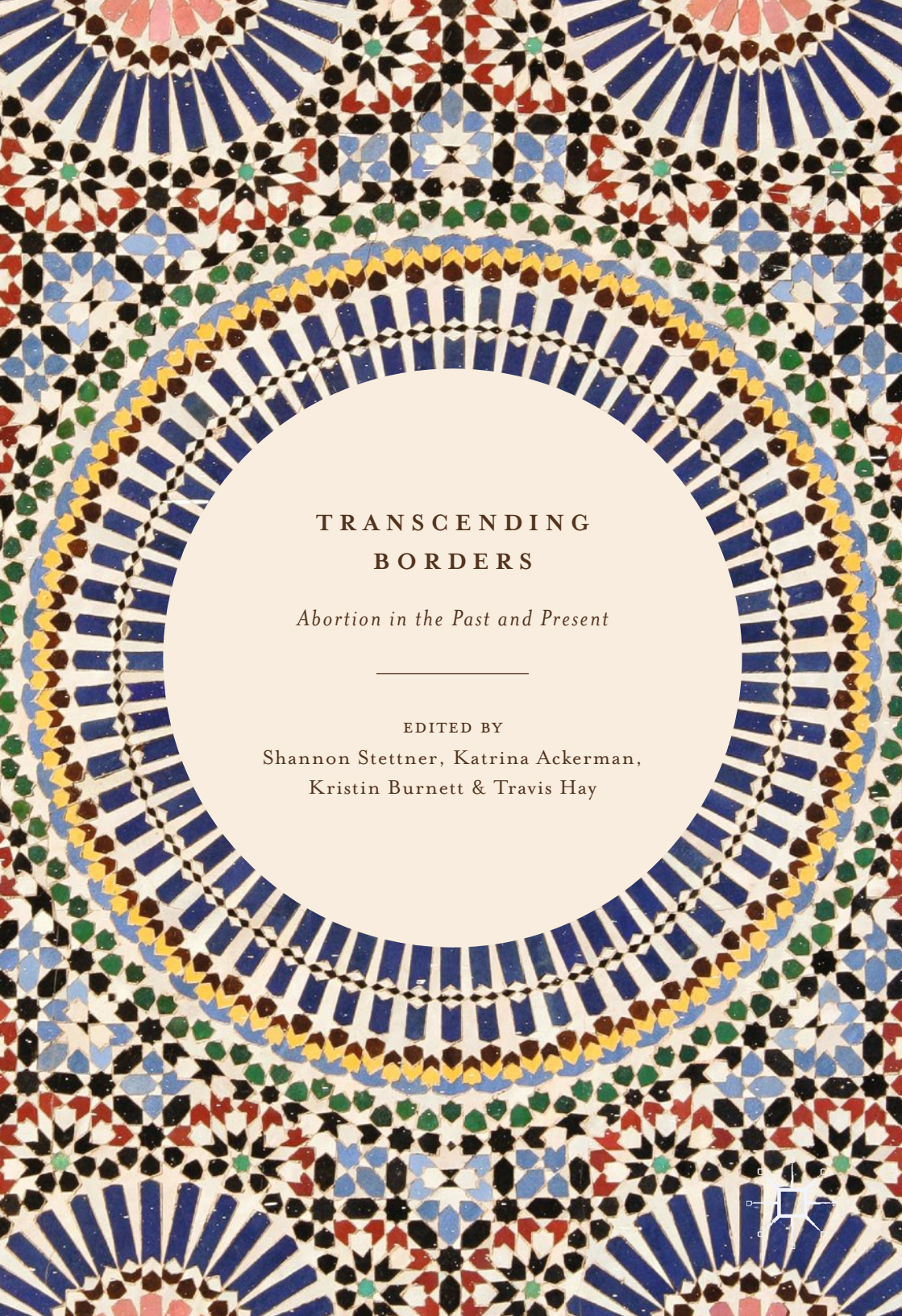

TRANSCENDING BORDERS

Abortion in the Past and Present

EDITED BY

Shannon Stettner, Katrina Ackerman,
Kristin Burnett & Travis Hay

Transcending Borders

Shannon Stettner • Katrina Ackerman • Kristin Burnett • Travis Hay
Editors

Transcending Borders

Abortion in the Past and Present

palgrave
macmillan

Editors
Shannon Stettner
Department of Women's Studies
University of Waterloo
Ontario, Canada

Katrina Ackerman
Department of History
University of Regina
Saskatchewan, Canada

Kristin Burnett
Indigenous Learning Department
Lakehead University
Ontario, Canada

Travis Hay
History Department
York University
Ontario, Canada

ISBN 978-3-319-48398-6 ISBN 978-3-319-48399-3 (eBook)
DOI 10.1007/978-3-319-48399-3

Library of Congress Control Number: 2017931665

Cover illustration: Findlay / Alamy Stock Photo
Design by Jenny Vong

Printed on acid-free paper

This Palgrave Macmillan imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Contents

Notes on Contributors

Katrina Ackerman is an SSHRC postdoctoral fellow at the University of Regina. She completed her PhD at the University of Waterloo and has published on anti-abortion and reproductive rights activism in several peer-reviewed journals. Her broader research project investigates the emergence and longevity of social movement organizations and their impact on abortion barriers that continue to shape access to the procedure in Atlantic Canada.

Daniel Bendix is a post-doc researcher at and lecturer in the Department for Development and Postcolonial Studies, the University of Kassel, Germany. His research focuses on global inequality, (post)colonialism, population and reproductive health policy, and global citizenship education. Daniel is a member of glokal, a postcolonial education collective based in Berlin.

Kristin Burnett is an associate professor in the Department of Indigenous Learning and is the coordinator of the new graduate program in Social Justice Studies at Lakehead University. She was recently a Lakehead University Research Chair in Indigenous Health and Well-Being and is the author of *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta, 1880–1930*. Her current research project looks at the relationships between health, food sovereignty, and colonialism in northern First Nations communities. Burnett's work with rural and northern First Nations is community informed, participatory, and action oriented.

Mark Dorosin is the Managing Attorney at the University of North Carolina Center for Civil Rights. He teaches political and civil rights at the law school and is the faculty advisor to the Julius Chambers Civil Rights Moot Court team. In 2010, Dorosin was chosen as the Pro Bono Faculty Member of the Year. He also serves on the Orange County Board of Commissioners.

Pamela Feldman-Savelsberg is Broom Professor of Social Demography and Anthropology at Carleton College, Minnesota, USA. She is the author of *Plundered Kitchens, Empty Wombs: Threatened Reproduction and Identity in the Cameroon Grassfields* (1999), *Mothers on the Move: Reproducing Belonging between Africa and Europe* (2016), and *Migranten, Recht und Identität: Afrikanische Mütter und der Kampf um Zugehörigkeit in Berlin* (2016), as well as editor of the volume *Reproduction, Collective Memory, and Generation in Africa* (2005).

Kate Gleeson is Senior Lecturer in Law at Macquarie Law School. She has an enduring interest in conservative politics.

Travis Hay is a doctoral candidate in the History Department at York University who has received an SSHRC Doctoral Scholarship and a Ramsay Cook Fellowship for Canadian History. He received his Master's from Lakehead University and has written articles on federal Indian policy, settler colonialism, and scientific knowledge production.

Rebecca Hodes is a medical historian, and the Director of the AIDS and Society Research Unit, based at the University of Cape Town. Her current research focuses on the histories of science, race and sex. She is the co-principal investigator of the Mzantsi Wakho study, about the health practices of teenagers and youth in South Africa. Her first monograph, *Broadcasting the Pandemic: A History of HIV/AIDS on South African Television*, was published by the Human Sciences Research Council Press in 2014.

Natalie L. Kimball is an assistant professor of history at the City University of New York (CUNY), College of Staten Island. Her research focuses on gender, sexuality, and reproduction in Latin America. Her book manuscript, which is under contract with Rutgers University Press, is entitled *An Open Secret: The History of Unwanted Pregnancy and Abortion in Modern Bolivia*.

Lena Lennerhed is Professor of History of Ideas at Södertörn University in Stockholm, Sweden. She has written books and articles about sex reform, sex education, and abortion in the twentieth century. Her book on illegal abortion in Sweden, Historier om ett brott ("Histories about a crime") was published in 2008. Recent publications in English are "Sexual Liberalism in Sweden," in Gert Hekma & Alain Giami (eds), Sexual Revolutions (Basingstoke: Palgrave Macmillan, 2014), and "Sherri Finkbine's choice. Abortion, sex-liberalism and feminism in Sweden in the 1960's and 1970s" in *Women's History Magazine*, issue 73 Autumn 2013. She is currently writing a book about abortion reform in Sweden in the twentieth century.

Erica Millar is an interdisciplinary gender scholar in the Department of Gender Studies and Social Analysis at the University of Adelaide, Australia. Her work examines

the cultural politics, sociology, and biopolitics of reproduction. Her first monograph *Happy Abortions: Our Bodies in the Era of Choice* will be published by Zed Books.

Joanna Mishtal is an Associate Professor of Anthropology at the University of Central Florida. She received her PhD in cultural anthropology from the University of Colorado at Boulder, and held a Postdoctoral Fellowship at Columbia University, Mailman School of Public Health. Her research examines reproductive rights, health, and policies in Poland, Ireland, and the United Kingdom, contextualized within European Union governance. Her Polish fieldwork is the subject of her ethnography, *The Politics of Morality: The Church, the State and Reproductive Rights in Postsocialist Poland* published by Ohio University Press in 2015.

Bayla Ostrach Assistant Professor of Family Medicine and a member of the core faculty for the Master's of Science program in Medical Anthropology & Cross-Cultural Practice at Boston University School of Medicine. Ostrach is a Fellow of the Society of Family Planning and an invited member of the Scholars Strategy Network. Ostrach's research focuses on reproductive justice, publicly funded health systems, the ways that structural violence and marginalization contribute to disease interactions known as syndemics, and the role of intersectional stigma and other forms of injustice in producing or exacerbating health inequality.

Andreana C. Prichard is the Wick Cary Assistant Professor of Honors at the Joe C. and Carole Kerr McClendon Honors College at the University of Oklahoma. Prichard received her PhD in African History from Northwestern University in 2011, and now researches and teaches about the intersections of Christianity, gender, and politics in East Africa. Her first book, *Sisters in Spirit: Christianity, Affect, and Community Building in East Africa, 1860–1970*, will be published by Michigan State University Press in Spring 2017. She is currently working on a history of evangelical/faith-based child sponsorship programs in East Africa.

Eiko Saeki is an associate professor at the Faculty of Sustainability Studies, Hosei University, Tokyo. Her research interests include culture and cognition, sociology of the body, history of medicine, and gender. Her current research examines the competing conceptualizations of the beginning of life in the late Tokugawa period in Japan (the mid-eighteenth to the late nineteenth century).

Sylvie Schuster is a gynecologist/obstetrician and medical anthropologist, and head of the program on diversity management at the University Hospital of Basel. Her research interests include reproductive and sexual health with a special focus on contraception and abortion, patient-provider communication and interaction, diversity, and cultural competence. The research on abortion in Cameroon formed the basis for her doctoral thesis in medicine remarked with "summa cum laude." She has published a book, book chapters, and numerous articles.

Elyse Ona Singer is a doctoral candidate in sociocultural anthropology at Washington University, Saint Louis. She will also graduate with a certificate in women's, gender, and sexuality studies. Her research centers on reproductive governance, women's rights, health and medical systems, and Mexico, Latin America, and the United States. Her research examines processes of moral reckoning around abortion in the wake of Mexico City's watershed abortion legalization. Her research has been funded by the National Science Foundation and the Wenner-Gren Foundation.

Shannon Stettner teaches in the Women's Studies Department at the University of Waterloo. Her research examines women's abortion rights activism in Canada. She is the co-founder of the Reproductive Activism and Abortion Research Network. Her edited collection, *Without Apology: Writings on Abortion in Canada*, was published in autumn 2016.

Jennifer L. Sweatman is Assistant Professor of History at Washington and Jefferson College, Washington, PA, where she teaches modern European history. Jennifer does research on the French women's movement and post-1945 cultural and intellectual history. Her book *The Risky Business of French Feminism: Publishing, Politics and Artistry* was released with Lexington Books in 2014 and she is currently working on projects related to French-Algerian writer Leïla Sebbar and feminist concepts of the body since 1945.

Brianna Theobald is a Chancellor's postdoctoral fellow in American Indian Studies at the University of Illinois, Urbana-Champaign. She holds a PhD in History from Arizona State University, where she also earned a certificate in women's and gender studies. Her research interests include indigenous studies, gender, and health and medicine, and she is currently working on a book manuscript entitled *Reproduction on the Reservation: Federal Indian Policy, Pregnancy, and Childbirth in the Twentieth Century*.

Tanfer Emin Tunç is an associate professor in the Department of American Culture and Literature at Hacettepe University in Ankara, Turkey. She holds a PhD in History from the State University of New York at Stony Brook, and specializes in Women's Studies with an emphasis on the history of medicine, sexuality, and reproduction. Tunc has published extensively in this field, and her work can be found in journals such as *Dynamis*, *Women's History Review*, *Journal of Women's History*, *Journal of Family Planning and Reproductive Health Care*, and *European Journal of Contraception and Reproductive Health Care*. She is the co-editor of six books, and the author of two, including *Technologies of Choice: A History of Abortion Techniques in the United States, 1850–1980* (VDM 2008). Tunc is also a member of the editorial advisory board of *Medical History*; Vice President of the

American Studies Association of Turkey; and a member of the European Association for American Studies Women's Caucus Steering Committee. In 2015, she was a visiting scholar at the Hastings Center for Bioethics and Public Policy, where she conducted research on fetal surgery.

Mary Ziegler is the Stearns Weaver Miller Professor at Florida State University College of Law, the author of *After Roe: The Lost History of the Abortion Debate* (Harvard UP, 2015), and the winner of the Thomas J. Wilson Prize for best first manuscript published by the press in any discipline. In addition to more than 20 articles on the history of reproductive health, Ziegler has written for or been quoted in major media outlets, including the *Atlantic,* the *Economist*, the *New York Times*, the *Wall St. Journal*, and the *Washington Post.*

CHAPTER 1

"Every *Body* Has Its Own Feminism": Introducing Transcending Borders

Katrina Ackerman, Kristin Burnett, Travis Hay, and Shannon Stettner

In 2000, the United Nations declared "improving maternal health" as one of its Millennial Development Goals, but more than 15 years later, the criminalization and inaccessibility of safe abortion remains a global public health crisis. In 2014 alone, between 22,500 and 44,000 women died from (needlessly) unsafe abortions, accounting for 8–18% of maternal

K. Ackerman
Department of History, University of Regina, Regina, SK, Canada

K. Burnett (✉)
Indigenous Learning Department, Lakehead University, Thunder Bay, ON, Canada

T. Hay
History Department, York University, Toronto, ON, Canada

S. Stettner
Department of Women's Studies, University of Waterloo, Waterloo, ON, Canada

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_1

deaths worldwide (Guttmacher Institute, "May 2016 Fact Sheet: Induced Abortion Worldwide"). Access to safe abortions remains conditional upon women's resources, geographic location, race, class, and ethnicity regardless of their country of residence or the legal status of abortion therein (e.g., Finer and Fine 2013; Fried 2000; Sethna and Doull 2013). In part, these circumstances persist because "abortion is still largely discussed and addressed as an issue of women's reproductive health and rights alone," despite irrefutable evidence of "clear links between unsafe abortion, poverty, and social inequality" (Adewoleet et al. 2006, 47). Yet abortion has never simply been about women's bodies and personal choices; rather, it involves and indicts the power relationships that link together global formations, nation-states, local communities, capital, and social relations (Gurr 2015). Women's reproductive health and choices are often co-opted by the state, health care professionals, the courts, interest groups, and social movement organizations in the pursuit of their own personal, professional, ideological, and political agendas. The women most affected by these social, religious, political, and economic debates and conflicts—that is, poor and racialized women—continue to disproportionately suffer the physical and emotional consequences of lacking access to safe abortions on request.

Transcending Borders: Abortion in the Past and Present is a multidisciplinary investigation about how abortion and reproductive practices differ across time, space, geography, national boundaries, and cultures. In particular, the articles in this collection draw on integrative and intersectional approaches that attend to the vast differences and challenges faced by women who occupy multiple, overlapping, and often conflicting categories of identity. This collection works to complicate the many histories and ongoing politics of abortion by situating them within the broader conditions in which women have been forced to make decisions about whether or not to terminate a pregnancy. The authors in this collection specialize in the reproductive politics of Australia, Bolivia, Cameroon, France, "German East Africa," Ireland, Japan, Sweden, South Africa, the United States, and Zanzibar, with historical focuses on the pre-modern era, nineteenth and twentieth centuries, and contemporary conditions. In bringing together these different perspectives on reproductive politics, we want to emphasize the importance of localized contexts and abortion experiences in past and present global discourses. Situating these experiences in both time and space is an important part of resisting the universalizing of abortion discourses.

This collection is multidisciplinary in its approach and brings together scholars from a number of specialties including history, women's studies, Indigenous studies, sociology, environmental studies, law and society, ethnography, and cultural theory, to demonstrate the complexity of past debates and their continuing relevance to current abortion politics. The methodologies within this collection are purposefully eclectic and varied. Multiple frameworks are employed to help us explore the interplay between the global and the local. We draw on transnational feminism, transculturalism, intersectionality, and reproductive justice to illuminate the similarities and variances in past and contemporary studies of reproductive politics. Focusing on national policies, state particularities, legal frameworks, social movement activism, and medical and religious regimes allows the authors to explore the power relations within which local abortion experiences occur. Since top-down strategies of understanding reproductive politics have the tendency to erase or displace the lived experiences of women within these medical, legal, and statist structures, we have also included analyses that explore abortion as a lived experience constituted by social relations. In doing so, the collection seeks to illuminate how knowledge about the histories of reproductive justice and oppression has been produced and differs fundamentally from other areas of inquiry that are less politicized and more impersonal.

"Transnational feminism," in our increasingly globalized world, has come to inform feminist scholarship, including collections dedicated to reproductive politics (e.g., Rohlinger and Meyer 2005; Cook et al. 2014; Solinger and Nakachi 2016). Transnational feminism seeks to decenter the imperial, colonial, white, and Western roots of non-subjugated feminisms (Grewal and Kaplan 2001; Trouillot 2002; Nagar and Swarr 2010; Minh-Ha 1995). In particular, feminists of color have identified very clear links between the reproductive oppressions they have faced at the hands of their own states—such as eugenics and sterilization programs—and those carried out elsewhere. The logics of reproductive control over non-white populations are not monolithic; it operates differently across multiple contexts (see, e.g., Silliman and Bhattacharjee 2002; Silliman et al. 2004). The relationship between colonial metropoles and imperial peripheries reflects the further need for the kinds of situated transcultural and transnational studies offered in this collection (Alexander and Mohanty 1996, 26). However, we want to avoid, as Richa Nagar and Amanda Lock Swarr warn, "homogenizing women's struggles for sociopolitical justice, especially in colonial and neocolonial contexts" (2010, 4). The homogenizing

tendency of feminisms demands cautiousness, as "it is from those who have suffered the sentence of history—subjugation, domination, diaspora, displacement—that we learn our most enduring lessons for living and thinking" (Bhabha 1994, 246).

Colonialism and imperialism have ensured that the histories of reproductive injustice transgress contemporary national boundaries. Our use of transnational is purposeful and intended to be distinctive from "international." As a concept, "*inter*national" operates to sustain the naturalness of political boundaries and reproduce the geopolitical choreographies of Westphalian modes of sovereignty and statehood. The term "international" also reduces the theorizing of global social relations to the interaction of individuals and organizations situated in already rigidly defined regions shaped by geographical and historical contexts that are believed to form the basis of all "*inter*national" exchanges. In settler colonial contexts especially, these "*inter*national" constructions run the risk of concealing or collapsing many varieties of Indigenous feminisms into categories of containment such as "Canadian," "American," "Australian," or "South African" (Byrd 2011, 124). While our formulation of *trans*national certainly rejects the naturalness of geopolitical borders and barriers, our formulation of transnationalism seeks to simultaneously disrupt and deconstruct the naturalness of the nation-state.

We similarly draw on transculturalism to conceptualize the ways in which women's different abortion experiences functioned in an increasingly globalized world. The concept, which found particular resonance within the emergent field of nursing studies in the mid-1950s and 1960s, was premised on the idea that universals existed across human cultures, and that they could be meaningfully attended to through careful and ongoing anthropological engagement with particular local contexts in which these globalizing modes of health care operated (Murphy 2006, E143–E151). The assumptive premise that animated much of the discussion around transcultural nursing, then, was that cultures were not incommensurable, that common experiences could be carefully extracted through practices that attended to difference, and that transformative health care practices could emerge when attention was paid to similarities across cultural experience. However, criticism mounted against the essentialist conception of cultures as static and discrete entities that interacted with each other as separate wholes, rather than as complex, co-imbricated, and constellated cultures that were layered together in an overlapping fashion (Culley 2006, 146). Furthermore, critics argued that transcultural nursing

theory was based on a traveling body of knowledge created by Western nurses in the post-war period and "operate[d] from a *liberal standpoint* that stresse[d] the individual and individual rights, freedoms, responsibilities and action" (Gustafson 2005, 5; Culley 2006, 146–147). Therefore, much like the concept of the transnational, which has been challenged and reformulated to better reflect the operation of power relations within the field, the transcultural framework has been similarly problematized to ensure that its usage does not "perpetuat[e], rather than interrup[t], the dominant ways of interpreting and addressing human and social differences" (Gustafson 2005, 14).

