines, but then realized they had latitude to direct women toward the pills for medical abortion that she did not.

One Mexican activist, Verónica Cruz Sánchez, is a social worker who lives in the conservative state of Guanajuato, where abortion is illegal in most cases. In 2000, authorities there started cracking down on women who used misoprostol to end their pregnancies. "We started a network to help girls who were rape victims get the drug," Sánchez told me over the phone through a translator. There was no formal organization, just a handful of women who would figure out how to get the pills from Mexico City and then help girls through the cramping and bleeding of the induced miscarriage.

In 2006, Sánchez expanded her reach beyond rape victims. "What we do is simple: We accompany," she said. "First it was a small group. Then women who had taken the pills themselves joined us, to support other women. Then it became husbands or boyfriends who would be the ones to go with the women. It has become more normalized." Sánchez said the

accompaniment project had helped 5,000 women end their pregnancies over the years.

I wondered whether mainstream abortion rights groups in the United States might ever encourage this emphasis on do-it-yourself options. It would be a major shift: For decades, the abortion rights mantra has been that an abortion is between a woman and her doctor. Clinics, not websites or hotlines, have been at the center of delivering care. Amy Hagstrom Miller, the founder of a network of clinics called Whole Woman's Health, told me she has been thinking about what might be possible. Facing the closure of her 11-year-old Austin clinic, she was considering whether she might open some sort of "miscarriage management" facility in the Rio Grande Valley. Women could come for ultrasounds to date their pregnancies, and then if they could get their hands on the pills and have an abortion at home, come back to make sure it was successful. "It's my understanding that's legal," Miller said. But Miller said she couldn't get involved in helping women obtain the pills the way Gomperts and Sánchez do. "Look, I've been very conservative," she said. "I have to be, to keep my license. But abortion is legal in this country. Why should we be talking about teaching women to do illegal abortions here? It's maddening."

Some abortion rights campaigners say that their movement's focus should be on normalizing medical abortion at home. In an essay in February on the website RH Reality Check, Francine Coeytaux and Victoria Nichols argued for over-the-counter status for misoprostol, the less restricted of the two drugs. They called it Plan C, a reference to the morning-after pill, Plan B, which they see as a model for how the abortion pills might one day become readily available, even if it seems politically impossible now.

The parallel is an instructive one. The F.D.A. approved Plan B, which prevents pregnancy for 72 hours after intercourse, as prescription-only in 1999. Seven years later, after lengthy political wrangling, the administration of George W. Bush approved the sale of Plan B without a prescription for women 18 and older. Pharmacies had to require proof of age for purchase and couldn't put it out on the shelf. The Obama administration stuck with that policy. Last spring, however, a federal judge in New York ordered Plan B onto the shelves. He cited recent studies showing that teenage girls can take it safely. The government's motivation for continuing to block over-the-counter access "was obviously political," the judge wrote.

Beverly Winikoff, founder of Gynuity Health Projects, a research group in New York City, says the first step toward more access to medical abortion would be making mifepristone available "as a normal pharmaceutical product physicians can write a prescription for." After that, she said, "we could carefully think about how the combination of mife and miso might become available over the counter. How do you organize that, with the proper safeguards, so that women have the information they need? That's the next set of questions."

A few weeks after leaving Amsterdam, I emailed Renata at Women on Web to ask about the 22-year-old in Brazil who had been waiting for her package of pills. On July 14, the day after the Brazilian woman emailed to say she was worried about the missing tracking number for her package, Renata ordered a reshipment from Kale Impex, which went out the next day. This time, Renata could see the tracking number in the postal system. Still, she warned the woman that the package could take up to four weeks to arrive, if the customs officials let it through at all.

On July 22, Renata checked again and found that the package had made it into Brazil. It was at the customs office in the city of Curitiba. She emailed the woman to let her know. Nine days later, the package was still sitting there, one of the nearly two dozen packages from Kale Impex that had not been allowed through. "I'm really distraught at the delay," the woman wrote.

Renata wrote back eight hours later to say she thought, based on the other blocked deliveries, that the package would not get there. "We don't think they will let it out of Curitiba," she wrote. She re-sent the woman information about getting an abortion outside the country and added that Women on Web would probably have to suspend service to Brazil entirely.

"I don't think it is fair to even raise the possibility of help if you know less than half of the packages are getting through," Gomperts told me. She wanted to set up a different kind of system in Brazil, but she didn't yet know how. It distressed her to imagine all the women with nowhere else to turn. "We're trying," she said. "It is something we are still working on."

The 22-year-old woman was not giving up. "Please, you cannot stop helping us in Brazil," the woman wrote at 3 p.m. on Aug. 1. "I understand I have to take responsibility for my mistakes, but a lot of things will be lost in my life. I'm studying, and I could lose my funding, and I'd have to stop working. It's magnificent what you're doing, to help women realize their dreams for themselves."

Then 45 minutes later she wrote again: "You will not believe it, but the package has come!"

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A version of this article appears in print on August 31, 2014, on page MM22 of the Sunday Magazine with the headline: The Post-Clinic Abortion.