Despite these important and constructive critiques of transculturalism, our engagement with transnationalism and transculturalism emerges out of a tradition that seeks to illuminate the disturbing similarities in reproductive oppressions, especially in the current climate (Briggs 2002). While this edited collection highlights local experiences, it also demonstrates that there are "transnational dimensions of culture" that have shaped and continue to shape the ubiquitous nature of abortion globally (Schulze-Engler 2009, xii). By highlighting the "transcultural commonalities" in both the history of abortion and ongoing reproductive health politics (Welsch 2009, 4), this book contributes to scholarship that draws on non-Western studies to highlight the many and varied histories of abortion (e.g., Cook et al. 2014). As Rosalind P. Petchesky and Karen Judd demonstrate in *Negotiating Reproductive Lives: Women's Perspectives across Countries and Cultures* (1998), it is only through examining women's experiences "across countries and continents" that we can explore the "cross-fertilization of ideas" and decenter the West (3). While we theorize abortion within a transnational context, we are also trying to think about abortion as a transcultural experience that can be discussed and theorized as global *but never as universal or homogenous.* As the articles in this collection reveal, there is much to be gained from putting conversations about abortion and contraception, reproduction, and personhood alongside one another in this transcultural fashion to complicate ways of understanding reproductive health. In doing so, we are not seeking to create a universal or singular narrative of reproductive health. Rather, a transcultural framework allows us to pinpoint the unique configuration of women's experiences in local contexts *while at the same time* linking together stories and struggles within broader stories of globalization. This collection examines local experiences, histories, understandings, and practices of abortion from a transcultural perspective, yet it also remains cog-

nizant of the fact that the local is always situated in a global configuration of national and international political histories.

In many ways, it is the reproductive justice framework, conceived of by SisterSong—a women of color grassroots organization founded in the United States in 1997—that informs recent scholarship on the many and varied histories and understandings of abortion and women's reproductive experiences. Loretta Ross, one of the founders and a long-time National Coordinator of SisterSong, defines reproductive justice as the "complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Ross 2006, 14). Reproductive justice scholarship draws from epistemological interventions made by Black American feminist and legal scholars who considered how "one's location in multiple socially constructed categories affects one's lived experiences, social roles, and relative privilege or disadvantage" (Jones 2014, 100; Lorde 1984; Spillers 1991; King 1988; Crenshaw 1989; Collins 1990). The reproductive justice framework is particularly useful in light of the Western pro-choice movements' limited success in ensuring women's access to abortion on request. Although the courts struck down restrictive abortion legislation in several Western nations in the twentieth century, women continue to have to fight to ensure that abortion remains legal. In North America, the individualization of the right to an abortion has reduced the decision to a private one abstracted from the larger social, economic, and political conditions that determine women's and their communities' choices.

The reproductive justice framework reminds us that racism, classism, and sexism, among other categories of identity, constantly intersect and that recognition of various systems of oppression deepens our understanding of reproductive politics (Silliman et al. 2004, 2). This intersectional approach is especially useful in this collection because the authors consider the multiple histories of abortion from different disciplinary perspectives and conceive of abortion as a broader social phenomenon that long predates reproductive technologies such as medically induced abortions and fetal imaging techniques. From farmers using infanticide in nineteenth-century Japan to limit family size (Saeki) to Cameroonian women in the "Grassfields" depending on social networks to obtain contraceptives and abortion in the late twentieth and early twenty-first centuries (Feldman-Savelsberg and Schuster), the articles in this collection illustrate how class dynamics came to the forefront in women's reproductive health experiences. Both race and class were often intertwined in issues of access to

safe and legal abortion and contraception (Reagan 1997; Solinger 2001). Other chapters, such as Daniel Bendix's analysis of German colonizers' attempts to manage the reproductive practices of women in "German East Africa" and Brianna Theobald's study on the Bureau of Indian Affairs' assimilationist policies in the United States, including the "sterilization and the removal of children from their homes," demonstrate the extent to which the reproductive lives of women of color were and continue to be sites of "governmental and societal scrutiny."

Responding to these histories of reproductive choices, global imperialism, and nation-state sponsorship of particular reproductive regimes, the articles in the collection draw from a wide array of disciplinary traditions. Several of the authors are emerging scholars employing a broad range of sources, including institutional and archival records, oral histories, participant interviews, news media, and statistical data from health care institutions. The collection tries to broaden the scope of abortion discussions and adopt diverse methodological approaches that grapple with the intricacies and choreographies of abortion and choice. This endeavor is precisely why a volume on abortion that is so varied demands a multidisciplinary and intersectional approach in order to draw our attention to the foundational problems of theorizing reproductive choices. It is essential that discussions of abortion in global and local contexts attend to the multiply constituted modes of reproductive oppression that link together these very differently situated struggles. Attention to the historical and contemporary manifestations of abortion politics and experiences is important and yet too often they are explored separately.

Section and Chapter Breakdown

Historical Examinations of Abortion Experiences

Section 1, "Historical Examinations of Abortion Experiences," analyzes experiences of abortion in pre-modern Japan, nineteenth-century America, early twentieth-century "German East Africa" and Zanzibar, and mid-twentieth-century Sweden. These chapters cover shifting perceptions of abortion across time and place; disparities between abortion law and practice; competing ideas about women's roles and related efforts to control and police women and their bodies; the place of abortion in fertility control; contestations of authority between medical, legal, religious, and state agents; and changing conceptions of the fetus.

Demonstrating the historical contingency and situatedness of notions of personhood and normative practices of family planning, Eiko Saeki's "Abortion, Infanticide, and a Return to the Gods: Politics of Pregnancy in Early Modern Japan" traces the trajectory of thoughts about family planning and decenters Western discourses of fetal personhood. Saeki's contribution also illustrates that early modern Japan, like other historical arenas, contained competing discourses, moral codes, and conceptions of permissibility related to abortion and infanticide. Saeki illuminates the rise of anti-abortion and infanticide campaigns in early modern Japan as local government officials endeavored to stop farming families from limiting their family size, thereby reducing tax revenue. The "moral suasion campaigns" endeavored to impose meanings and values upon the fetus and infant and dissuade families from limiting reproduction. While local domain officials attempted to regulate reproduction by casting abortion and infanticide as sinful and criminal acts in moralistic texts, families concerned about the economic cost of rearing unwanted children used abortion and infanticide to regulate family size and ensure their survival.

In the next chapter, Tanfer Emin Tunç similarly explores the meanings, assumptions, and moral codes inscribed onto practices of abortion in the nineteenth century. In "Unlocking the Mysterious Trunk: Nineteenth-Century American Criminal Abortion Narratives," Tunç demonstrates that sensationalist, scandalous, and salacious dime novels penned by American authors capitalized on women's gruesome deaths from unsuccessful abortions. Despite the fact that by the 1870s abortion was criminalized in most states, Tunç's chapter illustrates that women continued to seek illegal abortion services. These criminal abortion narratives became cautionary tales for women considering abortion and served as disciplinary tools. Through graphic and gratuitous depictions of botched abortions, the novels both documented and reinforced the rising authority of medical and legal systems over the criminality of abortion.

The following article in this section, "Impossible to Get to Know These Secret Means"—Colonial Anxiety and the Quest for Controlling Reproduction in "German East Africa" by Daniel Bendix, situates debates over reproduction and abortion as constituted ambivalently at the nexus of German patriarchal–colonial power and the agency of East African women. As German administrators, missionaries, and physicians cautioned against a "population decline," which historians note was a common refrain in twentieth-century population policies globally (Solinger

and Nakachi 2016), East African women responded with non-compliance to colonial desires. Through a critical reading of colonial documents, with careful attention to constructions of race, class, and gender, Bendix argues that the German anxieties revealed within the texts illuminate African women's resistance to colonial impositions.

Similarly, Andreana C. Prichard investigates abortion in the colonial context in "'Grievously Sinful Attempt to Destroy the Life Which God Has Given': Abortion, Anglicanism, and Debates About Community Composition in Twentieth-Century Zanzibar." Attempting to discern the contours of local politics of abortion in the wake of British imperial responses to the family planning practices in twentieth-century Zanzibar, Prichard offers a fascinating dissection of moralizing discourses and the shifting boundaries of acceptable behavior in a colonial context. Her analysis of a local scandal sheds light on contrasting ideas about the best way to compose communities and on the competing definitions of Anglicanism that circulated in early twentieth-century Zanzibar. Prichard's attention to the local community's understanding of abortion—in juxtaposition to colonial thought—highlights the importance of studying the local, and not just national or global, politics of abortion.

Competing understandings of abortion also factor into Lena Lennerhed's study of the emergence and securing of an authoritative psychiatric discourse of abortion in the final article of this section, "Troubled Women: Abortion and Psychiatry in Sweden in the 1940s and 1950s." Her chapter explores ideas about the maternal body and its configuration within an emergent paradigm of modernity. Unlike physicians and midwives, who performed abortions, psychiatrists became centrally involved in abortion services by the mid-twentieth century when public debates on abortion began to liberalize and requests for mental health reasons were approved. Lennerhed illuminates how the revision of Sweden's abortion law to permit abortions when a woman's "physical and mental stability" were endangered created an avenue through which psychiatrists could become experts on the contentious issue. With the shift from abortion requests for physical health or socioeconomic circumstances to applications based on mental health reasons, psychiatrists situated themselves as experts on abortion, as well as its gatekeeper, until abortion on demand was legalized in 1975. Lennerhed's contribution importantly illuminates that psychiatrists grappled with increased demands for abortion, complicating our common and unquestioned perception of Sweden as a country that was at the forefront of adopting more liberal attitudes toward abortion.

Much of the history of abortion can be understood as a contestation of authority. The traditional authoritative figures—physicians, politicians, ministers, lawyers, and even journalists—were at odds with the women who tried to manage their reproduction and the family, friends, and community members who assisted them. Abortion also regularly served as a substitute for other issues. As Tunç's chapter indicates, the discourse on abortion was informed by shifting views on industrialization, urbanization, and professionalization. During periods of social upheaval, debates over abortion often reflected reactions to changing gender roles, as Lennerhed's article demonstrates. From exploring class issues in early modern Japan to colonial attitudes in Zanzibar and "German East Africa," this section emphasizes that reproductive politics reflected broader cultural, economic, social, and political issues both locally and globally.

Abortion Politics

This section comprises a series of interrogations of historical and contemporary abortion campaigns in France, Australia, the United States, South Africa, and Ireland. They examine how those on both sides of the issue framed abortion, as well as legal and political challenges to abortion laws, and how competing actors—that is, women, physicians, and activists, among others—jockeyed for the ability to define and control the political meanings of abortion. These chapters delineate the successes, failures, and ongoing challenges to abortion laws globally. Several of the chapters also pinpoint the centrality of "culturally competent providers" in both past and present-day reproductive health services (Silliman et al., 6). Women's resort to abortion is ubiquitous historically and currently, and health care providers have been central figures in shaping access to reproductive health care. Due to the restrictive nature of abortion laws in numerous countries, there has been a surge in global medical tourism, and the cost burden often falls on women who seek abortions outside of national boundaries (Connell 2013; Gilmartin and White 2011; Mishtal 2010; Kenny 2006). In this section, we see that abortion politics have always been in flux, with meanings contested, and power always an ongoing interplay between multiple actors.

Jennifer Sweatman's "'It Is Not Your Personal Concern': Challenging Expertise in the Campaign to Legalize Abortion in France" is a discourse analysis of the transcript from the 1972 trial of four women charged with procuring and performing illegal abortions. In France, the Bobigny case

garnered national media attention and facilitated the decriminalization of abortion in 1975. Sweatman argues that the defense used tactics of civil disobedience and radical feminist epistemology to challenge strictly legal standards of what constituted evidence, thus creating in the court a discursive space that allowed a range of expert witnesses to expand the very idea of expertise to include women's experiences. This opening allowed for a feminist notion of "distress" that included not only physiological harm, but also social, psychological, and moral harms, leading to broader social acceptance of abortion as a right for women.

Like France, Australia similarly grappled with the abortion issue in the 1970s. Erica Millar's "Feminism, Foetocentrism, and the Politics of Abortion Choice in 1970s Australia" complicates our understanding of Australian pro-choice activism by illuminating the contentious framing devices feminists employed to legitimize women's abortion choices. Millar demonstrates that the abortion rights campaigns cast abortion-seeking women as desperate and unfit mothers to provide reasoning for their "morally problematic choice of abortion." Activists' attempts to frame abortion as necessary, while reinforcing the notion that abortion was an "illegitimate" medical procedure, aided the emerging anti-abortion movement in their efforts to prevent "abortion on demand."

"We're All Feminists Now: How to Pass an Anti-Abortion Law in Australia" by Kate Gleeson builds on the themes in Millar's chapter by illuminating the consequences of liberal feminists' framing devices in Australian abortion politics. In her analysis of abortion politics within the context of Australian federalism, Gleeson argues that conservative Christian groups co-opted feminist language, such as "choice," to push through anti-abortion and neocolonial policies. By framing abortion as oppressive to women, anti-abortion activists highlighted the "persuasiveness of feminism." Due to the ease with which opponents were able to co-opt feminist language to ban access to RU486, a pharmaceutical drug taken to induce an abortion, the achievements of abortion rights groups were curtailed.

Moving to the United States, in "A Provider's Right to Choose: A Legal History," Mary Ziegler similarly highlights how framings of abortion can have unexpected outcomes. She traces how anti-abortion activists were successful in shaping structural interventions by the state through their manipulation of pro-choice messaging that sought to present abortion as a woman's right independent of physician involvement. Ziegler's chapter presents a fascinating analysis of the rise and fall of the physician as

a central figure in abortion access. She argues that although the Supreme Court once portrayed providers as rights-holders, American jurisprudence increasingly presented them as manipulators requiring state supervision. She argues that in the United States, the right to abortion will mean little if providers are left out of access campaigns. Ziegler's article not only provides an important reminder of the need to secure the place of physicians in the provision of abortion, but also underscores that legal access means little if there are structural barriers preventing physicians from performing abortions. Abortion providers are a crucial component in the fight against reproductive oppression, and Ziegler's chapter calls on us to reconsider viewing physicians simply as gatekeepers.

Shifting to the conceptual space of contemporary settler colonialism, the next article in this section, "Abortion Politics in a State in Transition: Contesting South Africa's 'Choice Act'" interrogates the logic for and against the institution of legalized access to abortion in the wake of the 1996 Choice on Termination of Pregnancy Act. Rebecca Hodes explores the core contradictions that characterize politics of abortion in the colonial context; more specifically, she historicizes the contemporary situation wherein illegal abortions remain woefully common in South Africa even after the practice became sanctioned as legal by the settler state. Hodes underscores the important role language plays in shifting public perception.

Joanna Mishtal similarly explores the important role of doctors in resisting anti-abortion policies in "Quiet Contestations of Abortion Law: Abortion Politics in Flux?" She examines the vital role that physicians play in the provision of abortion due to the influence of the Catholic Church on abortion and family planning services in Ireland. Despite the efforts of feminist grassroots movements to overturn the restrictive abortion and family planning policies, Mishtal argues that the medical community, state, and Catholic Church were embroiled in the "politics of 'semantic subterfuge'—the reluctance to engage in an open discourse about reproductive health policies." Semantic subterfuge maintained the image of Ireland as a "pro-life nation" and obscured the substantial number of women resisting the anti-abortion law by traveling abroad for abortion services. Interviews with Irish physicians illuminated acts of resistance by doctors willing to oppose the abortion law in "quiet and individualized ways." While the Church's anti-abortion stance continued to influence the views of doctors, many of whom were raised Catholic, Mishtal's fieldwork uncovers the various ways in which doctors supported women's covert acts to obtain abortion services, which remain ongoing.

"Abortion Politics" highlights that framing abortion discourses is critical to campaigns for reproductive rights. Both Millar and Gleeson trace how feminist framings of abortion had unintended consequences by implying that women seeking abortions were somehow suspect or that abortion harms women. Medicalization is often viewed through a negative lens, and the medicalization of women's bodies is not different. Scholars often critically refer to "medicalization" when what we actually mean is "overmedicalization"—these chapters remind us that we should be careful to distinguish between good and bad forms of medicalization (Parens 2013, 28–29). While Lennerhed's chapter on the psychiatrization of abortion can be read as a negative form of medicalization, Ziegler's chapter serves as an important reminder of why abortion was framed as a medical issue in the first place: such framing allowed advocates to contest restrictive abortion laws as interfering with a physician's right to practice medicine if the physician, with the patient, determined that abortion was the best way forward. While many of us would resist casting physicians in a gatekeeping role—they remain important allies in access to abortion—we are well served by preserving their rights while simultaneously advocating for women's unrestricted access to abortion. We can criticize the overmedicalization of women's bodies while retaining important alliances within the medical field.

The Social and Discursive Spaces of Abortion

The final section examines the spaces in which abortions occur and their different meanings in local and global contexts. These examinations take us from Bolivia, to the United States, to Cameroon. Focusing on the making and (un)making of space—that is, physical, legal, discursive, and theoretical space—the articles included in this section investigate legal and medical discourses that affect women's lived experiences of abortion. These articles demonstrate that discourses of choice and autonomy are not fixed in their histories and that grammars of reproductive choices can take various forms (spoken, silenced, appropriated, etc.) and even serve competing functions within the same national boundaries.

The first article, "The Landscape of Unwanted Pregnancy and Abortion in Highland Bolivia, 1982–2010" by Natalie Kimball, discusses the role of reproduction in the formation of the modern Bolivian state and the politics associated with discourses of contraception and abortion. Kimball argues that women's experiences with abortion and post-abortion care directly contributed to changes in reproductive health policy and services

across the period. Kimball further demonstrates that women's experiences with abortion were imbued with particular stress, due primarily to the illegal and stigmatized status of abortion in Bolivia.

Next, in "Settler Colonialism, Native American Motherhood, and the Politics of Terminating Pregnancies" Brianna Theobald examines the contradictory practices of the settler state that simultaneously prohibited Indigenous women's access to safe or legal abortions while targeting them for state-sponsored sterilization programs. This chapter suggests that two moments separated by space and time can share similar elements of colonial authority and violence. At the turn of the twentieth century, as social reformers and federal authorities promoted assimilationist policies, European-American observers stigmatized Indigenous reproductive practices and blamed impoverished conditions on the bodies and behaviors of Indigenous women. That Indigenous communities adopted European-American attitudes regarding women's bodily autonomy and rejected Indigenous reproductive practices illustrates the violence and insidious nature of the colonial project.

Pamela Feldman-Savelsberg and Sylvie Schuster's piece, "Revelation and Secrecy: Women's Social Networks and the Contraception-Abortion Process in Cameroon" draws on fieldwork conducted with practitioners and patients to explore the informal and personal space that informed women's decisions around abortion, as well as the role that social spaces played in ensuring access to contraception and abortion. Feldman-Savelsberg and Schuster examine Cameroonian women's reproductive health decisions and the various social pressures women encountered throughout the contraceptive-abortion experience. They demonstrate that social networks were key components of women's abortion experiences. Whereas "urban educated elite women" were able to access "medically safe and therefore socially discreet abortions" through close network ties, young unmarried and married non-elite and rural women were forced more often to seek out unsafe abortion procedures. The authors' research highlights the dangers of homogenizing women's abortion and contraceptive experiences within national spaces and the importance of using an intersectional approach when exploring the reproductive health decisions women make.

The next chapter, "The End of Feminist Abortion Counseling?: Threats to Women's Health and Workers' Job Satisfaction" by Elyse Ona Singer and Bayla Ostrach, also explores reproductive health decisions by examining the discursive spaces inside abortion clinics. Singer and Ostrach dem-

onstrate that the enduring battle over abortion access in the United States affects both the working experiences of abortion counselors and, potentially, the abortion experiences of American women. The authors outline an ongoing shift in the field of abortion care in the United States, in which unhurried counseling is disappearing from abortion care, replaced with the minimum of legally required informed consent. The authors view this trend as a triumph of the medical model of counseling over the feminist model. The trend is also connected to anti-abortion activism and the institution of numerous Targeted Regulations of Abortion Providers policies that increase administrative demands on understaffed clinics and ultimately lessen the time that counselors can spend with staff (even when counseling is mandated).

The final chapter in this collection explores the impact of anti-abortion activism on abortion access. Although the 1973 *Roe v. Wade* decision ostensibly legalized abortion, access across the United States remains highly contested, often violently so. Mark Dorosin's "True Threats: Wanted Posters, Stalking, and the First Amendment" examines the discursive legal terrain on which challenges to abortion always occur. Dorosin reviews "true threat" legal doctrine and related cases to help illuminate how courts consider the context of abortion-related violence in reviewing free speech claims. His chapter underscores the fragility of legal victories: the grounds upon which rights are seemingly won are only guaranteed as long as sympathetic state actors remain in office. This chapter underscores that meanings are ever-shifting, with interpretations all too often dependent upon the sympathies of the interpreters.

When we examine how abortion is framed, it is important to consider its place within the larger terrain of women's lives. Joanna Mishtal frames women's travel for abortion as "individualized contestations." Many women—across countries and over time, spanning centuries—have refused to abide by restrictive laws that would force them to continue unwanted pregnancies. Whether in early modern Japan, nineteenth-century America, early-to-mid-twentieth-century "German East Africa," Zanzibar, and Sweden, 1970s France and Australia, or contemporary Ireland, Bolivia, and Cameroon, women in each of these countries have fought state and colonial law, religious teachings, and popular understandings of morality in order to terminate pregnancies. They risked scandal, prosecution, and their lives in an effort to control their bodies.

Conclusion

Indigenous scholar Lee Maracle critiques global feminist politics as trapped in a history of interlocking systems of oppression but resists the foreclosure of a worldwide feminist movement as an inescapably compromised intellectual and social project. She writes,

> A good number of non-white women have addressed the women's movement and decried the fact that we are outside the women's movement. I have never felt outside of that movement… I have never felt that the women's movement was centered or defined by women here in North America… We are part of a global movement of women in the world, struggling for emancipation. The world will define the movement. We are part of the women who will define it… I represent the future of the women in North America, just as any other woman does. That white women only want to hear from me as a Native and not as a voice in the women's movement is their loss (1988:180–182).

We believe the above passage is a fitting conclusion to the introduction because it affirms the value of women drawing strength from each other through shared struggles and experiences while also acknowledging and valuing our differences.

The snapshots contained within this collection examine how abortion and reproductive choices differ across time, space, geography, and culture but elucidate the ways in which access to abortion continues to be highly contested regardless of when and where they do (or do not) take place. Access to abortion is about more than women's reproductive health or the ability to exercise reproductive autonomy: it is deeply embedded within the structural violence and oppressions that shape women's day-to-day lives albeit in dissimilar ways for different women. Indeed, if studied closely, these histories of abortion affirm the principle that "feminism is for everybody," and that every *body* has its own feminism.[1]

[1] Our language here recalls bell hooks' *Feminism Is for Everybody: Passionate Politics* (Cambridge: South End Press, 2000), as well as Verna St. Denis, "Feminism is for Everybody: Aboriginal Women, Feminism, and Diversity" in *Making Space for Indigenous Feminism* (Halifax: Fernwood Publishing, 2007).

PART I

Historical Examinations of Abortion

CHAPTER 2

Abortion, Infanticide, and a Return to the Gods: Politics of Pregnancy in Early Modern Japan

Eiko Saeki

During the second half of the Tokugawa era (1603–1868), Japan witnessed a shift in beliefs about the genesis of life. These changes coincided with the emergence of indigenous obstetrics (Ogata 1980; Shinmura 1996; Sugitatsu 2002), heightened concern over family survival among ordinary people, and the intensification of campaigns against abortion and infanticide (Chiba 1983; Drixler 2013; Ohta, 1997, 2006, 2007; Sawayama 2005; Takahashi 1936). By the early eighteenth century, family continuity was a significant concern not only for the elite warrior class, but also for farming families (Ohta 2007). As the family became the economic unit for farmers (Oto 1996, p. 113), increasing importance was placed on the work provided by young women, and their absence from work during pregnancy or childrearing was an undue economic burden. One of the ways women controlled their fertility was through abortion and infanticide. In this context, while farmers were trying to maximize their

E. Saeki (✉)
Hosei University, Tokyo, Japan

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_2

chance of survival and economic success, rulers were increasingly concerned about declining tax revenues for local governments.

Drawing on recent developments in historical demography, studies on anti-abortion and infanticide policies, and an original analysis of moralistic texts against such practices (see Appendix), this chapter examines the politics of abortion and infanticide in the late Tokugawa period. After outlining the scholarship on abortion and infanticide, I investigate evidence of these practices and look at the actors involved and the practices and methods they employed. Then the chapter examines regulatory and moralistic discourses about reproduction during this period. I conclude by considering the implications of such social dynamics on the conceptualizations of the genesis of life.

Desire to Control Family Size

The dominant understanding of abortion and infanticide in early modern Japan was based on the notion that Japanese culture considered children under seven years old as near-deities. Most notably, the prominent folklorist, Yanagita Kunio[1] (1996), wrote that those who committed infanticide believed that this practice was "not the killing of a child, but as the act of not raising the being" (p. 395). Scholars who took this position emphasized that personhood was attained in a gradual manner through successive rites of passage, and because infants were not considered persons per se, infanticide did not evoke the same sense of guilt or stigma that was attached to the murder of an adult person. Expressions employed in the Tokugawa period can be used as one piece of evidence of such mentality. Ordinary people in rural areas used terms such as "returning of a child" (*kogaeshi*), "humbly return" (*okaeshimousu*), and "giving it back" (*modosu*) to talk about infanticide. Phrases such as "not picking up" (*toriagezu*) and "not raising" (*sodatezu*) were used in different parts of Japan from the late eighteenth to the end of the nineteenth century as well (Ohta 2007, p. 25).[2]

[1] Japanese names follow the convention of surname first.

[2] The modern Japanese term for abortion is *jinkō ninshin chūzetsu* (artificial abortion/termination of pregnancy), or typically *chūzetsu* (abortion/termination) for short, and infanticide can be translated as *nyūji satsugai* (killing of an infant), but these terms were not used in the Tokugawa period.

While those who practiced abortion and infanticide framed their actions as the returning of prehuman beings "to the gods," elites in urban centers censured farmers' activities by referring to them as *mabiki*. *Mabiki* meant culling or thinning out of seedlings and was based on the belief that creating proper distance between each sprout allowed each to grow stronger than they would otherwise. Applying this concept to children, it was possible to raise children better by having fewer, thus suggesting that parents were making a conscious decision about the number of children they would have (Ohta 2006, p. 110).

As a number of contemporary writers pointed out, people had a strong preference for smaller families with few children. The author of *The Guide for the Prosperity of Descendants* (the year of original publication unknown, reprints published in 1850, 1851, and 1857),[3] for example, stated, "In the country side, having too many children is considered as a burden on the family." Official documents from the Aizu region in eastern Japan in 1745 stated that having numerous children would not necessarily result in unhappiness (Ohta 2007, p. 166), suggesting that many ordinary people associated having many children with hardship. A Confucian scholar, Ashi Tōzan, wrote in 1754 that people came to limit the number of children to two, and even wealthy families would not have more than three or four children (Sawayama 1997, p. 40). Similarly, a domain warrior from Sendai, Owada Gonbē, wrote in 1793 that the mid-level farmers would keep only two or three children no matter how many children they gave birth to, and poorer farmers would not raise more than two children (Sawayama 1997, p. 40). There was, in fact, a stigma attached to families with many children. The author of *On Childrearing* (1791–1792), Ehata Jirō Uemon, wrote that people ridiculed those with many children and sometimes suggested that these families should practice infanticide because having too many children created too much inconvenience. Likewise, the author of *Teachings about Childrearing* (1822), Sekiguchi Toyotane, wrote that one should not feel ashamed of having many children, again implying that it was seen as shameful.

Having too many children was considered a threat to family survival because it meant the loss of young women's labor and more mouths to feed (Ohta 2007, p. 423). At the same time it was also important for families to have enough children to ensure that their family line would

[3] The original Japanese titles and other information on each text can be found in the Appendix.

continue. Since it was essential that every member of the family contributed to the economic wellbeing of the household, fewer healthy children were preferable. This meant that those infants perceived to be unhealthy or weak were more likely to be killed (Sawayama 2004, p. 94). Such cases included infants with birth defects and multiples, who not only tended to be weaker but required more care. A shortage of breast milk for multiples was another concern (Ohta 2006, p. 125). The negative perception regarding multiples was reinforced by the belief that they resembled animal offspring and were the result of too much sexual intercourse during pregnancy, something criticized in various Confucian publications. The author of *The Guide for Raising Infants* (1794) wrote that having twins and triplets was auspicious, but people felt ashamed of it, killed the infants, and prayed that it would never happen again. Infants born with the umbilical cord wrapped around their necks were also candidates for infanticide, as they were considered to be a sign of a high-risk birth that could easily result in the death of the baby. Similarly, preterm and premature infants were seen as too weak to thrive. A prominent doctor, Kazuki Gozan, wrote in his text, *On Raising Small Children* (1703), that "[t]here are many people who kill babies born after seven or eight months of pregnancy, who are very small and appear as if they should not grow up." All of these narratives suggest that infants were valued based on the potential long-term contributions they could make to the wellbeing of the family.

Historical Evidence of Abortion and Infanticide

Early studies that discussed abortion and infanticide centered on their prevalence and impact on population growth or lack thereof. In his influential *Study on Abortion and Infanticide* ([1936] 1981), Takahashi Bonsen considered abortion and infanticide as one of the strongest factors that contributed to the declining population during the late Tokugawa period. Based on an analysis of the policies and demography at the local domain level, as well as discourses on infanticide from intellectuals, Takahashi concluded that the prevalence of infanticide increased with the starvation and poverty associated with famine of the late Tokugawa period. The folklore scholar Chiba Tokuji (1983) challenged Takahashi's argument, suggesting that the population decline was due to epidemics and the growing number of people migrating to urban areas in search of work. Chiba considered that infanticide decreased in the late Tokugawa period and that the justification for the practice was based on the perspectives on

life and death in Japan that did not invoke a sense of guilt over such an act. More recent scholarship on the history of abortion and infanticide in Japan has employed rigorous empirical investigations of legal documents and personal diaries (e.g., Ohta 2007, 2011; Sawayama 2005), as well as the incorporation of sophisticated historical demography research (e.g., Drixler 2013). These scholars further contextualized their findings within broader social changes in the historical period to produce a more nuanced understanding of reproductive dynamics.

While scholars have not reached consensus on the prevalence of abortion and infanticide, most agree that these practices existed during the Tokugawa period. The improbably high number of late-term miscarriages and stillbirths recorded was part of the evidence contemporary researchers used to conclude that reported cases must have included cases of late-term abortion and infanticide. For example, the historian Sawayama Mikako (2009, p. 63) found that in the 1810 records from Ichinoseki (present-day Iwate prefecture in northern Japan), 72% of reported fetal deaths among the warrior class and 87% among farmers occurred between the seventh and tenth month of pregnancy. Takamura (2002, p. 18) studied 13 cases of perinatal deaths in Mito (present-day Ibaraki prefecture in eastern Japan) between 1821 and 1841 and found that all cases happened between the seventh and tenth month of pregnancy. High rates of late-term miscarriage and stillbirth were associated with popular methods of abortion and infanticide. While today most abortions are performed in the early stage of pregnancy, late-term abortion was more common in Tokugawa Japan. Pregnancy was not officially recognized until the fifth month, around the time that pregnant women experienced quickening, and by definition, people could not perform an abortion until then. There was also a notion that it was safer and more effective to perform abortion after the fetus became large, as the popular method of abortion involved puncturing the uterus through the vagina with a stick.

The high rates of late-term miscarriage and stillbirth were also related to the ways in which people tried to hide abortion and infanticide. People often disguised abortion and infanticide by claiming that they had a miscarriage or stillbirth. In a personal diary, a farmer, Tsunoda Tōzaemon, wrote that he "told a lie and reported that the infant was born dead," after committing infanticide (Ohta 2006, p. 115). Obstetricians were aware of this, as an obstetrician, Kagawa Mantei, reportedly said that "some women pretend that they had a miscarriage when they actually had an abortion" (Kure and Fujikawa 1898, p. 254). The ability to discern whether women

had abortions or miscarriages was a critical skill for obstetricians in order to determine appropriate treatment. A number of obstetrical textbooks discussed how to make such determinations, which, again, suggested that women often claimed that they miscarried or the baby was stillborn, when in fact they had an abortion.

Comparisons of birth statistics based on class and gender are another way in which researchers have found that people of this era committed abortion and infanticide. The skewed sex ratio of reported fetal and infant deaths among warrior-class families, for whom the continuation of the family through male offspring was particularly important, revealed that female infants were more likely to be the victim of infanticide than male infants. In Ichinoseki, among the 45 cases of reported fetal deaths among the warrior-class population, 14 were male and 31 were female, while among farmers, the numbers were both 17 (Sawayama 2009, p. 63).

While no skewed sex ratio was found, farmers' records showed that there were seasonal patterns in which births took place. For farmers, labor provided by female family members was essential for survival, and because women's work was unavailable during and shortly after the birth, efforts were made to time pregnancies and births to correspond with the farming calendar (Shinmura 1996, p. 222). Records show higher birth rates in the early part of the slow season, which minimized labor shortages associated with pregnancy and birth, and maximized the time that mothers could breastfeed, increasing the chance of survival for infants (Sawayama 2006, p. 36). For example, among 244 births in a village in Iwate between 1811 and 1821, 25% took place in January according to the Chinese (lunar) calendar, which coincided with the beginning of the slow farming season in the village (Mukoda 2006). Similarly, 13% of births took place in February in a neighboring village, in which the slow farming season was from the end of December to the end of April (Takagi 1996). The births in the Kamitozawa district in Sendai were also concentrated around the end of the busy farming season and during the slow farming season (Kikuchi 1997, p. 143).

Historical materials also revealed the actors involved and methods employed in regard to abortion and infanticide. Abstinence was practiced when men worked away from home, and prolonged breastfeeding was promoted to avoid unwanted pregnancy,[4] but effective methods of contraception were limited. Studies of obstetrical textbooks, policy documents,

[4]For example, Kazuki Gozan wrote in his *Shōni Hitsuyō Sodategusa* (1703) that with breastfeeding, women could space the ages of children by three to four years, while those who hire a wet-nurse could get pregnant every year.

and moralistic texts indicated that midwives and doctors performed abortions. Midwives were often the trusted reproductive specialists within communities, and they offered various forms of aid, including abortion and infanticide, in addition to assisting in births. While the domains' official doctors were technically against abortion and infanticide, doctors who worked closely with people responded to the needs of families, which sometimes included the termination of unwanted pregnancies. The fact that some doctors explicitly included their refusal to perform abortion in their rules for the apprentices suggests that it was not unusual for women to seek out the aid of doctors when they wished to terminate pregnancies. Most famously, the first school of obstetrics in Japan, the Kagawa School, included the prohibition of abortion in their bylaws (Ochiai 1994, p. 72). A doctor in Ichinoseki domain, Chiba Rian, also had his disciples sign an oath that included a clause stating that they would not prescribe abortive medicine (Sawayama 2009).

As noted earlier, the most common method of abortion was the puncturing of the uterus with a stick through the vagina. A domain official doctor from Sendai, Sasaki Bokuan, wrote in 1858 that midwives put musk on the tip of a stick (e.g., ox knee root, burdock root, or daikon root) and inserted it into the vagina to terminate unwanted pregnancies (Sawayama 1997, p. 126). The obstetrician Kagawa Mantei also explained that an abortion could be performed through the insertion of the root of the ox knee plant through the vagina, after rounding the tip of the root (Kure and Fujikawa 1898, p. 254). According to Bokuan, abortion was a highly dangerous procedure as a result of which many women lost their lives. The obstetrician Kondo Naoyoshi also wrote in his medical textbook (1854) that it was particularly difficult to treat cases in which people put musk or clove on the tip of a stick to puncture the uterus, as the poisoning could be severe (Kure and Fujikawa 1898, p. 705). The risk associated with abortion was one of the reasons people resorted to infanticide. A midwife or the mother of the infant typically performed infanticide by suffocating the infant as soon as it was expelled from the maternal body.

Regulation of Reproduction

For domains with financial difficulties, the declining child population was a serious concern. Regulation of reproduction began in the early seventeenth century by local domain officials and intensified over time. The oldest ordinance was issued in 1611 in the Satsuma domain (present-day Kagoshima prefecture in southwestern Japan), and the policy targeted

warrior and farming classes (Ohta 1997, p. 17). The first national law that included a clause protecting infants was the Edicts on Compassion for Living Things of 1687 (*Shōruiawaremi-rei*), which banned infanticide and the abandonment of a child (Tsukamoto 1983). Even though this edict was overturned in 1709 after the death of the Shogun Tokugawa Tsunayoshi, the leader who issued it, control over reproduction continued and intensified throughout the eighteenth century.

The shogun-led military government and domain officials became further concerned with population declines following several devastating famines in the late eighteenth century (Burns 2002). A number of domains implemented edicts to prohibit infanticide and abortion, as well as to exercise surveillance and control over the maternal body by registering pregnant women. For example, the Tsuyama domain (present-day Okayama prefecture in western Japan) implemented a law to prohibit abortion and infanticide in 1756, and added punitive clauses to regulate the registration of pregnancy and childbirth in a similar law issued in 1781. Further, from 1786, failing to file a pregnancy notice was considered a de facto attempt to conduct an abortion or infanticide, and those who did not file were punished severely, even when the infant was born without any problems (Sawayama 2005, pp. 93–94).

Domains began implementing a system of surveillance in the early nineteenth century by mandating the submission of various types of reports pertaining to reproduction. The Sendai domain, for example, required the reporting of reproduction in 1804. The number of such documents increased significantly in the 1840s. Among the 24 sets of reports on pregnancy, births, and perinatal deaths available today, 18 are dated between 1840 and 1875 (Kikuchi 1997, p. 142). Documents from early nineteenth-century Ichinoseki also show that its domain officials had a great interest in closely following people's reproductive activities. In Ichinoseki, pregnancy had to be registered around five months after the last period, and after birth, families were expected to report the name, birth order, gender, and whether it was a single or twin or triplet birth (Sawayama 2006). The implementation of mutual surveillance among community members was another way in which domain officials tried to control people's reproductive activities. Birth reports from 1811 in the Tsuyama domain show that not only were families required to file reports for both pregnancy and birth, community members were expected to attend births to make sure that everything was done properly. Community members were also held accountable when domain officials found any evidence of abortion or infanticide (Sawayama 2005, p. 99).

Since infanticide was often performed under the guise of miscarriage or stillbirth, domain officials tried to discern whether reported perinatal deaths were spontaneous or artificial. They found it suspicious when perinatal death reports identified the cause of death as falling, food poisoning, and an extended trip (Sawayama 2006). For cases of prenatal deaths, the submission of a death report and a doctor's note was required (Sawayama 2006), and an investigation could be quite involved. For example, when a 28-year-old woman from a farming family in the Karita district of Sendai domain had a stillbirth in 1848, a farmer in charge of enforcing the anti-abortion and infanticide policy inspected the body of the dead infant, in front of a mutual-surveillance group. The report from this inspection showed that they checked the gender, length, eyes, mouth, hands, legs, genitals, anus, placenta, umbilical cord, and the color of the body (Kikuchi 1997, pp. 197–200).

In addition to extending surveillance, domain officials targeted midwives and doctors for the prohibition of abortion and infanticide. Officials watched their work closely and ordered the suspension of their business when doctors or midwives were found to be engaging in abortion or infanticide (Sawayama 2006). They were particularly concerned with the activities of doctors, who were visiting the domain from other parts of the country, considering that it was such doctors who often performed abortions and reported them as miscarriages or stillbirths. For example, officials in Sendai domain problematized the activities of Hiruta Gensen, a self-taught obstetrician from the Mito area (eastern Japan). Hiruta was believed to have not only performed abortions but also taught the techniques to midwives. The domain issued a decree in 1816, urging people to report the names of midwives who learned abortion techniques from Hiruta (Sawayama 2009). While domain officials problematized his activities, Hiruta was a popular doctor because he not only responded to the needs of families, but also saved the lives of many women (Ogata 1980, p. 18). In another case, officials in Ichinoseki domain found the activities of a doctor named Takashina San'ei suspicious. Records on this doctor from 1852 to 1853 showed that all of his patients traveled long distances to see him, and the cases he treated had a high rate of perinatal deaths. Sawayama (2004, p. 100) noted that Takashina used abdominal massage, which was typically used during difficult births, so that he could make abortion appear as miscarriage or stillbirth.

Beyond existing legal penalties, several domains came to implement welfare programs in the early nineteenth century, as a measure to prevent infanticide. While such financial support was typically inadequate (Kikuchi

1997, p. 145; Ohta 2007, p. 179; Sawayama 2006), it was probably effective in cultivating the moral awareness that abortion and infanticide were crimes and people were expected to carry all pregnancies to term and raise children thereafter.

Abortion and Infanticide in Moralistic Texts

Anti-abortion and infanticide messages were also conveyed through the circulation of moralistic texts that condemned such acts. Buddhist monks, Confucian scholars, doctors, and domain officials emphasized the sinfulness of abortion and infanticide in these texts. Commonly, authors argued that even though those who committed such acts had the face of a human, they had the heart of a demon. The most widely circulated text of this genre, *The Guide for the Prosperity of Descendants* (n.d.), for example, included a picture of a woman suffocating an infant, with a text stating, "This woman has a gentle face but she kills even her own child. She must not feel anything killing other people's children. She has the heart of a demon."

To invoke a sense of guilt and shame, some authors listed stories of animals sacrificing themselves for their offspring, arguing that infanticide was an aberration from nature and those who practiced such acts were worse than animals. For example, *The Guide for the Prosperity of Descendants* had stories of a pheasant which died after trying to protect her eggs from fire, as well as a story about hens that plucked their own feathers to keep their eggs warm. It also included a story of a man who became a monk because of his guilt after shooting an arrow into a pregnant female dog and watching the dog die as she tried to pick up her litter of puppies while they fell out of her belly. Similar stories could be found in other texts including *Praise of Birth and Childrearing* (n.d.) and *Songs to Admonish against Abandoning of Children* (1861).

The authors of these texts attempted to invoke a sense of fear by taking advantage of people's belief in divine punishment and hauntings. Threats of divine retribution suggested that punishment would begin while those who committed abortion and infanticide were still alive. The author of *The Guide for the Prosperity of Descendants* wrote, "If one practices infanticide, the family would experience a number of hardships caused by the malice of the child," suggesting that the infant was an agentic being, capable of bringing about bad fortune. *Expostulation* (1851) stated that if one committed infanticide, even the children whom the parents decided to raise might die from sudden illnesses. The author also wrote that there were more than a few cases of women who had killed their infants and subsequently died from

complications associated with childbirth. A doctor from the Aizu region, Ishida Ryūgen, wrote a parable of a woman who committed infanticide, and subsequently became homeless, died of starvation, and dogs and birds ate her corpse because no one buried her body. He also wrote that a midwife who had committed infanticide lost her son when he was still young, and she was beaten up by her two "disabled" and "deformed" grandchildren. Punishment would continue as people died as well. A Buddhist monk, Tachibana Giten, wrote in his *Songs to Admonish against Abandoning of Children* that "[w]hen a woman who had killed her child was dying, she said that she was suffering from numerous infants attacking her." Even novels stressed the mercilessness of abortion and infanticide. A popular poet and storywriter, Ihara Saikaku, wrote in his *The Life of an Amorous Woman* (*Kōshoku Ichidai On'na*) (1686) that when the protagonist was about to die, she looked out a window and saw numerous children, wearing lotus leaf-shaped placentas on their heads with their lower bodies soaked in blood. They were crying and saying, "[You are] a terrible mother." The character realized that these were children she had aborted in the past.

Excruciating suffering in hell for those who committed abortion and infanticide was another common theme in such texts. For example, the aforementioned Ishida Ryūgen wrote that once the midwife died, she went to eternal hell in which all the babies she had killed came and pulled at her hands and feet, tearing her body in half. The author of *Praise of Birth and Childrearing* wrote that a person who had committed abortion or infanticide would go to hell and suffer torment. The description of hell depicted by Tachibana Giten is as follows:

> Killing of living beings results in being hit with an iron pole. Your body is broken into pieces like sand, and the shredding of your body is like cooking fish and meat… You suffer from being burned in the ferocious inferno, and blades would fall like rain and stab your body… This is the punishment for killing birds and animals. Imagine what would be to kill a human.

In addition to criticizing the practice of abortion and infanticide, the authors of moralistic texts presented the notion of children as a treasure, rather than a financial burden for the family. For example, the author of *Guide for Raising Children* wrote, "Since ancient times, wise people considered people, rather than money, as treasure." Tachibana Giten wrote that children were a more important treasure than a storehouse full of riches. This did not mean, however, that the authors considered infants as rights-bearing individuals. Rather, they depicted infants as benefitting parents and

families in the future. The author of *Praise of Birth and Childrearing* wrote, "[w]hen you die, the only people who will perform your memorial service would be your own children. The prosperity of families is derived from not killing. Children are the treasure of the family." Similarly, *Songs to Admonish against Abandoning of Children* stated that "[o]nce grown, children would take care of you when you are sick, and perform memorial services after you die." The notion of children as treasure was based on the belief that they would bring social and economic security to the family.

Further, the authors tried to evoke a sense of guilt over abortion and infanticide by presenting images of the fetus and infant to the readers. One idea discussed in some texts was that personhood began with conception. The author of *On Childrearing* argued that the fetus and infant were persons worthy of protection:

> There is no person who would not be sad when a two to five year old child died from disease. A newborn baby might not speak or move his or her hands or feet, but if you kill something that had the body of a human, it is a killing of a human… How would you feel if someone captured you and killed you, suffocating your mouth and putting a rope around your hands and feet.

Tachibana Giten stated that the fetus and infant had the ability to feel pain. He argued that pregnancy and birth themselves were painful experiences for the fetus, drawing intimate connections between the existence of the fetus and the actions of the mother. He wrote:

> In the mother's womb, [the fetus] experiences the heat as if bathing in boiling water when the mother drinks hot water or tea. When she eats something cold, [the fetus] experiences the extreme coldness… Delivery is like going through the mountains with rocks on both sides. Once being outside the maternal body, [the infant] cries because everything [the infant] touches with its thin skin feels like being stabbed with a sword.

Another argument against abortion and infanticide in moralistic texts was based on the notion that the fetus and the infant were gods or had god-like qualities. For example, *Teachings about Childrearing* (n.d.) repeatedly emphasized the notion that a baby was born with the heart of Buddha, and suggested that each person had the potential to become a Buddha, citing Amitabha Sutra. Similarly, the author of *Praise of Birth and Childrearing* wrote that a child was a god taking the form of a boy or a girl. Tachibana Giten argued that it was a tremendous sin to kill a child who was born with the body that resembled gods and Buddha.

Other texts argued that infants should not be killed because the creation of children was a divine decision, not a personal matter for parents. For example, *Expostulate* and *On Raising Infants by Chichibu Shasō* (1863) both stated that pregnancy and birth happened based on a divine intervention, and it was important to follow the gods' will. They argued that the child did not belong to the parents; rather that it was the child that gods and Buddha lent you (*Expostulate*) or that nature gave you (*On Raising Infants by Chichibu Shasō*). *Teachings about Childrearing* stressed this point by stating that the fact that a woman could not know when conception occurred for the first few months of pregnancy was the sign that the child belonged to gods rather than human parents. Further, *On Raising Infants by Chichibu Shasō* stated that it was a mistake to think that having many children would cause financial difficulties, as once the gods decided to create a child, they would provide food, clothing, and shelter.

How then did ordinary people reconcile this widely publicized idea that personified or deified the fetus and infant with their urgent need to control family size for survival? What was their understanding of the beginning of life? While the notion of life starting from conception worked theoretically, it did not match the experience of women and their families. They typically did not acknowledge pregnancy until around the fifth month of gestation, when women felt the fetal movement for the first time. For ordinary people, what mattered for the conceptualization of the beginning of life was parents' commitment to raise the child. Sawayama (2009, p. 65) wrote, "[t]he process of acknowledging the life of a child was the process of acknowledging the will to raise the child." That is, whether parents saw the fetus or infant as their child depended on whether they wanted to raise it as their child.

When parents decided to raise a child, the birth was treated as important. Once the child was born, families would perform a number of rites of passage. The significance of birth can be seen from the fact that the early nineteenth century was when the celebration of the birthday became popular among ordinary people (Shibata 2013, p. 157). Conversely, when they decided not to raise a child, ordinary people used the idea that early infant-hood was the extension of prehuman fetus-hood. By deemphasizing the birth, they categorized early childhood as a part of the fetal, spiritual stage. The blurred boundary between the fetus and infant corresponded with the blurred boundary between abortion and infanticide. Contemporary Japanese society treats the moment of birth as significant and considers abortion and infanticide as mutually exclusive categories, but this was not the case in the late Tokugawa period. In early modern

Japan, the categories of abortion and infanticide, as well as the distinction between the fetus and infant, were not as clear as we consider them today.

Conclusion

Ideology, policies, and people's perceptions and bodily experiences mutually constitute the ideas about the beginning of life. Highlighting the competing ideas and negotiations on the concepts of the genesis of life, this chapter demonstrated that views on abortion and infanticide differed significantly depending on the social locations of the individuals involved. Interestingly, however, both those who practiced and denounced abortion and infanticide highlighted the continuity between fetus-hood and infant-hood. That is, neither moral commentators nor ordinary people viewed the detachment of the fetus from the maternal body as a significant marker that defined the beginnings of personhood. Some moralistic writers argued that abortion and infanticide were sins because the fetus and infant were just as much a person as children and adults were. When justifying abortion and infanticide, ordinary people also relied on the idea that there was essentially no difference between the fetus and the infant.

Notions of personhood were not historically stable. Moral suasion campaigns against abortion and infanticide and the implementation of various reproductive policies contributed to the creation of the idea that abortion and infanticide were sinful acts. Moralistic texts emphasized the idea that the fetus and infant were a treasure of the family, worthy of protection, and committing abortion and infanticide would result in tremendous suffering in hell. While the effectiveness of welfare programs was questionable in terms of easing the financial burden of childrearing among the poor, they were at least partially successful as an attempt to cultivate the notion that people were obligated to raise their children responsibly.

The meaning of personhood and the conceptualization of the beginning of life are socially and historically contingent and constantly under negotiation. Reproductive bodies come under scrutiny in different cultural and historical contexts. In Tokugawa Japan, the boundaries between abortion and infanticide, as well as the fetus and infant, were not as self-evident as we typically consider them today. While rulers presented the view that personhood began during pregnancy, for ordinary people, coming into being was not an automatic process. Explicit recognition by parents was needed for an infant to be considered part of the family and community, and the birth came to be treated as significant only when parents were committed to raise the infant as their child.

Appendix

List of Moralistic Texts Studied

Title	*Title in English*	*Year*	*Author/Publisher*
Ikujiben	On Childrearing	1791–1792	Ehata Jirōemon
Akago Yōiku Kanjin no Hiki	Guide for Raising Infants	1794	Rin'nōji Daiken
Ikujishū	Compilation of Writings on Childrearing	1802–1811	Okano Ōhara
Yōiku Kyōyu	Teachings about Childrearing	1822	Sekiguchi Toyotane
Kodakaraben	On Children as Treasure	1830	Takenaka Umenoshin
Shison Hanjō Tebikigusa (reprint)	Guide for the Prosperity of Descendants	1850	Jōsenji
Shison Hanjō Tebikigusa (reprint)	Guide for the Prosperity of Descendants	1851	Igarashi Tomiyasu
Satoshikusa	Expostulation	1851	Nakamura Kanoe
Banmin Kokoro no Kagami	Mirror of the Heart	1854	Ishida Ryūgen
Shison Hanjō Tebikigusa (reprint)	Guide for the Prosperity of Descendants	1857	Hirayama Chūbē
Sutego Kyōkai no Uta	Songs to Admonish against Abandoning of Children	1861	Tachibana Giten
Sanka Kyōdōben	Teachings for Families with Infants	1862	Morikawa Yōgen
Chichibu Shasō Ikuei Kōdokusho	On Raising Infants by Chichibu Shasō	1863	Inoue Nyojō
Shison Hanjō Tebikigusa (original)	Guide for the Prosperity of Descendants	Unknown	Chichibu Kikusuidera
Enmei Kosodate Wasan	Praise of Childrearing	Unknown	Ueno Usui Giten
San'iku Wasan	Praise of Birth and Childrearing	Unknown	Unknown
Kosodate Wasan	Praise of Raising Children	Unknown	Unknown
Kosodate no Oshie	Teachings about Childrearing	Unknown	Unknown
Ikuji Zusetsu	Illustrated Guide for Childrearing	Unknown	Saruta Genteki
Kosodategusa	On Childrearing	Unknown	Unknown
Nōgyō Shōni Shikyōben	Teachings on Farming and Raising Children	Unknown	Takahashi Gondō
Mozu no Saezuri	Chirping of Shrike	Unknown	Heinosuke
Sekishi Yashinaigusa	On Raising Babies	Unknown	Arai Nobuaki

CHAPTER 3

Unlocking the Mysterious Trunk: Nineteenth-Century American Criminal Abortion Narratives

Tanfer Emin Tunç

During the campaign to criminalize abortion in the United States (1850s–1870s), there was a veritable explosion of "criminal abortion narratives," or sensational "true crime" novels and novellas. These narratives were usually published during the investigation and public exposure of illicit pregnancy termination cases, and supported the political movement initiated by allopathic physicians, who, through institutions such as the newly formed American Medical Association (AMA; established in 1847), were seeking to gain professional, legal,* and medical control over their trade. Although some of the first examples of these narratives emerged during the final years of the Early Republic (1830s), by mid-century these works had become a popular literary genre. Criminal abortion narratives blended titillating sensationalist scandal, classical mystery writing, elements of (non-)fiction, journalism, legal drama, urban legend, and medical case study to create fact-based morality tales that, like most

T.E. Tunç (✉)
Department of American Culture and Literature, Hacettepe University, Ankara, Turkey

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_3

of the cautionary literature of the time, sought to define social behavior according to gender. Most of this literature, however, also advocated the criminalization of abortion, thus reinforcing the political authority of medical and legal professionals as the regulators of nineteenth-century American mores.

This chapter focuses on how criminal abortion narratives aggrandized the authority of the American medical and legal systems by deploying technical "scientific" information, which granted professionals the social influence to control pregnancy termination. Known for their dramatic and moralistic language, these understudied narratives also functioned as disciplinary tools that regulated female sexuality and women's control over their bodies by evoking fear of sexual intercourse outside of marriage, with death by criminal abortion serving as a major deterrent. The narratives were formulaic, often involving working-class women in their twenties who died from botched abortions, and whose corpses were sometimes hidden in trunks and/or dumped in bodies of water in an attempt to conceal the actual cause of death. Their repetitiveness stemmed from the fact that such sensational narratives were in high demand, and that most *publicized* criminal abortion cases followed these patterns. Their effectiveness lay in their power as didactic instruments, as well as in their ability to illustrate how unrelenting police detective work and the scientific method of physicians were essential in unraveling criminal abortion cases. This, in turn, reinforced the authority of the American medical and legal systems, which maintained the criminality of abortion in the United States until the *Roe v. Wade* decision (1973).

Criminal Abortion Narratives as Popular Literature

As Mohr (1979) elucidates, pregnancy termination did not become a political issue in the United States until the mid-nineteenth century when American physicians, under the banner of the AMA, began to consolidate their growing professional power and medical expertise through a distinct claim to specialized, scientific knowledge. Criminalizing abortion augmented this project by eliminating competition from lay healers, midwives, and non-allopathic practitioners such as homeopaths and herbalists. Consequently, during the 1850s, pregnancy termination increasingly came under the scrutiny of medical and legal experts who, using their growing social and cultural authority, initiated a national campaign that transformed abortion from a personal issue into a public, political polemic.

The result was that by the late 1870s, abortion performed at any stage of pregnancy was criminal in most states, with the exception of therapeutic abortions to safeguard maternal life. Criminal abortion was rendered even more "criminal" when the procedure resulted in the death of the woman ("abortion-murder"). Although illicit pregnancy terminations were performed by a range of practitioners including regular allopathic physicians themselves, criminal abortion narratives reinforced mainstream physicians' authority by ensuring that abortions performed outside the therapeutic system would always be considered "criminal" and subject to the scrutiny of medical jurisprudence, a new professional specialty that combined the expertise of doctors (medicine), attorneys (law), and criminal investigators (forensics).

"Criminal" abortions occurred on a daily basis in the United States during the nineteenth century, and those that culminated in the gruesome demise of the women seeking pregnancy termination often became public scandals and fodder for the publishing industry. Interest in criminal abortion was catalyzed in the 1840s by the arrest and sensational trial of Ann Lohman (Caroline Ann Trow), the infamous New York abortion provider also known as Madame Restell (Browder 1988). This case not only provided material for the AMA's burgeoning abortion criminalization campaign, but it also simultaneously sparked public fascination with criminal abortion narratives. After the Lohman case, almost every major abortion trial that gained national notoriety was transformed into a narrative, resulting in the establishment of a popular literary genre that reflected discourses such as the impact of industrialization on American lives; urbanization and the shift in gender roles; sexuality, reproduction, and pregnancy termination; the power of medical and legal professionals; and forensic/detective science as an objective disciplinary structure.

Criminal abortion narratives represent an intersection between numerous nineteenth-century literary genres: fact-based prose, "true crime" novels, titillating sensationalist scandal, detective mystery, medical case study, didactic morality/cautionary tales, confession narratives, urban drama, and gothic fiction. Due to its "immorality" and the "threat" it posed to the domestic sphere, illicit pregnancy termination was a topic that was well-suited to this type of writing. It also deployed familiar tropes from sentimental novels such as love, betrayal, family, fidelity, duty, honor, melodrama, violence, seduction, illness, suffering, money, and death, thus weaving "reality" into fiction. However, in this case, fiction does not necessarily mean fabricated elements, but rather the "imaginative reen-

actments" and plausible speculation that, for many, rendered these texts "more authentic representations than the ostensibly factual reports and official legal records to which they responded" (Blandford 2011, p. 4). Since separating fact from fiction is almost impossible in nineteenth-century abortion narratives, they are, at best, only "fact-based" because each narrative is a social construct involving "a fictive process, which reveals much about the mental and emotional strategies employed within a given historical culture for responding to serious transgression in its midst" (Halttunen 1998, p. 2).

Social change was occurring rapidly in the years immediately before and after the American Civil War (1861–1865). "In literate societies," as Halttunen (1998) notes, "the cultural work of coming to terms" with such rapid social change often "takes crucial form in the crafting and reading of written narratives," "the chief purpose of which is to assign meaning" to "incidents" (p. 2). Criminal abortion narratives exposed the secret crimes of urban life and included a mix of mystery and horror, which "employed inflated language and treatments of violence and its aftermath in order to shock the reader into an emotional state that mingled fear with hatred and disgust" (Halttunen 1998, p. 3). Gothic literary conventions were also a convenient way to explain social transgressions; thus, many of its tropes, such as "veiled ladies, disappearing corpses, intrusions of the supernatural, the dead returned to life," and "terrible evils practiced in private space" are found in criminal abortion narratives because they gave "meaning and coherence" to nineteenth-century horrors (Halttunen 1998, pp. 116, 124). Such elements also confirmed the "normalcy" of the "law-abiding" reader, made the unspeakable speakable, and provided "narrative closure" for citizen-readers (Halttunen 1998, pp. 4, 5, 133, 235). The penny press, which originated in New York in 1833 and was accessible to all Americans because publications cost one cent, reinforced "the fears of the middle class through its daily recitation of sensational crime stories, lurid tales of violence and sex, and a focus on the underside of urban life" (Crist 2005, p. 22). It also exploited such urban tales for profit, publically exposing pregnancy termination through its abortion advertisements and coverage of sensational criminal trials, such as those of Madame Restell (Mohr 1979, p. 49).

Even though the majority of women who sought abortions were white, middle and upper class, married, native-born Protestants, the media overwhelmingly sensationalized young, single, "beautiful" urban working-class "girls" because as Poe (1846) noted, the "death of a beautiful

woman is, unquestionably, the most poetical"—and lucrative—"topic in the world" (p. 165). Moreover, wealthy families could bribe newspapers to conceal abortion deaths, further influencing whose criminal abortions would be narrated (Caron 2009, p. 13). Thus, abortion narratives often focused on the victims' innocence and seduction, implied "that the woman's death was the direct or indirect result of a sexual 'fall,'" and included "graphic (and occasionally erotic or pornographic) descriptions of the victim's corpse" (Cohen 1997, p. 278). They always incorporated intimate details, ranging from descriptions of families and childhoods, to education, employment, disposition and temperament, previous illegal activity, and reputation, all of which added melodrama and sentiment to the works. Most "victims" wanted to destroy the proof of their sinful "fall" because their partners refused to marry them, they feared parental or social rebuke, or they were ashamed of their "disobedience" (Caron 2009, p. 2).

Another common element in the narratives was dialogue, which was extracted from trial reports and court proceedings, or in some cases fictionalized to add interest and catalyze the plot. Sometimes abortion techniques—instrumental pregnancy termination, herbal remedies, violent force, and the insertion of objects into the uterus—were also described. Moreover, the majority of the women sought help from the men who impregnated them, who usually hastened their demise. The most obvious unifying factor of these narratives, however, is that all the abortions were unsuccessful, resulting in the death and gruesome discovery—usually in a trunk, river, or obscure hiding place—of the abortion-seeking woman's (sometimes mutilated or dismembered) body.

The Narratives

The year 1833 is significant because it marks the public trials of the criminal abortion cases of Sally Burdick and Sarah Maria Cornell, two Rhode Island women who became flashpoints for discourses concerning premarital female sexuality; the deterioration of traditional gender roles caused by industrialization and urbanization; and pregnancy termination, which was not a crime in the state at the time. Although Sally Burdick's case did not prompt the writing of a narrative, its trial report, which luridly details her autopsy, established the tenor of the invasive investigations, medicolegal gaze, and graphic accounts that would accompany criminal abortion narratives over the course of the century. Dr. Cyrus James's description of tar-like putrid matter, handfuls of coagulated blood, and a vaginal opening

that was so large it could easily accommodate his fist or, as he misogynistically commented, "a large rat" (*Report* 1833, p. 8), certainly set the bar of sensationalism quite high. Gory even by contemporary standards, the trial report is an example of gothic "body-horror," a writing style that "fully exposed the process by which murder victims' bodies were damaged, dismembered, and medically disemboweled" (Halttunen 1998, p. 79). Such "sexual autopsies" not only used science to produce knowledge that would reinforce the status of physicians, medical examiners, and legal professionals, but also "sought to penetrate the mystery of abortion deaths by exposing and scrutinizing the female reproductive system, an operation performed physically by physicians and imaginatively by courtroom audiences and trial-report readers" (Halttunen 1998, p. 192). They constructed the pathological female body as a scientific specimen to be penetrated, dissected, disembodied, and analyzed by authoritative professionals, delving into parts of the female anatomy that, during life, would normally be off-limits. Moreover, the autopsies also enabled physicians to use the female body as a stage on which to perform allopathic medicine, allowing them to reinforce their professional position through the gathering of the scientific "proof" needed to arrest abortion providers. Thus, while the "sentimental narrative shaped the standard storyline of the abortion-homicide," the "medical autopsy report ultimately located the horror of the crime" to female sexuality and anatomy (Halttunen 1998, pp. 192–193).

Dr. Cyrus James's gruesome testimony contributed to abortionist Frances (Fanny) Leach's conviction. Moreover, James's autopsy report, along with the outcome of both the Burdick and Cornell trials, also prompted changes in Rhode Island's abortion laws, clearly suggesting the burgeoning power of the medical profession to shape public opinion, the course of official proceedings, and the legal code itself. Unlike the Burdick case, Sarah Maria Cornell's death led to extensive media coverage and a sensational criminal abortion narrative, Catharine Read Arnold Williams's *Fall River: An Authentic Narrative* (1833). The case involved Cornell, a Lowell Mill girl, and the Reverend Ephraim K. Avery, a married, socially connected pastor of a local Methodist church. "Seduced under the mask of religion," Cornell in due course became pregnant, and Avery allegedly tried to induce a miscarriage through violent force to her abdomen, killing her instead. In order to conceal the murder, he purportedly made it look like a suicide by hanging Cornell from the barn rafters of a local farm, near a haystack, which earned the case the moniker "The Haystack Murder." However, the death began to draw attention when a note was

discovered in Cornell's trunk expressing, "If I am missing inquire of Rev. Mr. Avery of Bristol, he will know where I am gone" (Caron 2008, p. 32). This immediately prompted a public investigation of the Reverend and his relationship with Cornell.

Although Avery was ultimately vindicated of murder, the trial punished Cornell for her transgression of prescribed gender roles and illustrated the deleterious impact that urbanization and industrialization were having on social norms. Moreover, it also conveyed the growing influence of physicians and their medical expertise in shaping the course of a legal case. The physicians involved not only provided information concerning Cornell's pregnancy, autopsy, and sexual history, but also medicalized her speech and behavior, which were unlike that of an "ordinary" woman, serving as "evidence" of her moral turpitude. The jury placed its full confidence in the physicians called by the defense, even though they contradicted each other, and at times themselves, and they could not agree on the gestational age of the pregnancy (Caron 2008, p. 36). The jury acquitted Avery based on the medical testimony that best fit the story of a devout minister ensnared by a desperate "fallen woman" looking for a father for her child. Ultimately, the jury believed those physicians who claimed that Cornell's fetus was conceived before their first sexual encounter; thus, Avery was innocent and could not have murdered Cornell because he had no motive. Despite Avery's acquittal, the consensus was that he had murdered Cornell, and that his influence and connections as a minister, as well as bias against Cornell during the trial, determined its outcome.

A "mixture of journalism, social tract, true crime and semifiction" (DeWaard 2002, p. 374), *Fall River* functions as a "corrective" for what Catharine Williams believed was an unfair and distorted trial. The narrative is told through numerous perspectives, in particular that of Cornell, billing itself as an "authentic" narrative which, ironically, prompts the reader to question its authenticity. Nevertheless, the work conveys stylistic complexity as an outlet for polyvocal protest by allowing those outside the political power structure—women—including the author herself, to "speak their own versions of the truth." While this revisionist narrative deploys literary license, weaving together dialogue and plot, and playing on sentiment through cautionary language, it also serves as a "forensic reconstruction": "a hybrid literary-legal artifact that derives" its "authority from the popularity of the materials it assembles," including testimony from medical experts (Blandford 2011, pp. 16, 150).

In the beginning of the narrative, a pregnant Cornell consults with Dr. Thomas Wilbur, a local Fall River physician whose testimony is heard in court. Cornell confides to the doctor that Avery is the father of her child and that "he wished her to take a medicine," the dangerous herbal abortifacient oil of tansy, to "obliterate the effects of their connexion [sic]" (Williams 1834, p. 24). After Cornell dies, she is buried and then disinterred for an autopsy by three physicians and surgeons who examine "the external bruises, and ascertain she had told no falsehood with respect to her situation [pregnancy]. From the state of the lungs it appeared she died of suffocation, and from the mark of the rope around her neck, that she could not have died by hanging" (p. 33). As Williams conveys, Cornell did not hang herself but was rather hanged, either before or after she was murdered, presumably by Avery, who was trying to destroy all traces of their union.

While Williams respects the authority of medical testimony, she, much like the jurors who acquitted Avery, displays a preference for those medical experts who reinforce her own interpretation of the proceedings (in this case, those called by the prosecution). She even discredits the defense's physicians by critiquing their testimony. According to Williams, they "endeavoured to prove, first, that the deceased might have hung herself," then "that the prisoner could not have been the father of the child." It "is certain that *one single question* put to those physicians" (When was the child conceived?) "if properly answered" would have "put the whole to rest at once" (pp. 58–59). As Williams suggests, because this crucial question was never directly asked, or clearly answered, the defense had no real case. Yet, Avery was acquitted, which to her was a travesty of justice that was based on questionable medical testimony.

While *Fall River* established the sentimental framework of future works, it is the case of Mary Cecilia Rogers, also known as the "Beautiful Cigar Girl of New York," that helped secure the criminal abortion narrative as a literary genre. The case began in 1841 when Rogers's mutilated body washed up on Hoboken Beach in New Jersey. Rogers was a popular employee at a New York tobacco shop, and the discovery of her body attracted curious onlookers, including Daniel Payne, who "calmly trudged to where his fiancée had met her demise," "took a swig of poison from a vial," and committed suicide (Kantrowitz 2011). While no one was ever arrested, indicted, or prosecuted for the murder, Rogers's death created an explosion in the literary and legal worlds. The consensus was that she

died from a botched abortion and that whoever mutilated and disposed of her body in the river was attempting to conceal the crime by making it look like a murder or suicide. However, Rogers's death, much like those of Burdick and Cornell, ultimately symbolized a whole range of "evils," from the vices of urbanization and industrialization, to the growing urgency to curtail abortion, which was expanding rapidly in the 1840s along with the influx of women to cities, to the breakdown in gender roles and social disorder, which many believed encouraged such illicit activities (Srebnick 1993, pp. 149–150).

Rogers's discovery could not have happened at a more opportune moment for law enforcers and medical professionals seeking to criminalize and regulate pregnancy termination and discipline those who were engaging in the practice. The notorious Madame Restell was on trial for the first time in 1841, and the bodies of women who had died from botched abortions were washing up regularly on city beaches. Rogers, who had been seen in the company of abortionist Frederica Loss immediately before her death, became part of this complex network at the end of her life. Although no direct connection was ever established between Restell and Loss, some maintained that Loss's premises was a Restell "outpost," while others believed she was merely "following in the footsteps" of the notorious woman by either performing abortions herself, or by providing physicians with a venue to terminate pregnancies illegally (Shashower 2006, pp. 252–253). Nevertheless, the Rogers tragedy and the Restell trial fueled the passage of two crucial pieces of legislation in 1845: the New York City Police Reform Act, which restructured the city's failing police force, and a stricter abortion law, which was supported by Assemblyman Frederick Mather who, ironically, was Rogers's distant cousin (Crist 2005, p. 24).

Rogers's "sexual autopsy" fed the press, which "published detailed and medically specific coroner's reports" (Srebnick 1993, p. 150). The autopsy report described how her "hands had been tied. Raw skin on her back indicated that she had been dragged. Fabric from her clothing had been ripped away; one piece used as a gag, another used to pull her. Bruises and abrasions covered her feminine regions" (Kantrowitz 2011). The same report also suggested that Rogers had been "raped by several men, then strangled to death, after which her body was tied again and thrown into the water" (Srebnick 1993, p. 160). Ironically, as Srebnick (1993) notes, "the final destruction of Mary's body, the ultimate violation, is carried out not by her killers but by the coroner's lancet. Furthermore, the report

is chilling not only in its use of scientific investigation but also in how it employs medical discourse to create a narrative" of the crime (p. 158).

Above all, Rogers's "beautiful" corpse inspired the publishing industry (Srebnick 1993, p. 150). Even established authors, such as Edgar Allan Poe, did not forego the opportunity to turn this tragedy into a gothic story. According to Halttunen (1998), Poe "invented" detective fiction in the 1840s, and added to the popularity of the "nonfictional literature of murder" with "The Murders in the Rue Morgue" and "The Mystery of Mary Roget," the latter of which was based on the Rogers case (pp. 3, 172–173; Srebnick 1995, p. 112; Weingarten 2014, pp. 150–151 fn. 43). Set in Paris and not New York, Poe's "Roget" is a thinly veiled fictionalization of the actual murder, with Poe "convincingly argu[ing] that the murder of Rogers was connected to a group of abortionists operating in and around the city" (Smith 1990, p. 21). In fact, "Edgar Allen Poe wrote his story as the real one unfolded." Just like in the actual case, "Poe never named a culprit. He did, however, have a particular interest in the event. He, too, was a customer of Andersons Tobacco Emporium and a great fan of the beautiful Mary Rogers" (Kantrowitz 2011). Other literary adaptations of the case include a highly fictionalized 600-page pastiche by Ned Buntline (Edward Zane Carroll Judson, Sr.) entitled *The Mysteries and Miseries of New York: A Story of Real Life*, and Joseph Holt Ingraham's *The Beautiful Cigar Girl or, the Mysteries of Broadway*, whose fairy tale ending elides Rogers's gruesome death. Andrew Jackson Davis's *Tale of a Physician; Or, the Seeds and Fruits of Crime*, which dramatizes the life of abortionist Madame La Stelle (a fictionalized Madame Restell), also alludes to the Rogers case (Srebnick 1995, pp. 134–137; Weingarten 2014, p. 28).

Two other notorious cases from this period were the criminal abortion deaths of Sarah Furber (1848), a Lowell, Massachusetts mill girl who died from peritonitis caused by an instrumental abortion performed by New Hampshire physician Dr. John McNab, and Berengera Caswell (1850), whose story was also widely fictionalized. The Furber case was particularly scandalous because McNab sold Furber's corpse (for dissection) to prominent Harvard professor and poet Dr. Oliver Wendell Holmes. After examining the cadaver, Holmes knew that the death had not been from "natural causes" as McNab had maintained, and had the body embalmed so it could serve as criminal evidence. Holmes also used the opportunity to express his outrage at illicit abortion: "Never in my practice have I seen anything like this [uterine] puncture; hope I never shall again." This

justified intervention by the AMA and its medicolegal network of disciplinary power, and the result was the criminalization of almost all forms of abortion in New Hampshire in 1849 (Halttunen 1998, pp. 72–74; 192–193; Benedetto 2013, pp. 27–29).

The abortion-homicide of Berengera Dalton Caswell (a.k.a. Mary Bean) also caused social outrage. Caswell was a factory girl whose body was found, partially clothed and tied to a board, in a brook in Saco, Maine in 1850. The coroner, Thomas P. Tufts, the investigating jury, and Dr. Edwin Hall, an allopathic surgeon who "removed Bean's reproductive and other organs and placed this medical evidence in glass jars, which were taken to [his] office for further study," concluded that she "had died from peritoneal or puerperal inflammation, a massive infection resulting from an abortion" (De Wolfe 2007b, pp. 17–18). James Hervey Smith, an irregular botanic practitioner with whom Caswell had lived for a few weeks while undergoing treatment (herbal methods followed by a wire instrument which punctured her amniotic sac and uterus and caused her death), was arrested, tried, and in 1851 found guilty of second-degree murder (De Wolfe 2007a, p. 121). However, the ruling was later overturned, and Smith was released with time served due to a conflict between Maine's common law, which criminalized only post-quickening abortions (those that occurred after fetal movement), and the state's statutory law, which criminalized all pregnancy termination—a discrepancy that fueled the AMA's concern over the murky legal status of abortion in most states.

Locals made sense of the event by drawing on the tropes of sensational fiction: the beautiful murder victim, seduction by a fellow factory worker (William Long), "illicit sex," dissolving morals, and the sexual dissection of a rat-chewed corpse that had been denied a Christian burial by Smith, the ultimate villain (De Wolfe 2007a, p. 122). Meanwhile, the print media constructed a "world of men" around Caswell—lawyers, coroners, and physicians who used the case to reinforce their political, social, and cultural power. In fact, while "rendering the court's decision, the presiding judge [even] praised the testimony of the physicians" involved as carrying "great weight" from "scientific and eminent men" (De Wolfe 2007a, pp. 121, 126). Once again, this was an "indication of the growing recognition of 'expert' testimony in nineteenth-century court cases" (De Wolfe 2007b, p. 43).

The true crime narratives inspired by the Caswell case reiterated the clinical details of her death and underscored the growing authority of physicians and legal investigators. One example, Reverend Mr. Miller's

Narrative of the Life of George Hamilton (1852), focuses on the fate of Mary Bean's fictionalized seducer, George, whose story bears little resemblance to that of William Long (De Wolfe 2007b, p. 71). In the opening scene of the cautionary tale, Bean's body is discovered in a city stream, thus reinforcing the connection between criminal abortion, urbanization, and the changing social landscape of nineteenth-century America. Immediately, police officers, the coroner, a team of physicians, and a jury of examiners are called to the crime scene where they inspect the corpse and its wounds. Following a trail of evidence, including gloves bearing the name "Frederick Hamilton" (George's brother), the authorities arrest not George, Mary's lover, but his sibling.

Mr. Oakley, a "reputable attorney," discovers that Frederick was framed by George in order to conceal his own role in the abortion-homicide, which was committed in collaboration with the irregular practitioner Dr. Savin (named after a herbal abortifacient). Haunted by guilt, the ghost of Mary Bean, and the fact that an innocent man will be executed, Savin feverishly confesses that George struck the fatal blow that killed Mary. After securing a pardon for Frederick from the governor, Bigelow and Oakley are able, through clever detective work and collaboration with the "powers of the law" (De Wolfe 2007b, p. 179), to have George arrested, tried, and convicted of murder. George, however, commits suicide in prison right before his execution, and Savin is "convicted of murder in the second degree, and sent to the state prison for life" (De Wolfe 2007b, p. 181). Thus, at least in the realm of fiction, Mary Bean (Caswell) is vicariously able to acquire the justice she was denied in life.

Unlocking the Mysterious Trunk

Criminal abortion narratives framed as mysteries involving corpses stuffed into trunks and/or submerged in bodies of water became popular in the post-Civil War period. Corpses in trunks, particularly if they were dismembered or mutilated, "had the effect of graphically prolonging the violence of the murder beyond death" (Halttunen 1998, p. 75), which undoubtedly boosted publishers' sales. However, the increasingly graphic nature and number of these narratives can also be linked to the completion of the state-by-state abortion criminalization campaign during the 1870s. Now that pregnancy termination (beyond therapeutic abortion) was illegal, policing criminal abortion was even more of a concern, and physicians became key figures in this process. This was reflected in abortion

narratives: by the 1870s, physicians were main characters in these works and not simply authorities who weaved in and out during trials.

During the last quarter of the nineteenth century, experts in medical jurisprudence emerged, specializing in the detection of criminal abortion and its presentation in court. Working alongside coroners, medical examiners, grand juries, and later forensic pathologists, these professionals, who were usually physicians, integrated the scientific method, with its irrefutable "facts" and exacting justice, into crime detection and what became criminology. These "men of science" "offered assurances that justice would be served and the social order preserved. The field's scientific practitioners would identify the unknown victim and determine the cause of death," in this case abortion-murder, and "the manner in which it occurred." "In the court of law, the full weight of scientific evidence would be brought to bear, ensuring conviction" (Johnson-McGrath 1995, pp. 439–440). This not only reaffirmed the social, cultural, and political power of regular, allopathic physicians—especially those specializing in medical jurisprudence—but also helped drive out any remaining lay and irregular competitors.

The scandalous "trunk mysteries" of the late nineteenth century emerged against this medicolegal backdrop. Perhaps the most shocking example occurred in New York in 1871, and involved Alice Augusta Bowlsby, "a pretty, young woman, with golden hair," who was found "naked, in [the] fetal position," wrapped in blankets, and "jammed into [a] trunk" bound for Chicago. A railroad porter, who noticed a foul odor emanating from the trunk, immediately notified the police and the "Great Trunk Mystery" was born (Wilhelm 2011a; Weingarten 2014, p. 21). The autopsy, which was performed at Bellevue Hospital by Dr. Cushman and supervised by Warden Brennan, revealed two critical pieces of information: that Bowlsby was probably placed into the trunk while still alive (her mouth was wide open as if gasping for air), and that she died of uterine inflammation from a botched abortion (Wilhelm 2011a; Sachar 2013). Eventually, authorities traced the trunk back to "Dr." Jacob Rosenzweig, a notorious abortionist who had no medical or scientific training (Weingarten 2014, pp. 21, 25).

Rosenzweig was arrested for murder, and in true horror-show fashion, the unidentified body, which was "deteriorating fast," was "put on public display in hopes that someone would identify the young woman. Hundreds of people, masking their noses with cloth saturated with carbolic acid to hide the smell, gawked at the body," and "most just came to view it out of morbid curiosity" (Wilhelm 2011a). Eventually, a physician from Paterson, New Jersey, Dr. Theodore G. Kinne, and a colleague,

dentist Joseph F. Parker, were able to identify Bowlsby as one of their patients by the "distinctive vaccination scar she had under her left elbow," "two fillings, an extracted tooth, a scar from an ulcerated tooth," and a large mole on the right side of her neck (Wilhelm 2011a). Rosenzweig was found guilty of second-degree murder; however, like James Hervey Smith, Rosenzweig was released from prison with time served (less than a year) due to a legal technicality. A "tragic" case on many levels—it involved the brutal death of a promising young woman and the suicide of Walter Conklin, the man who impregnated her, as well as the release of the abortionist—it inspired *The Trunk Tragedy: Or, The Late Mysterious Murder in New York of the Young and Lovely Miss Alice A. Bowlsby, of Patterson, N.J.* (1871).

The Trunk Tragedy, like many penny press "flash narratives," has no official author and was published by C.W. Alexander of Philadelphia as quickly as possible to capitalize on the public interest in Bowlsby's murder. It narrates the plot of "the tragedy" while emphasizing the role that detectives and physicians played in the gathering of evidence. Inspector Walling, who is assigned to the case becomes, after Bowlsby, the most significant character in the narrative. Through vigilance, resourcefulness, and meticulous organization, Walling locates the villainous Rosenzweig's house, where his team finds another trunk awaiting its next victim, bloody women's undergarments, and a desk full of incriminating documents: death certificates for "still-born" babies signed by Rosenzweig, newspaper advertisements for abortion services, and suspicious receipts, addresses, and letters. This evidence strengthens the case against Rosenzweig while presenting New York law enforcement as a picture of methodical competency.

The trial is likewise a showcase of scientific expertise, with Bowlsby's Patterson doctors supplying technical information about her medical history. Interestingly, *The Trunk Tragedy* also includes a list of resolutions concerning criminal abortion written by the New York Academy of Medicine (NYAM), which was established in 1847, the same year as the AMA, and is still one of the most prestigious medical organizations in the United States. Not only does NYAM commend the presiding judge, Gunning S. Bedford, for incarcerating notorious abortionists such as "Drs." Wolff and Lookup-Evans, but it also supports his call for the death penalty for illicit pregnancy termination and his "moral duty"—to bring "law to the lawless" and to destroy the "atmosphere of abortion" pervading the city. Furthermore, NYAM praises the efficiency of District

Attorney Garvin, emphasizes the role of medical jurisprudence in such cases, and requests that their resolutions be sent to the New York daily papers, thereby acknowledging the power of the press, and their own political and professional influence, in criminal abortion cases (p. 40).

Ultimately, Bowlsby became a "martyr" on the altar of criminal abortion, and her tragic ending a cautionary call to parents to monitor their children, especially those working in cities (Weingarten 2014, p. 31). The "Lynn Mystery Trunk" case reignited such discourses a few years later in 1879 when Jennie P. Clark was found in a trunk, with her hand protruding out of the top, floating down the Saugus River near Lynn, Massachusetts. Like Bowlsby, her body had been twisted to fit into the small enclosure, and she was scantily clad. However, her body was mutilated: in addition to the large abdominal wound caused by the abortion, her hair, nose, and upper lip had been cut off in an attempt to obscure her identity ("Mystery Trunk Murder, 1879," 2013). Even though "Madame" Caroline C. Goodrich and "Dr." Daniel F. Kimball were incarcerated for Clark's murder, an undeniable irony concerning illegal pregnancy termination began to emerge. Criminalizing abortion was meant to curtail pregnancy termination (with the exception of therapeutic abortion); yet, the practice continued in full force. As Caron (2008) notes, "Doctors surmised that two million procedures occurred annually. Admitting to these statistics must have been discomforting: they implied that the AMA campaign was not as successful as they had hoped. This sense of failure led some doctors to launch a second anti-abortion campaign in 1895" designed to reinforce the legal and social reforms made between the 1850s and 1870s (p. 42).

Although abortion was still flourishing as an illegal activity, the number of narratives declined sharply after the 1870s. There are two possible reasons for this: either "indecent" narratives were being suppressed or discouraged by medical and legal authorities, perhaps through the 1873 Comstock Act; or such formulaic narratives were no longer in demand. Arguably, the last notable criminal abortion narrative of the nineteenth century is *The Mysterious Murder of Pearl Bryan, Or, The Headless Horror* (1896), which sought to deter illegal pregnancy termination by illustrating how new scientific methods, techniques, and efficient law enforcement were making detection, arrest, and punishment inevitable. The "mystery" began in 1896 when Bryan's headless body was found in Fort Thomas, Kentucky, on the banks of the Ohio River (Wilhelm 2011b). Unlike other abortion-murder cases, the father of Bryan's child was never

confirmed, but was most likely either her second cousin William Wood, or Scott Jackson, a dental student. Each blamed the other for impregnating Bryan, but both agreed that she went to Cincinnati for an abortion, which was allegedly arranged by Alonzo Walling, Scott Jackson's roommate and fellow dental student. Neither Walling nor Jackson confessed, and the head was never found; yet, they were both convicted of Bryan's murder and sentenced to death—a very harsh punishment in 1896—on circumstantial evidence and false confessions. Proclaiming their innocence to the end, both men were hanged together on March 20, 1897 (Wilhelm 2011b).

Much like *The Trunk Tragedy* (1871), the authorless *The Mysterious Murder of Pearl Bryan*, originally published by Cincinnati's Barclay & Co., is a flash narrative that sensationalizes the horror surrounding the abortion-homicide. However, what distinguishes it is its focus on the "Bertillian [sic] Method" and how it guided the detective work and medical analysis that ultimately "solved" the case. In fact, the abortion itself is not the focal point of the narrative; science and the "clever" criminal investigators and physicians are the ultimate heroes. Immediately after the body is found, "the best detective talent" is "put to work" (p. 21), including the use of bloodhounds, the draining of a local reservoir to find the missing head, and the examination of footprints found at the scene. Jackson is arrested and processed through the "Bertillian [sic] System," a method of crime detection that was popular at the time because it applied scientific developments in the field of biometrics and anthropometry to police work. Developed by Alphonse Bertillon (1853–1914), the system organized, standardized, and systemized criminal investigation by rendering it measureable and therefore efficient, authoritative, and allegedly indisputable. Drawing on the eugenic pseudoscience of craniometry, it involved measuring suspects' skull size and shape and comparing them to the measurements of known criminals to determine "criminal disposition." It also included measuring and examining other body parts and markings (scars and tattoos), photography (mug shots and crime scene pictures), and assessing handwriting and personality traits. Data could then be codified and entered into a formula that yielded an individual result for each criminal (Houck 2009, pp. 31–36; Rafter 2009, pp. 221–228). Although this system was highly inaccurate due to human error and examiner prejudice, and was eventually superseded by fingerprinting and ballistic analysis (Newton 2008, pp. 6–10), it was used in

the United States at the turn of the twentieth century, and is deployed in the narrative to reinforce the authority of detectives and physicians.

As the narrative conveys, after Scott Jackson's arrest, he is turned over to Sergeant Kiffmeyer of the Cincinnati police force, who employs "the Bertillion [sic] system of measuring and identifying criminals." "Recognized as an authority on criminals," Kiffmeyer measures Jackson, for "every man's head tells its own story." In this case, Jackson's skull is "unusually long in proportion to its breadth. It is abnormally developed on the right side in front and on the left side in the rear of the head," which indicates that he "has the cunning to plot and plan, and to conceal." Moreover, Jackson's "fingers are disproportionately long to his height" and his portrait conveys that he is a "natural monster, or monstrosity." In other words, "Jackson has all the characteristics of a criminal by nature" (p. 27). Similarly, Alonzo "Walling's head is that of a commonplace criminal." "No appeal, not even the fear of punishment, will have any impression on Walling" (p. 31). Furthermore, their photographs fit perfectly in the "Rogues Gallery," which reaffirms their status as "criminal types" and secures their guilt.

Two post-mortem examinations, conducted and supervised by "men of science," further incriminate Jackson and Walling. As the narrative describes, Dr. Robert Carothers's thorough, hour-long autopsy reveals "a fetus of between four or five months' gestation." Bryan's stomach was then "taken out and turned over to Dr. W.H. Crane, of the Medical College of Ohio, in Cincinnati" who, after making "all the known tests for the various poisons that might have been administered," finds cocaine in her system (pp. 42–43, 88). The second autopsy also exposes startling evidence: "Pearl Bryan died by the knife and was conscious when she was killed"; "the cut on the left hand shows that she fought with her murderer." Moreover, "there was absolutely not a drop of blood in the body of the woman; all of it had flowed from her" (pp. 82–83). In the end, "facts" procured by "hard cold science" result in Jackson's and Walling's executions. Wood, on the other hand, escapes prosecution because as a young man of "good stock," with no trace of the "criminal type," he is never a serious suspect for the narrative's authorities.

The criminal abortion narratives discussed in this chapter were only one part of the much larger disciplinary structure that kept pregnancy termination illegal in the United States until 1973, when it was decriminalized by the *Roe v. Wade* Supreme Court decision. Although this decision declared abortion a constitutional right, it did not put the issue of preg-

nancy termination to rest. On the contrary, abortion remains a national obsession in the United States, especially among conservatives who, for over 40 years, have been working to reverse *Roe*. Consequently, it is not surprising that the deaths of Pearl Bryan, Berengera Caswell, and Mary Rogers continue to haunt American popular culture, inspiring novels, short stories, comic books, songs, poems, ballads, sensational retellings, and scholarly monographs as the most cursory Internet search reveals. In fact, one interesting work of fiction, Nancy and Todd Nielsen's *Eddy: The Trial of Edgar Allan Poe for the Murder of Mary Rogers* (2008), is even based on the premise that Poe murdered Mary Rogers for literary subject matter.

Clearly, because of their senseless deaths at the hands of a patriarchal, restrictive, and punitive system, these women gained a level of fame through death that they probably never would have achieved in life. Their tragedies have granted them immortality in the annals of history and have provided intimate windows into a world that, under normal circumstances, should have remained closed to outsiders. Unfortunately, Americans are still grappling with many of the ghosts raised by these narratives—the legality of abortion, the separation of reproduction from sexuality, the "immorality" and "danger" of premarital sex, the idea that a woman must choose marriage and motherhood over work, and that somehow it is divine justice if a woman suffers or dies because of her choice to terminate a pregnancy.

CHAPTER 4

"Impossible to Get to Know These Secret Means"—Colonial Anxiety and the Quest for Controlling Reproduction in "German East Africa"

Daniel Bendix

With the advent of reformist agendas after the turn of the twentieth century, and especially after the Maji Maji War, the German colonial administration in "German East Africa" became interested in questions of population and reproduction. The official German statistics of the number of offspring per family confirmed a "very low reproduction" rate and a "decline" in population for some areas (Medizinalreferat in Daressalam 1914, pp. 440–1), and commentators warned of an "Africa in danger of 'extinction'" (Deutsche Gesellschaft für Eingebornenschutz 1914a, p. 228).[1] Colonial historiography suggests that actual "population decline" probably never occurred in "German East Africa" and that the "depopulation" which the German colonizers claimed to have observed

[1] All translations of historical sources are my own.

D. Bendix (✉)
Department for Development and Postcolonial Studies, University of Kassel, Kassel, Germany

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_4

rather had to do with labor migration and people moving away from the colonial administration's sphere of influence (Koponen 1994). Nonetheless, colonial administrators, missionaries, physicians, and scientists cautioned against a "population decline," and East Africans[2] became considered to be a resource in need of "protection," "preservation," and "enhancement" (cf. Stoecker 1991).

At the heart of discussions on "population decline" in "German East Africa" were birth rates; infant and child mortality; and induced abortions and miscarriages (Der Professorenrat des Hamburgischen Kolonialinstituts 1913; Ittameier 1923; Medizinalreferat in Daressalam 1914). German colonizers held that the social position of women in East Africa, marital relations, customs, obstetric care, diseases, morals and values, and the labor system introduced by the Germans caused poor health and "population decline." While East African women were generally depicted as ignorant and oppressed in such discussions, the problematization of abortions and the issue of women consulting German health facilities for delivery point to German colonizers' anxiety regarding the agency of East African women. This chapter examines the (in)ability of German colonizers to control the realm of population and reproduction, highlights the operation and instability of colonial power in discourses and practices using the example of abortions and birthing during German colonialism, and discerns possible agency of East African women in these spheres.

Historical studies have alerted us to the fact that Western intervention into abortive, birthing, and child-rearing practices in the Global South began during colonial occupation (Hesselink 2011; Hunt 1999; Nestel 1998; Widmer 2008). Class-based policies in many European countries and in North America were mirrored by projects in the colonies (Jolly 1998). Experiences of motherhood, fertility control, birthing practices, and obstetric care in the colonies—just like healing and therapeutic practices in general (Langwick 2011)—were transformed by missionaries and colonial state policies in the name of "civilization" and "modernity" (Ram and Jolly 1998; Vaughan 1991).

Scholars of health and medicine have pointed out that colonial-era interventions were based on a hierarchical categorization of bodies, societies, systems of thought, and practices along the lines of colonial difference (Arnold 1988). Colonial government and missionary health interventions "played an important part in constructing 'the African' as an object of

[2] I refer to the African inhabitants of the territory that the German Empire had occupied and exploited in East Africa from the mid-1880s until approximately 1920 as "East Africans."

knowledge, and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power" (Vaughan 1991, p. 8). While a range of analogies to European gender and class hierarchies were expressed in health policies during colonial rule, so were "distinctive features of the colonial poetics of pollution" which meant that colonizers drew lines that "traced more explicitly than in Europe the boundaries of race" (Anderson 2000, p. 236).

This chapter builds upon these insights into policies on reproductive and midwifery practices, and explores interventions in abortive practices and obstetric care by German actors during the occupation of "German East Africa." Few studies address German colonial demographic and maternal and child health policies (Bruchhausen 2003; Colwell 2001; Deuser 2010). This chapter emphasizes East African women's agency and highlights how issues surrounding women's choice of birth locations and abortion are instructive for grasping the instability of colonial power in "German East Africa."

Colonial Power and Agency of the Colonized

A large number of studies on German colonialism focus on forms of power such as the use of force (Olusoga and Erichsen 2010; Zimmerer and Zeller 2008). This chapter, however, rather builds on insights into the intertwining of knowledge and power as highlighted in cultural studies' take on German colonialism (Ames et al. 2005; Conrad and Osterhammel 2004; Friedrichsmeyer et al. 1998; Walgenbach 2005; Zantop 1997). Power is thus understood in a Foucaultian sense to be a socio-historically distinct arrangement of discourses, conventionalized ways of acting, institutions, and political-economic circumstances (Foucault 1978, 1989). Such an analytical framework allows for taking into account the interrelationship of colonial discourses of difference and material dimensions of intervening into the lives of the colonized.

Colonialism was legitimized by establishing hierarchical "difference" between colonizers and colonized with regard to religion, biology, culture, stage of "development," and so on (Mbembe 2001; Mignolo 2000; Quijano 2000). Thus, German doctors who worked in "German East Africa," for example, referred to colonial interventions as "a bitter struggle between the darkness of the pagan being and the light of Christian insight and charity" (Feldmann 1923, pp. 141–2). Accordingly, European epistemology (scientific, technical rationality) and ways of economically, politi-

cally, and socially organizing society have been projected globally since the advent of colonialism (Hauck 2003; Mignolo 2000). In this manner, colonial power operates not only through the conviction that non-Western societies should follow the European model, but also through operationalizing these beliefs at a practical and intimate level. Focusing on the discourses and practices evident in German colonial publications, this chapter illustrates how colonial power operated in the case of interventions in reproduction and population in "German East Africa." However, colonial policies were never seamlessly applied, and the interventions of colonizers have always been questioned, negotiated, subverted, and contested (Bhabha 1994; Scott 1990). "[B]y singling out the gaps and anxieties in the operation of power" (Biccum 2002, p. 49), this chapter sheds light on the "agency and resistance" exercised by the colonized. Thus, the challenges made by East African women against the articulation of colonial power are an important means of understanding the instability of colonial power.

For the German colonial period, there are no written sources that document East African women's views on colonial health practices (Bruchhausen 2006, pp. 31–2). The only option is thus a critical reading of German colonial sources—scientific and government publications as well as archival sources of the colonial administration from ca. 1905 until the formal end of German colonial rule (1920)—in order to find out how East African women challenged colonial policies and practices. According to Ann Stoler (Stoler 2010), such official sources can be used to investigate the doubts and uncertainties of the colonizers. While some scholars of colonialism deny the possibility of retrieving "subaltern consciousness, voice, or agency … through colonial texts" because it ignores "the organization and representation of colonized subjects as a subordinate proposition within primary discourses" (Lalu cit. in Wainwright 2008, p. 16), this chapter suggests that German anxieties, revealed in colonial texts, can be used to make visible how East African women refused to comply with colonial desires. Before analyzing childbirth-related practices and abortions in "German East Africa," it is necessary to outline the historical circumstances in which these respective debates were situated.

German Colonialism, "Rational" Colonial Rule, and the Economization of African People

German colonialism "dates back at least to the fifteenth and sixteenth centuries, when thousands of Germans took part in the conquest and colonization of the 'New World'" (Friedrichsmeyer et al. 1998, p. 8). During

this large-scale "state-sponsored" formal colonization, which effectively lasted from the mid-1880s until approximately 1920, a total of 2,953,000 square kilometers in Africa and Asia was occupied by Germany, a geographical area five times greater than its national surface area (Kößler and Melber 2004; van Laak 2004). Scholars have pointed out that, despite its comparative shortness, German "state-sponsored colonialism" was not dramatically different from that of other colonizing nations, such as France and Great Britain (Smith 2011).

Opinions vary as to when "German East Africa" was effectively established and when it ended (cf. Colwell 2001). In the mid-1850s German Protestant and Catholic missionaries had already arrived. Later the private German East Africa Company (in 1884) and the German Empire (in 1890) occupied the territories which they then referred to as "German East Africa." It was not until 1904, through great brutality and ruthlessness, that the German Empire was able to fully bring the territory of East Africa and its people under control. However, German rule was again challenged in the Maji Maji War (1905–1907), in which approximately 300,000 Africans died (Boahen 1996; Koponen 1994). "German East Africa" constituted the largest German colony and served as a "plantation colony," facilitating economic exploitation via agricultural enterprises (Marx 2004, p. 83). German "settlers" (in contrast to administrators, entrepreneurs, and missionaries) played a relatively marginal role in "German East Africa," and were primarily confined to the area around the Kilimanjaro and the Usambara mountains (Marx 2004). In 1913, there were 882 German agricultural settlers in "German East Africa" out of more than 4000 Germans, including military personnel, traders, government officials, missionaries, nurses, doctors, and their families. The total white population of "German East Africa" was 5336 (Friedrichsmeyer et al. 1998).

Colonial historiography suggests that discussions regarding population decline were initiated by colonial administrations by the turn of the twentieth century in the context of colonial reforms toward "rationality" and "efficiency" (Grosse 2000; Widmer 2008). Recruiting workers for various colonial economic endeavors was a primary concern for the German colonial administration in "German East Africa" (Colwell 2001; Koponen 1994; Sunseri 2002). Thus, the issue of labor supply became a central policy concern and the "labor question" was hotly debated (Conrad 2004). Reformists regarded a "healthy, numerous native population [as] the prerequisite for an effective and continuous exploitation" (Deutsche Gesellschaft für Eingebornenschutz 1914b,

p. 3). With the introduction of wage labor, and measures to force people to take up such labor, East Africans were supposed to become "economic persons" who would enable the exploitation of the colony and who would also be able to purchase German products (Gann 1987). Even though German "settlers" were skeptical of reformist agendas and did not see the need to "care" for East Africans' health and social conditions, all German stakeholders in "German East Africa" were in agreement that a dependable labor supply was important to maintain the colony (Koponen 1994).

Given the need for labor, policies emerged which began to represent African inhabitants of the colony as "[t]he most important resource" (Dernburg 1907, p. 7). In line with the conceptualization of human beings as "biological capital" (Goldscheid cit. in Halling et al. 2005, p. 388, my translation), the "consumption of humans" or the "predatory exploitation" of "human material" in East Africa was bemoaned by German commentators (Löbner 1914, p. 269; Peiper 1920b, p. 435). Accordingly, German missionaries, physicians, and administrators showed great concern for East African practices of birth control, as well as for obstetric care and child rearing. This must be understood as part of a larger European project of discussing and intervening into the reproductive sphere of colonized people (Hesselink 2011; Hunt 1999; Vaughan 1991).

Childbirth-Related Practices

In order to control the sphere of reproduction, German doctors, missionaries, and the colonial administration began to take an interest in East African child and maternal health and to evaluate and assess practices of midwifery and infant care. Some childbirth-related practices were deemed functional by German physicians, missionaries, and administrators, others inappropriate, but most of all, they noted deficiencies in obstetric care. Commentaries such as the following by Otto Peiper, who was employed as a senior staff surgeon in Kilwa from 1908 to 1911, serve as evidence of such examinations and estimations of the knowledge and skills practiced by East African midwives:

> In cases of lateral or posterior positions, a correction is undertaken through hand pressure and massage; one also drinks a medicine in such cases … In case of premature bleeding during the pregnancy, one also applies dawa—medicine—internally, bed rest is also prescribed; in serious cases …, the

> mother dies unsalvageable due to exsanguinations, since they do not know internal interventions … In case of strong contractions, she [the midwife—author's note] massages the body with both hands, stroking from the chest towards the abdomen. In case of lateral positions, mother and child die unsalvageable; the people do not consider it possible to bring help in such cases. (Peiper 1910, pp. 461–2)

While this quotation indicates that the German doctor acknowledged certain practices such as massages and prescribing bed rest as useful, it also maintains that the East African midwives were unable to deal with serious complications.

German commentators regularly accentuated perceived deficiencies in obstetric care (Axenfeld 1913; Feldmann 1923; Ittameier 1923; Reichs-Kolonialamt 1913). Evaluations at times amounted to suggesting that there was a complete "lack of pregnancy and maternity protection" among East African people (Peiper 1920b, p. 19). Supposedly harmful standards of "hygiene" were also underlined by German agents (e.g., Peiper 1910). While some commentators referred to "native midwives" and thus acknowledged the existence of women who specialized in midwifery (Axenfeld 1913, p. 12), others stated that East Africans did not know of midwives "in our sense" or referred to "women assigned to the midwifery task," "elderly, experienced women" (Peiper 1910, p. 461), or "mothers-in-law" (Sister Nikola cit. in Walter 1992, p. 304), thereby casting doubt on their knowledge and skills.

In order to improve the situation of pregnant and delivering women and to transform obstetric care, the German colonial administration, physicians, missionaries, and colonial "reformist" lobby groups made numerous suggestions. These included increasing the number of German medical doctors and midwives, training East Africans in Western-style nursing and midwifery, building health facilities, and propagating Christianity in order to root out the influence of what they called "pagan mothers-in-law" (Feldmann 1923, p. 142). The call for an increase in "European trained sanitary personnel" entailed dispatching German physicians and nursing staff "in their thousands" and "training … nurses for the service of the native population, particularly in the area of midwifery and infant care" on the one hand, and qualifying East Africans as nurses and midwives while discouraging their existing practices on the other (Axenfeld 1913, pp. 128–9). Some commentators also considered the recruitment and training of those East African women who "stand out due to their ability and certain empirically acquired knowledge" (Feldmann 1923, p. 129).

Calls for transforming obstetrics and health care in "German East Africa" were matched with practical interventions. More government physicians and medical officers were in fact hired, mission societies sent midwives, and the training of "adequate native women as midwives" started just prior to the end of German occupation (Reichs-Kolonialamt 1914, p. 880; Feldmann 1923). Interventions also included behavioral advice for pregnant women via the dissemination of leaflets. The Medical Administration, for example, printed a leaflet with advice on how to raise children and what to do in cases of complications during pregnancy:

> To avoid miscarriages, the mother should already be careful during her pregnancy, should not carry heavy loads and should not hoe on the field extensively … If blood shows, she should lie down in bed until the blood is gone. If the child and mother are ill, they should immediately consult a European doctor for his advice, who will gladly tell them what to do. (Cit. in Peiper 1912, p. 259)

Ten thousand such leaflets were printed and distributed throughout "German East Africa" at the beginning of 1911 by the respective district administrations (Eckart 1997). Such interventions into childbirth-related matters may be understood as a part of a "comprehensive medicalization of the female part of the population" (Grosse 2000, p. 142, my translation).

There was a perception among German colonizers that East African women's "suspicion and timidity" (Ittameier 1923, p. 56) caused them to fail to consult German physicians and midwives; they would only do so in the "most dire" circumstances (Ittameier 1923, p. 50). German hospital statistics confirm the reluctance of East African women to attend German health facilities. In the Medical Reports on the German Potectorates of 1903/2004, 1909/2010, and 1911/2012, only 0.12 to 0.19% of the diagnoses issued by government physicians for African patients were for "female disorder and obstetrics" (cit. in Colwell 2001, p. 89). The influence of elderly women and the persistence of "customs" of giving birth at home served as explanations for non-attendance. Thus, the Imperial Governor of German East Africa believed that more "homes for women in child bed" were not necessary because the principal reason for not delivering in hospitals was allegedly that African women did not want to leave their homes and families at the moment of birth (Gouverneur von Deutsch-Ostafrika 1909).

Ann Colwell identifies the argument that East African women were too timid and too culture-bound to consult German health facilities as a particular construction of African womanhood which justified inaction by the German administration. The "trope of the timid tribeswoman" served to blame African women and their "culture" for not attending European health facilities, rather than the dearth or lack of facilities to accommodate women (Colwell 2001). This construction allegedly allowed the German administration to legitimize its reluctance to invest in curative health services for East Africans, especially for women. According to Colwell, East African women kept their distance from the colonizers' health care because German government facilities did not cater to women in their infrastructure (lack of wards and beds) and because of stories of women who had gone to deliver in the facilities and had died or lost their babies. This argument implies that women (or their families) would actually have wanted to attend the hospitals, had they been more efficient and accommodating. Colwell's reasoning is grounded in her assumption that East African women actually consulted mission health facilities to a larger extent than those of the colonial government because they were more accommodating to East African women.

However, I find no indication in Colwell's work or elsewhere which supports the theory that large numbers of women attended mission hospitals specifically for birthing. On the contrary, Bernita Walter's analysis of the mission archive of the Benedictine Sisters of South-East Tanzania (Walter 1992) and Walter Bruchhausen's study of health and medicine in Tanzania (Bruchhausen 2006) point to the fact that mission facilities had significant problems attracting East African women for pregnancy-related issues and delivery. For example, a German mission annalist from Kwiro wrote in 1911 that "[o]ur young women would have none of the help of the midwifery sisters. They rather stick to the desturi [customs—author's note] of their elders" (cit. in Walter 1992, pp. 312–3, my translation).

German missionaries put a lot of effort into drawing East African women to their facilities (Walter 1992), and were probably aware that "African 'midwives' … exercised a large degree of social and moral control which had to be broken if Christianity was to succeed" (Vaughan 1991, p. 66). The complexity of birthing practices and their embeddedness in societal and political life among many East African societies are well documented (Blystad 1999; Green 1999). It thus seems more plausible to assume that East African women did not consult German health facilities, be they missionary or governmental, because the whole process of birth-

ing was too important for the social and cultural reproduction of East African societies to be opened up to and controlled by German missionaries, doctors, and the colonial administration. In the light of the centrality of childbirth-related practices to political, social, and cultural life, one can assume that fundamental changes to this realm were much less acceptable to East Africans than making use of other preventive and curative Western medical treatments (cf. Bruchhausen 2006, p. 445).

Abortions

In times of public concerns about "population decline," increasing birth numbers and improving child rearing on the one hand and prohibiting birth control practices such as abortions on the other are commonly addressed conjointly. Accordingly, the German project of controlling the reproductive sphere of East Africans not only concentrated on changing maternity and infant care, but also entailed interventions in the realm of birth control. German missionaries, physicians, and administrators were thus committed to finding out about abortive practices. They identified the prevalence of abortions as a key factor contributing to "population decline." Several commentators lamented an alleged secrecy around abortions and abortive medicine, as well as the difficulty of finding out about and controlling this sphere (cf. Grosse 2000, pp. 139–40). Exemplary of this stance is the following statement by staff surgeon Hermann Feldmann: "Given the timidity that the natives have regarding the intrusion of European observation into their secretly kept customs, … the extent of the malpractice of abortion can hardly be ascertained" (Feldmann 1923, p. 110). Because of the reluctance of women to reveal abortive practices, it was seen as virtually "impossible to get to know these secret means" (Van der Burgt 1914, p. 721).

The explanations for a prevalence of abortions mirrored those for "population decline" more generally. German reformist administrators, physicians, and missionaries lamented the negative effects of colonization on the East African population, and held that the number of abortions had risen during the course of European intrusion due to material want, cultural transformation, and a break with "traditions" (Grosse 2000, p. 139). The increase in abortions was related to the German labor system and the influence of "sophisticated living conditions" of a "foreign and overwhelming culture," which was thought to have caused "proletarianization," a decline of subsistence agriculture, break-up of family ties, and an

increase in "adultery and polygamy" (Peiper 1920a, pp. 433–4). These views rearticulated the idea of the "extinction of the primitive peoples" that was formulated by liberal anthropology in the mid-nineteenth century (cf. Grosse 2000). East Africans were seen as living in "primitive," "natural" conditions which were disrupted by contact with a complex, flexible, moving German "modernity."

In addition to the idea that colonial occupation and exploitation caused abortions, German professionals also highlighted the moral problems they saw as inherent to East African societies. German observers said that "artificial abortions" were "not regarded as morally despicable anywhere" (Lion 1909, p. 414) and attributed the high number of abortions to "more or less loose morals," to a lack of order imposed on the sexual life of young people, as well as to societal pressure on girls who feared disgrace and punishment (Ittameier 1923, pp. 25, 29–30). German colonial physicians and administrators believed the practice of abortion reflected what they perceived to be the low social and economic position of women. German reformists highlighted the hard labor of women, male polygamy, abusive sexual relations of older men with young girls, and other alleged "customs" as reasons for women's low social position as harmful to their health and the cause of spontaneous and induced abortions (Peiper 1920b; Van der Burgt 1913). Pointing to repressive gender relations among colonized people was a common strategy employed by colonizing nations in order to establish racialized difference between colonizers and colonized and to legitimize colonial imposition into the intimate lives of African people (Oyèwùmí 2005; Spivak 2003).

Having determined a "population decline" in East Africa, German reformists sought to fight it "through all available hygienic, social and similar means" (Reichs-Kolonialamt 1914, p. 78). Research into the issue of "birth decline" and measures to counter it were encouraged. German colonizers showed great commitment to finding out about the prevalence of induced abortions, the means employed, and the biological and chemical composition of methods (Feldmann 1923, pp. 110–1). Carl Ittameier, for example, listed 26 different plants and trees that were used as abortifacients among the Wadshagga, in addition to manual and instrumental methods (Ittameier 1923, pp. 31–4).

Proposals to fight abortions ranged from strict regulation and control to those which sought to "civilize" or "modernize" East Africans through less explicitly forceful means. In the following quotation, colonial physician and scientist Ludwig Külz, who had led a demographic-medical

"expedition" to "German New-Guinea" for the Colonial Imperial Office in 1913 and 1914, suggests intervention through force: "[The increase of the birth rate through the containment of all harms—author's note] entails all measures for a protection of Negro mothers as such: […], particularly, however, intervention against abortions, which have become rampant in many places" (Külz 1913, p. 327). He referred to the German "tropical colonies" as a whole. German commentators were unanimously in favor of prosecuting those responsible for abortions (Feldmann 1923; Van der Burgt 1913). While anti-abortion laws were never codified, German administrators were expected to punish all individuals involved in order to guarantee colonial rule in the districts in "German East Africa" (Feldmann 1923, p. 110). Neither archives nor the academic literature indicates that such punishments actually took place in "German East Africa." However, the German staff surgeon Wolff noted that "now and then barks and small pieces of wood, which are allegedly used for abortive treatments, are taken away from native doctors" (cit. in Peiper 1920b, p. 18). This statement evidences that the German colonial administration de facto did persecute those East Africans who provided assistance with abortions.

In addition to legal or criminal prosecution, German policies tended to be designed to alter women's social positions in "German East Africa." A transformation of female (and male) roles was expected to improve the health of women, to yield higher birth rates, to allow women to better look after their children, and last but not least to curb the prevalence of abortions. Christianity was perceived as particularly useful for transforming relations between men and women. Mission physician Carl Ittameier expressed the all-embracing curative potential of proselytization:

> … conveying Christianity to the natives should bear fruit. It should manifest itself in the moral uplifting of the people. The woman should be uplifted from her low position, in which the man only appreciated her as workforce or effectively as a slave. She would become a companion to the man, who shares the work fairly with her. Attention and care of the children would become more thorough. Practically, the value of an influence through Christianity has to manifest itself in a decline of abortions or miscarriages, in reduced child mortality and an increase in births. (Ittameier 1923, p. 56)

To understand German colonial professionals' positions on abortions, it is necessary to recall that in Germany since the end of the nineteenth century, a decline in births and an increase in abortions among the

"lower classes" had become an issue of public debate (Knecht 1994; Rainer 2003; Sauerteig 2001). At the turn of the twentieth century, the state as well as most physicians in Germany were against abortions (Seidler 1993, p. 130). In contrast, many German women—even "educated, religious and domestically virtuous women" ones—did not consider resorting to abortions an injustice (cf. Dienel 1993, p. 143; Seidler 1993, p. 125). Disputes on abortions have always been part of gender struggles (Knecht 1994).

The third explanation for the occurrence of abortions among East African women put forward by the German colonizers connects to the mentioned stance on abortions among many German women. Accordingly, abortions were perceived as an "act of convenience" for married women in East Africa because pregnancy, giving birth, and child rearing all meant work (Ittameier 1923, p. 29; Medizinalreferat in Daressalam 1914, p. 441). Also, being pregnant would bar women from having sex: pregnancy and breastfeeding supposedly implied that women were not allowed to engage in sexual intercourse (Ittameier 1923, p. 29). The physician Otto Peiper also put forward that women thought they would "stay young and beautiful and desirable without children" and thus opted for not having children (Peiper 1910, p. 469). As mentioned earlier, East African women were commonly portrayed by the German colonizers as oppressed, as "more or less without rights" (Ittameier 1923, p. 25) and without agency. Yet, in the discussion on abortions, and especially in the argument that they resorted to abortive practices in their own sexual interest, they emerged as subjects who made their own reproductive, sexual, and health choices.

Conclusion

This chapter examined colonial narratives and policies regarding abortions and childbirth-related practices. It highlighted the centrality of controlling the sphere of reproduction to German colonization of East Africa after the turn of the twentieth century in light of concerns about "population decline." German commentators attributed the "population decline," on the one hand, to colonial intrusion and the subsequent transformation of people's living conditions and, on the other, to East African "customs" and "culture." These ideas were grounded in the racialized assumption that East African societies epitomized "primitive tradition" as opposed to a complex German "modernity." German physicians, missionaries, and

administrators assumed social relations between men and women as well as women's oppression to be causes of "population decline." These diagnoses served to justify comprehensive intervention by German administrators, physicians, and missionaries—first through forceful legal regulation, and second through social policies and transformation of belief systems. All in all, in "German East Africa" one can discern the attempt—however rudimentary in practice due to limited resources and the demise of German occupation during the First World War—to regulate or influence all aspects of the economic, social, cultural, and medical conditions of East Africans deemed influential to "population decline."

The narratives and practices regarding childbirth-related practices and abortions in "German East Africa" need to be understood in the context of the masculinization of obstetric care in Germany and disputes over the control of the female body, sexuality, and reproduction. The research into and attempted control of childbirth and abortions was grounded in the desire for patriarchal–colonial control over female knowledge and decision-making. However, this desire itself should be understood as inextricably bound up with the quest for establishing capitalist modes of production for which the rationalization of reproductivity and the expropriation of female reproductive labor were crucial (cf. Federici 2004). Similar attempts to delegitimize and criminalize female knowledge and practices in the sexual and reproductive sphere had taken place in Europe since the advent of capitalism in the fifteenth and sixteenth centuries (Federici 2004). Such attempts were most pronounced in times of (perceived) economic, political, and social crises; and German colonialism in Africa was in crisis immediately after the turn of the century. While German colonial narratives and practices show how East African women were turned into objects of patriarchal-bourgeois-capitalist-colonial population and reproductive health policy, this chapter illustrates that despite substantial efforts German actors were unable to gain access to the realm of abortive practices and obstetric care of East African women. The accounts by German colonial professionals prove that knowledge of obstetric care as well as abortive methods was firmly in the hands of East African women and their communities. In Europe, the control and repression of women's sexuality and the destruction of female reproductive knowledge and agency had been of paramount importance since the sixteenth century in order to ensure the capitalist appropriation of women's bodies as sources of labor (Federici 2004). The realization that East African women knew how to

control fertility and stuck to their ways of giving birth, and especially the view that East African women would resort to abortions in order to retain their sexual autonomy, must have been troubling for the German colonizers' quest for control. The chapter thus points to the challenges to colonial power and its instability during this period. Borrowing from Richard Dyer's elaborations, April Biccum describes colonial identity as characterized by the "trope of enterprise." This "comprises the characteristics of energy, will (control of self and others), ambition and the ability to 'see things through'" (Biccum 2002, p. 39). Discussions by Germans of women consulting German health facilities for delivery and the problematization of abortions reflect the colonizers' anxiety in the face of East African women's non-compliance with colonial desires. It was the implicit acknowledgment of agency of East African women that must have destabilized the colonizers' identity of having "enterprise," that is, to be able to gain access to all spheres of life of the colonized and to mold the world to their desires.

CHAPTER 5

A "Grievously Sinful Attempt to Destroy the Life Which God Has Given:" Abortion, Anglicanism, and Debates About Community Composition in Twentieth-Century Zanzibar

Andreana C. Prichard

On November 27, 1921, the priest who maintained the logbook at a small Anglican mission station on the East African island of Zanzibar noted that over the last two years no less than three African women in his small flock had taken *dawa* (Kiswahili: medicine) to induce abortions. Far from inciting outrage among the Mbweni congregants, the official lamented, "people seemed to think nothing of it" because "the sin was fairly common." And, though "nearly everyone" seemed to know about the abortions, administrators believed their African congregants lacked "the courage" to discuss the events with church officials. Mbweni church administrators were scandalized not just by the alleged pregnancies and abortions, but also by their congregants' machinations to keep them secret. Arguing that it was their "duty to try and show the people the extreme seriousness of

A.C. Prichard (✉)
Honors College, University of Oklahoma, Norman, OK, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_5

such things," the clergy imposed strict punishments on the congregants: they canceled all sermons, all work details, and all classes at the Mbweni station's schools indefinitely. Administrators even threatened to sell the property and to abandon the settlement altogether, leaving the small community of African Christians unmoored on the otherwise Muslim island.[1]

This chapter uses historical archives to explore how and why administrators at the Mbweni station of the Universities' Mission to Central Africa (UMCA) came to frame these alleged abortion attempts as "scandals," and to impose such harsh punishments. Further, records kept by mission administrators reveal that in this particular moment abortion became a fulcrum around which broader debates about social reproduction and community integrity on the station revolved. What can these local politics of abortion tell us about the congregants' and church administrators' competing ideas about the role of procreation and reproduction in community composition, and about the competing definitions of Anglicanism that circulated in early twentieth-century Zanzibar? Drawing on the insights of scholars of community composition in precolonial Africa and England, this chapter uses the events that culminated in what I will call the "1921 Mbweni Abortion Scandal" as a lens to better understand the role that issues of procreation and reproduction play in individuals' attempts to strategically compose communities. Research on precolonial Africa suggests that Africans often understood marriage and reproduction as fundamental to individuals' attempts to compose communities in a manner that would ensure collective prosperity and perpetuity. In many places, Africans were acutely aware of, and often sought to manipulate and contain, the biological and—perhaps more important—social power of procreation. Church officials often approached these questions from a very different perspective, however, one that privileged individual rights, the sanctity of the life of the newborn, and concern for population growth over what Africans believed was the very real potential for community harm posed by pregnancies improperly conceived.

Abortion in Africa

Although church officials assumed the instances of abortion in the early 1920s were an anomaly, scholarship suggests that abortion was just one within a repertoire of strategies from which precolonial Africans drew

[1] 27 November 1921, Mbweni Logbook CB1-8 (hereafter ML CB1-8), UMCA CB Series, Zanzibar National Archives.

when dealing with socially dangerous pregnancies. In many communities, people believed that only pregnancies conceived by bodies properly prepared for procreation were "legitimate." In some areas, initiation rituals prepared women and men for procreation; in other areas, marriage rituals and exchanges did this work. Well into the colonial period people living in East Africa believed that a being conceived before such rituals occurred was not a proper person. Rather, it was a "creature of ill-omen" that had the capacity to bring about misfortune in the form of drought, famine, or other disasters. The Meru, for example, believed that children were a link between themselves and their ancestors; ancestors cursed children conceived by improperly prepared women in order to express their anger at those involved (Thomas 2003).

Abortion—and when that failed, infanticide—was one of precolonial Africans' "most common remedies for curbing the destructive potential" of pregnancies illegitimately conceived, of dealing with "social relations gone awry," and of "amending mistakes and avoiding public scrutiny" (Stambach 2003). The Zigua, for example, believed that the circumstances under which a child was conceived, carried to term, or born could have disastrous effects on the health and perpetuity of the community (Beidelman 1967). Children conceived by uninitiated Ngulu girls were slain for these reasons, and among the Chagga of Tanzania uninitiated couples found to have conceived were taken to the forest and made to lie on top of one another before their bodies were pierced through with a stake (Beidelman 1967; Stambach 2003). A Chagga woman who put her household to shame by "growing" two children at once (i.e., conceiving before an older child weaned) may have been forced to drink the juices of certain herbs or to insert the midrib of a leaf into her body to terminate the pregnancy (Stambach 2003).

Today, East African women continue to employ abortifacients to deal with undesirable pregnancies. They procure *dawa* from local herbalists; they attempt to convince medical students-in-training to perform free or lower-cost abortions; they self-administer concoctions of strong black tea, soda bicarbonate, wood ashes in solution, high doses of chloroquine, a solution of the laundry detergent "Blue," aspirin, and/or antibiotics as abortifacients; and they attempt to induce abortions manually (Stambach 2003; Plummer et al. 2008). As people do elsewhere, Africans continue to employ abortion as a family-planning tool and as a way to negotiate socially tenuous situations. For example, women in the Chagga region of Tanzania often resort to abortion in order to remain in school. They do so, however, not solely because of the burden of raising a child or

the challenges that it poses to their ability to continue their educations, but because they are seen to have deviated from expected processes of social development. Women also seek abortions—and make decisions about their partner's involvement in the procedure—based on an idealized future relationship with the father. By helping to procure and fund an abortion, men assert their intentions for a future relationship with the woman, and declare a stake in her reproductive future (Stambach 2003; Plummer et al. 2008).

Ethnographies and other scholarship about communities from whence Mbweni congregants hailed suggest that abortion was, and in fact remains, a socially acceptable option for dealing with extramarital and other "illegitimate" pregnancies, events that were often profoundly disgraceful or socially devastating.[2] In many communities, abortion was seen as a "necessary action taken to avoid social ostracism" and, in some cases, death (Stambach 2003). The nature of and rationale for East Africans' widespread use of abortion suggests that the social health and integrity of the community—the public good, as it were—often superseded that of a single individual.

Historical Setting

Zanzibar had for centuries been the nexus of the Indian Ocean luxury trade, a trade which included ivory, rhino horn, tortoise shell, coconut oil, cloth, and, most significantly in the nineteenth century, slaves. The UMCA's British missionaries chose the island as the headquarters for their work in east and central Africa for several reasons, not least of which was the direct access it provided to the spoils of the British Navy's campaign against slave trading in the region. Indeed, though Britain abolished the slave trade in 1807, it took over a century for the trade in East Africa to die down completely. The continued existence of the trade was a situation Western abolitionists felt compelled to address as an imminent humanitarian crisis.[3]

[2] For the Akamba see Hobley 1910; for Ngulu see Beidelman 1967; among the Usambara, Upare, and neighbors see Dundas 1921; Dale 1896; for the Nyamwezi see Dundas 1921; Rockel 2000; Raum 1965; Decle 1898; Abrahams 1967; for examples from the southern regions see Angus 1898; for East Africa more generally see Thomas 2003, 2006.

[3] For more on this, see Cooper 1980; Feierman 1995; Glassman 1995.

Members of a revival movement within the Church of England took up this challenge, founding the UMCA in 1861 to minister to slavers and the enslaved alike. The reformers were Tractarians, so-called for their adherence to the values laid out in a series of epistles published between 1833 and 1841 under the title *Tracts for the Times*. Tractarianism was an extension of a movement that first gained footing at Oxford College in the 1820s, when many of the University's High Church Anglicans began to express discontent at the state of religion in England. Reformers proposed a theological and spiritual return to the ancient, undivided Catholic Church (Faught 2003; Nockles 1994). Their reforms were inherently missiological, and they sought opportunities to recreate the church abroad. Africa, a place described by David Livingstone and other contemporary missionary explorers as exotic, pagan, and deadly, and debased by slavery, Islam, and a host of other troubling social ills, seemed to cry out for redemption. Africa's presumed plight inspired some among the Tractarians to found a mission for central Africa. By the 1920s, the UMCA had mission stations throughout the mainland of what is today Tanzania and Malawi.

Although the individuals who lived on the Mbweni *shamba* in the early 1920s were all congregants in the UMCA's church, their cultural and personal backgrounds varied. Missionaries initially opened the *shamba* in 1871 to shelter freed slaves. This group included children orphaned by the slave trade and adults who were legally emancipated, who were "rescued" by British abolitionists, or who ran away from their masters to seek succor with the mission. The trade that produced these slaves reached far into the interior of the continent, and the UMCA's adherents thus hailed from ethnolinguistic communities throughout eastern and central Africa. Once incorporated into the mission, many among its first generations of adherents attended the primary or industrial schools on the *shamba* before taking up farming or domestic service, pursuing teaching careers, or evangelizing on the mainland. By the 1920s, the *shamba* was a mix of individuals who British officials had removed from a life of enslavement or other relationships of dependence; who had been recently kidnapped, trafficked, or sold and who were bound for enslavement; who were first-generation Christians; and whose parents and/or grandparents were long-time mission adherents.

As is the case with any Christian community, the definition of "Christianity" among the *shamba* congregation also varied widely. Missionaries often distinguished between "true Christians" and those seemingly less faithful practitioners who retained "traditional," "pagan," or

"heathen" beliefs. The scholarly literature on the evangelical encounter in Africa and elsewhere, however, suggests that Africans filtered Christianity unevenly through their own idioms, languages, epistemologies, and cultures, adopting and adapting what they understood missionaries to be offering to their own ends. The "1921 Mbweni Abortion Scandal" affirms that Africans who considered themselves to be Christians continued to employ practices missionaries considered neither Christian nor religious without "necessarily seeing them as representing a competing discourse," and without any sense of contradiction (Landau 1999). The cultural diversity of the station and the relative degree of exposure and attachment on the part of individual congregants to a particular cultural heritage meant that congregants had a complex repertoire of beliefs and practices from which to draw when negotiating their place in the community.

Although membership in a mission community was an important part of the identity of Christians throughout the continent, it was especially so for adherents living on the UMCA's Zanzibar stations. In many situations, a mission's first "converts" were marginal members of their communities seeking new patrons, ideas, and status in social hierarchies. The first UMCA adherents were not much different in that they were orphans, freed slaves, runaways, and others defined by their inability to depend on either a lineage for protection or a corporate kin group for its attendant rights and privileges. This isolation was exacerbated in Zanzibar, where Christians lived in close proximity to former masters. Western missionaries and church elders stepped in and attempted to play the role of patron, elder, and parent simultaneously (and with varying degrees of success). Even several generations later, after congregants formed nuclear families and started lineages of their own, the UMCA's African congregants remained marginal to contemporary Zanzibari society because they boasted few local ties and could generally only lay claim to other congregants. They thus relied nearly entirely on their church patrons—and on their good standing within the mission—for food, clothing, shelter, land, spiritual fulfillment, and social status.[4] Thus, by its very nature, the "1921 Mbweni Abortion Scandal" was a moment that exposed long-standing debates over issues fundamental to community composition and identity.

[4] The relationship of patronage and dependency between formerly enslaved UMCA's congregants and the Mbweni church administrators very closely resembled relationships with former masters. For more on the "slaves of the Christians," see Glassman 1995.

The "1921 Mbweni Abortion Scandal"

In late August 1919, a young African mother named Olive "Lulu" Feruzi began to miscarry a pregnancy that, if carried to term, would have given her a second child.[5] Family members took Lulu to the hospital in Zanzibar's Stone Town, where she presented with "great pain."[6] At the time of the miscarriage, church authorities knew Lulu well from several events that occurred in the months leading up to her hospitalization. The first concerned the woman's young son. On 21st May, Lulu apparently "threw her baby down in a fit of temper." This was the "second or third time something of the sort" had happened, leading officials to believe that Lulu was "weak minded" and could not "be trusted with a male child." The priest-in-charge of the Mbweni station ordered the boy removed from the home to be raised by Mary Juma, the child's godmother. On 16th July Lulu then caused even more trouble for herself by running away from home for several days after a quarrel with her husband. Church officials were troubled by this pattern of behavior and lamented that "she has very little brains and it is impossible to do much with her."[7]

Lulu's behavior did not concern church officials for long, however. Just five days after arriving at hospital Lulu was dead. Suspicion clouded the circumstances of Lulu's death even before she was buried. The priest-in-charge reported that he and others close to Lulu suspected that some sort of *dawa* had played a role in her death. Appended to the final sentence of the entry in parentheses were the words "*kuharibu mimba*" (Kiswahili: destroy the pregnancy). The notation was a suggestion in the written equivalent of hushed tones that Lulu or someone near her had attempted to abort the pregnancy.[8]

[5] I have used pseudonyms throughout and changed immediately identifying details.

[6] 30 July 1919, ML CB1-8.

[7] 12 April 1919, ML CB1-8.

[8] 4 August 1919, ML CB1-8. Scholars have observed that missionaries' compulsive need to keep records was a method of gaining control over adherents' conduct. While Africans often played into Europeans' archetypes by signing their names to registers, confessing sins, and accepting reform, they also used the books to reframe arguments to their own advantage (Peterson 2006). At other times, they jettisoned this theater altogether in order to keep private affairs out of the hands of the church. Such moments appear in records as "cover-ups" or "complicity," revealing by their very presence the distinction missionaries drew between epistemologies that "shock and scandalize" and those that do not (Peterson 2006; White 2000).

Officials made no further comment about Lulu's fate until two and a half years later, when in November 1921 the priest-in-charge at Mbweni named Lulu in a group of *shamba* women suspected by their neighbors to have attempted to induce miscarriage. An anonymous letter tipped administrators off to these alleged transgressions. Though he was not certain, the priest-in-charge claimed he had "a lot of reasons for believing" that one Vera Tano had written the letter.[9] Such a claim was indeed plausible as several months earlier Vera, a student in the industrial arts program at the Mbweni Girls' School, had sought out administrators at Mbweni to confess she had "sinned with Denys Thackeray and was with child." Confession was brave given the consequences: Vera was "severely punished by her foster mother," summarily fired from her job with the mission, and "forced to sit in the back of the church" during services.[10] Equally bold was Vera's lover, Denys, who admitted his sins to the priest and declared his intentions to marry Vera. The priest eventually consented, and even helped Denys secure *mahari* (Kiswahili: brideprice).[11] Despite his forthrightness, however, Denys was punished with a beating.

The note the priest received five months after Vera's and Denys' confessions claimed Etheldrea Mabruki, an Mbweni congregant and age-mate of Vera's, had a "*mimba* (Kiswahili: pregnancy) by Samwil Musa but … the *mimba* had been destroyed."[12] Perhaps Vera wrote the letter with the very same sense of Christian virtue that initially drove her to confess her and Denys' own transgressions. Or maybe it was jealousy that Etheldrea might escape punishment for the same sins for which Vera had been punished. Regardless of who filed these strategic moral accusations, it is clear that the letter-writer intended to raise the alarm on behavior he or she found reprehensible.

Equally alarmed by the accusations, the priest-in-charge recruited a female teacher from the girls' school to visit Etheldrea's mother. Initially Grace "absolutely denied the whole thing," but eventually admitted that she suspected her daughter had not menstruated for at least two months. This, coupled with the "strong rumors" that her daughter "had sinned," caused her to grow suspicious. She arranged for a fellow congregant and *mkunga* (Kiswhaili: midwife) to examine Etheldrea. Despite the wide-

[9] 23 November 1921, ML CB1-8.
[10] 4 June 1921, ML CB1-8.
[11] 13 June 1921, ML CB1-8.
[12] 23 November 1921, ML CB1-8.

spread suspicion about Etheldrea's condition, Mama Mwajuma reported that nothing in her examination suggested that the girl was or had been pregnant. Unconvinced, the priest-in-charge took Etheldrea to town to be examined by the mission's own British nurses. Miss Winter and Miss Edwards determined "undoubtedly" that Etheldrea was "ruined" and that "recently she has been pregnant but is no longer now."[13] Etheldrea and Samwil nevertheless continued to deny the affair, the pregnancy, and the alleged abortion.

A lack of evidence might have stalled the investigation and compelled church officials to drop the matter, just as they appear to have done in the case of Olive "Lulu" Feruzi earlier. However, Vera's alleged link to the matter was but one of several troubling factors prompting administrators to expand their investigation. Especially difficult for church officials to overlook was the fact that at the time of her alleged affair with Samwil, Etheldrea was engaged to another man. Fellow congregant Godson Mwaimu had asked for Etheldrea's hand two years earlier but the pair delayed their marriage at the behest of her father, who cited her young age as the chief reason to wait.[14] Perhaps even more troubling to administrators was the rumor that it was Godson, Etheldrea's fiancé, who forced Samwil, Etheldrea's lover, to give her the abortifacient.[15] This was in fact highly plausible because among East African communities, it was often the lover or boyfriend who was responsible for securing the abortion (Thomas 2003).

Although the priest was sure the accusations brought against Etheldrea were "quite untrue," the suggestions themselves would have been enough for Samwil's family to call off the wedding, and for church officials to expel Etheldrea from school, kick her off the *shamba*, and excommunicate her. With such high stakes the priests-in-charge launched an investigation. Present at the public *baraza* (Kiswahili: community meeting) were Etheldrea's mother Grace, Etheldrea's grandmother *Bibi* Helen, *Bibi* Helen's friend and neighbor Fatima *binti* Ali, the *mkunga* Mama Mwajuma, Etheldrea's fiancé Godson Mwaimu, an African teacher named *Mwalimu* Evalyna, and the African priest-in-charge or "Padre." It is not clear whether Etheldrea herself attended, but she was sure to have known something about the gathering. The records of the *baraza* are scant, but the extant sources suggest that gossip and hearsay predominated.

[13] 24 November 1921, ML CB1-8.
[14] 27 June 1919, ML CB1-8.
[15] 25 November 1921, ML CB1-8.

For example, it appears that Etheldrea's grandmother first heard about Etheldrea's pregnancy from her friend Fatima *binti* Ali, who had heard the news from her husband, who had in turn heard from a neighbor. About the extended he-said-she-said, the priest-in-charge quipped that it was all "quite useless." Eventually, however, the attendees managed to reach a consensus: they conceded that although Etheldrea "probably … had *mimba*", they were absolutely certain that she had not "*haribu*ed the *mimba*."[16]

Attendees offered two pieces of evidence to support the argument that Etheldrea had not had an abortion. First, Etheldrea had not been ill prior to her suspected miscarriage. Attendees argued that both Olive "Lulu" Feruzi and another young *shamba* woman named Rebekah Hamisi had "taken *dawa*" to end pregnancies and grew severely ill before their deaths. (Until this *baraza*, church officials could only guess that these women had taken abortifacients; similar *mabaraza* after each case failed to illicit any incriminating evidence.) Second, the attendees argued, Etheldrea's *mimba* was "only 2 or 3 months" along, an inherently tenuous gestational age. Regardless, her supporters agreed, to intentionally destroy a pregnancy would have been "quite a sinfully [*sic.*] matter."[17] Whether they actually believed it, by decrying abortion as a sin the attendees made a public declaration in support of the missionaries' view of the matter.

The participants in the *baraza* were sure to know that the missionaries found pre and extramarital sex, pre and extramarital pregnancies, and abortion above all to be sins. Indeed, they may well have heard the missionaries articulate well-formulated theological justifications to this effect. In early twentieth-century Britain, abortion was perceived as a working-class phenomenon. To many officials, abortion was by its very nature a rejection of women's traditional role of child bearing, and antithetical to civilization because of the threat it posed to the hierarchical family structure. Many medical professionals and clerics labeled abortion a "grievously sinful attempt to destroy the life which God has given, from which the conscience of every woman ought to turn away in horror," and a "hideous excrescence of civilization." According to one British Anglican bishop, women who performed or procured abortions had "instincts worse than savages" (Knight 1977). While by 1900 the crime of abortion was largely "looked on in fashionable circles as no crime at all" and many mothers

[16] 25 November 1921, ML CB1-8.
[17] 25 November 1921, ML CB1-8.

seemed "not to understand that self-induced abortion was illegal," the Anglican Communion continued to argue well into the 1930s against birth control of any kind (Drife 2010; McLaren 1977). It wasn't until the 1930 Lambeth Conference that bishops relented in their view that procreation was the primary purpose of "sexual union" in marriage to give but "grudging authorization to the practice of birth control in marriage, under the dictates of the individual conscience and medical supervision" (Hauck 2003). Colonial officials were equally opposed to abortion, but for very different reasons. Rather than making a sanctity-of-life argument, the colonial state argued that abortion obstructed reproduction and population growth. In Kenya, for example, colonists argued that abortion confounded one of their chief responsibilities, which was "ensuring a steady supply of labor for settler farms and public-works projects" (Thomas 2003).

The congregants were well aware that church administrators did not want "savages" for mothers of this Christian community, and were savvy enough to use this knowledge to advance their argument of Etheldrea's innocence. By arguing the case on the missionaries' own terms, the congregants illustrated their willingness to participate in the missionaries' moral community and reaffirmed to the administrators the role of Christianity in their lives. While the *baraza* and the anonymous letter revealed the extent of abortion at Mbweni, the growing scandal also revealed the competing moral registers at play among various constituencies on the *shamba*. To be sure, what we know of East African communities in this period suggests that abortion and "premarital" pregnancy were not unusual. Congregants were keenly aware that church officials would see these events differently, and sought to hide these transgressions from administrators. The *baraza* revealed to administrators, seemingly for the first time, that congregants had conspired to conceal several "premarital" pregnancies and abortion attempts from them.

Congregants' conspiracy to conceal these transgressions did not sit well with church officials. The African Padre confronted the adults at the end of mass the next Sunday about "the case." He told congregants that if the "facts as stated were true," a grave sin had been committed. The priest was explicit in his condemnation, calling the sinners out by name: their investigations purportedly revealed that Etheldrea, Lulu, and Rebekah had "taken *dawa*." Worse was the administrators' discovery that these sins were "fairly common." Not only did people seem "to think nothing of it," but "nearly everyone on the *shamba* had talked about it" while

lacking "the courage" to stop the abortions themselves or to discuss them with church officials. On the other hand, if someone had falsely accused Etheldrea, Denys, Samwil, and Etheldrea's family of plotting the abortion, this was also "an unutterabl[e] … sin." Either way, the transgressions implicated the entire community, and the entire community would be punished. Due to the "extreme seriousness" of these matters, the Padre declared that "until further notice, there would be no more sermons in church, no more work and no more school."[18]

The rationale behind the Padre's temporary sanctions was likely twofold. First, Tractarian philosophy indicated that learning and the observance of sacraments were the cornerstones of Christianity. Tractarians idealized ceremonial practice and strict observance of fasts and festivals as not only fundamental to proper worship but as central to Christian identity (Nockles 1994). According to one UMCA bishop, access to the sacraments was central to the "high privilege it is to be a Christian;" it was a priest's job to "keep prominently before the people … what a calamity it is if, through their willful sins, they should be cut off from sharing in the blessings of community of the Church. To forbid a man to receive the Holy Eucharist is the greatest penalty we can give." Thus, in such cases of "open defiance of any plain law of Christian living," the sinner would face temporary or permanent excommunication.[19] Second, the Padre recognized that as descendants of freed slaves and immigrants to the island, Mbweni Christians did not have kin or other ties of obligation on Zanzibar on which they could draw in times of need. Without the ability to identify as Christians, and without access to the practices and institutions that gave congregants both social legitimacy and economic stability, the congregants were left with few prospects.

In response to the church administrators' threats the congregants called a community-wide *baraza* for the following Sunday. They elected a spokesman, *Fundi* (Kiswahili: skilled tradesman) Mathew, to represent them to the administration. The *fundi*'s case revolved around a very different concept of authority and community responsibility than the one church officials held. *Fundi* Mathew explained that although church officials claimed the entire community had long known about the case, in truth only some congregants knew. According to the *fundi*, most of the

[18] 27 November 1921, ML CB1-8.

[19] Anonymous, "Conference at Likoma: The Bishop's Address." Central Africa (1899).

shamba residents knew nothing and could not have participated in a cover-up. To *Fundi* Mathew and the congregants he represented, it seemed the administration was punishing the entire community for "the sins of one family."[20] While all agreed a sin had been committed, not all agreed that congregants outside of Etheldrea's family should be held responsible. In their minds, Etheldrea's lineage was the appropriate jural unit to stand punishment for her sins, not the entire community.

The congregants' lineage-based version of Christian authority stands in marked contrast to the version of authority in which church officials believed. According to officials' theological interpretation, the relationship between an individual and her Christian community was inextricable—a sin by an individual was a sin by the whole community. UMCA missionaries tended to believe in God's capacity to act through nations and in collective judgment on erring communities. In this, the UMCA's founders were in line with earlier iterations of the Protestant missionary ethic, a strand that was more classically millenarian. They believed in God's ability to single out nations for particular roles in the unfolding of the divine plan. (Conversely, of course, nations could also stand apart for chastening; Elbourne 2002.) If members of the community knew about Etheldrea's transgressions and did nothing, administrators argued, all members of the community were guilty.

At church the following Sunday, the Padre expressed the administrators' consternation through a lesson on Isaiah 1.[21] The Book of Isaiah recounts the story of the rebirth of Zion through the return of God's chosen people. It is ultimately a redemptive story of a Church that rises from its trials "cleansed, glorified, and blissful." What congregants heard that Sunday were not stories about a church renewed, however, but rather tales of a church laid waste by hypocrisy and sin (Spence-Jones 1890; Orelli 1889; Barnes 1866). Known as "The Great Arraignment," the opening chapter of Isaiah describes God's damning condemnation for the sins of His chosen people:

> I have nourished and brought up children, and they have rebelled against me. … Ah, sinful nation, a people laden with iniquity, a seed of evildoers, children that are corrupters: they have forsaken the Lord, they have pro-

[20] 6 December 1921, ML CB1-8.
[21] 6 December 1921, ML CB1-8.

> voked the Holy One of Israel unto anger, they are gone away backward. (*King James Bible*, Isaiah 1:4)

Here Isaiah, and by proxy the Mbweni church officials, laments the "apostasy, ingratitude, and deep depravity" of the chosen people of God (Barnes 1866). According to Isaiah, most damning among their sins was that the Jews "kept up the appearance of religion" while their "services of God [remained] so false and hollow." In short, they were deeply hypocritical. Isaiah urges his sinful nation to "turn from their sins, and to seek God" anew. Should they fail to repent, he warns, "heavier judgments should come upon them than they had yet experienced." According to contemporary British theologians, the effect of an individual's sins on the collective could be compared to the effect of a wound on the body. The Jews' sins were "a swelling, or tumefying wound, or plague," so pervasive that the whole body becomes "one continued bruise, and there remains no sound part to be stricken" (Barnes 1866). The Padre explained that it is not enough that an *individual* is simply a good Christian for "the church [is] the body of Christ, if one suffered, all suffered."[22] The parallels between themselves and the Israelites were doubtless not lost on the congregants, for UMCA officials frequently referenced Isaiah (albeit the more inspiring lessons) when speaking to and of their own chosen people.

The "1921 Mbweni Abortion Scandal" reveals important disparities in ideals regarding the relationship of the individual to the community. Mbweni's churchmen, for example, valued the autonomy and integrity of the individual as the salient unit of a community. Among congregants, however, dependence and obligation were not as straightforward: allegiance to extended networks of kin and lineage competed with allegiance to the church community. An Mbweni congregant was not autonomous in the way church administrators imagined her to be. Rather, she was bound by obligations to networks of kin, and embedded in complex political relationships that included mothers, fathers, brothers, uncles, extended family, neighbors, and former and current patrons (Peterson 2006). These cultural differences and their influence on constituents' ideas about and choices regarding abortion are a large part of what made the events of 1919–1921 so scandalous.

[22] 6 December 1921, ML CB1-8.

Social Context of the Scandal

We saw earlier that in the communities from which Mbweni congregants hailed, inauspicious children were often aborted or killed immediately after birth in a bid to preserve the health and integrity of the community. In the context of Mbweni and other twentieth-century Christian communities, however, it is easy to imagine that abortion would have replaced infanticide in cases of an undesirable pregnancy. It is unlikely that church officials or other congregants would have failed to notice a full-term pregnancy. A pregnancy that failed to produce an infant, and the death of any infant, would have prompted administrators to investigate. Abortion thus likely became a preferred strategy in dealing with socially threatening pregnancies, used in order to escape the judgment of church officials and other community members.

Etheldrea's pregnancy was sure to raise a few eyebrows among congregants and administrators. While church administrators would not have been pleased, African congregants would not necessarily have been offended by a "premarital" pregnancy fathered by a fiancé with whom the family had already begun marriage negotiations. As scholars of precolonial Africa argue, strategic compositional processes and deliberate coalition building—such as marriage—constituted the heart of many precolonial Africans' attempts to develop communities. The transfer of rights-in-people and other forms of wealth between lineages, communities, or other social units through marriage was a widely recognized means of tapping new social networks, of securing access to new resources, and of complementing an individual's or a community's particular capacities or knowledge. It was also fundamental to individuals' attempts to compose communities in a manner that would ensure collective prosperity and perpetuity. Marriage was thus a widely relied upon tool for strategic community composition. Among many of the mainland African communities represented at Mbweni, the processes that prepared individuals for marriage and the exchanges that cemented their unions often stretched over months and years. Ethnographies of such communities indicate that marriage was "invariably preceded by a period of betrothal, which may commence in early childhood. Among certain tribes it occurs that betrothal is concluded by agreement between parents even before the bethrothed are born" (Dundas 1921). The general practices surrounding the transfer of bridewealth were inconsistent across communities, except in that the payments were usually made in installments over a

series of months or years.[23] Marriage was thus a lengthy process, one that was constituted by the fulfillment of a continuous series of events over the course of months or years. In many precolonial East African communities, families contracted marriage agreements even before girls underwent initiation, signaling the existence of a sometimes lengthy gap between betrothal and the commencement of cohabitation or procreation (Beidelman 1967). Thus, months and years often intervened (and sometimes still do) between the initial negotiations and cohabitation, childbirth, or the fulfillment of all marriage obligations. During this time, potential partners and their families often engaged in what Caroline Bledsoe has called "conjugal testing," a process in which partners and families work "cautiously toward more stable unions" (Bledsoe 2002).

This gradual evolution of marriage created space in which young "engaged" women could—and often did, as Etheldrea's situation attests—test out relationships with multiple partners. To be sure, even as a process "marriage transactions do not constitute a clear linear sequence." Marriage ceremonies, exchanges, and events did not necessarily follow a predictable or consistent chronology, and it was possible for couples to move closer to and further away from a solidified marriage union depending on a variety of outside events. Thus, it would not have been uncommon for bridewealth disputes or charges of adultery to occur during this time, as they did in Etheldrea's case. Indeed, in Etheldrea's case, the real problem lay in the fact that she was pregnant with her lover's child, *not* with a child of her fiancé. A pregnancy with the "wrong" man jeopardized more than just Etheldrea's relationship with her fiancé Godson.

Conclusion

Rather than suffer the potential consequences of an extra-engagement pregnancy, it is likely Etheldrea's family turned to abortion as a time-tested means of dealing with pregnancies that threatened the family, their extended social ties, or the community at large. This move had the potential to preserve the social health of the Mbweni community by smoothing immediate tensions between Etheldrea's and Godson's families. Further,

[23] For the Yao and others from around Lake Nyasa, betrothals were protracted over a period of at least six months, if not longer. Among the Akamba around 1900, grooms paid bridewealth in installments, and the marriage was formally contracted at a point along the payment cycle. For the Sukuma see Cory 1953; for the Kware, Kargur, Zigua, and Luguru, see Beidelman 1967; for the Agoni and "Sutu" in Southern Tanzania, see Moser 1987.

knowing the decisive consequences of extramarital pregnancies and abortions, concealing abortion attempts was an expedient way to ensure the future of their small and tenuous community.

In this sense, it is possible to see abortion as one of the many inherited practices that Africans put to new uses during the colonial period. Abortion had long been a tool Africans used when negotiating community composition and coalition building, but during the colonial period Africans began to apply this tool to the work of building and strengthening entirely new types of communities. Rather than maintaining the health of villages or chiefdoms and negotiating relationships between lineages, across ridges, or between neighboring communities, Africans now began to turn their attentions toward building and cementing relationships with missionaries and colonial authorities, and toward embedding themselves more firmly in new status networks and modes of authority. Mission communities, with their emphasis on reading, Western education, and technological and skills-based training, provided one such avenue for individuals seeking to capitalize on the new opportunities the colonial era offered. In the Mbweni community, and indeed in Christian communities throughout the continent, Africans were thus attempting to reconcile longer-standing traditions and ideals with missionaries' expectations and beliefs in order to become more firmly embedded within the new communities and within emerging status hierarchies. Enterprising Africans did this in many ways, not all of which were visible to authorities. As Derek Peterson has argued for African Christians in this period, enacting these dramas "off-stage" was one such way congregants publically reconciled inherited discourses and practices with the demands of the locally specific core of the missionary message (Peterson 2006). Abortions, the political and social calculations that surrounded abortion, and the secrecy with which it was often undertaken were thus a way for Africans to negotiate membership in two communities at once. And, Africans often rationalized their behavior in the missionaries' language in an effort to embed themselves more fully in these new communities. In all of this, they moved between discourses available to them without any sense of contradiction.

This case also suggests some similarities in the way that East African and British women understood abortion in the nineteenth and twentieth centuries. In Africa and elsewhere, the practice has long been a form of female-controlled birth control and family planning, allowing women to plan an active part in determining family size and negotiating marital relationships. In Britain, physicians, legislators, and church officials understood

the practice—and indeed contraception more generally—to be unethical and physically harmful. Doctors either failed or refused to provide appropriate information on contraception, and women were forced to take fertility control into their own hands. Abortion, and the knowledge that attended it, was thus usually under women's purview. As Patricia Knight argues for Victorian and Edwardian England, "knowledge of drugs likely to produce abortion was part of local folklore, handed down from generation to generation, and passed from one woman to another. Most women obtained advice from friends and neighbours" (Knight 1977). It was thus "a home remedy passed on by word of mouth" (McLaren 1977). In Africa, the "bush schools" into which girls matriculated to prepare for initiation did much of the same work, and women of the grandmother's generation served as resources for young women seeking to control fertility or manipulate social relationships.

Further, though the Anglican missionaries would have been loath to admit it, East Africans and British missionaries also agreed about the compositional power of reproduction, and about the role that abortion could play in strategically composing communities. British missionaries of the late nineteenth and early twentieth centuries valorized women as "mothers of the nation," arguing that the place women held within a society was a direct indication of the society's advancement from a state of barbarism to civilization. Women were also the "natural repositories of religious piety." As wives and mothers, Christian women made "the home a haven safe from worldly temptations and the family the critical unit of worship" (Thorne 1999). Social Darwinist and eugenicist tendencies prophesied a decline in the numbers and quality of the British race and emphasized women's "role as mothers of numerous and healthy progeny," and lamented "the evils and dangers" of abortion "to the fulfillment of their natural functions as women" (Knight 1977). In Africa, on the other hand, abortion allowed women to control and manipulate their "natural functions as women" in accordance with community needs and interests. Whereas abortion threatened the continuity and strength of the British nation, it was the very tool that could ensure the strength and perpetuity of African communities.

In this, the "1921 Mbweni Abortion Scandal" exposed the limits of the church's control over the biological and social reproduction of their imagined spiritual community. That officials at Mbweni came to frame several alleged abortion attempts and an ensuing "cover-up" as a scandal suggests that they and their congregants disagreed on the definition of Christian ethics, and on the regulation of certain institutions and practices. Indeed, though all

seem to have agreed that procreation and reproduction were worth regulating, church officials and congregants did not agree on the best way to construct and perpetuate a moral community, or on the best way to define its borders. In this, abortion exposed the limits of the missionaries' control over the biological and social reproduction of their imagined spiritual community, and allowed African congregants to employ longer-standing idioms of community-building to embed themselves more fully in the community, and to redefine the boundaries of accepted and acceptable behavior.

CHAPTER 6

Troubled Women: Abortion and Psychiatry in Sweden in the 1940s and 1950s

Lena Lennerhed

In 1938, Sweden legalized abortion on medical, eugenic, and humanitarian grounds, largely motivated by the need to improve women's physical health. During the 1940s and 1950s, abortion increasingly came to be seen as a psychiatric issue with women's mental health receiving increased attention. A growing number of women applied for abortion for what appeared to be psychiatric reasons, and psychiatrists played a key role in handling abortion cases. This growing demand for legal abortions confused many politicians and physicians because in the Swedish welfare state, abortions were expected to be—to use an anachronistic phrase—safe, legal, and rare.

Psychiatrization, which is to be understood as an aspect of medicalization (i.e., the process of defining certain human qualities and acts as disorders or disease), was increasingly employed in an effort to understand the increased demand for abortion.[1] This chapter describes the effect that

[1] The concept of medicalization has been used as a theoretical tool by sociologists, feminist researchers, and others since the 1960s. The concept of psychiatrization has not gained ground in the same way but was used by Michel Foucault in his *Histoire de la sexualité. 1. La Volonté de savoir*, Paris: Gallimard, 1976.

L. Lennerhed (✉)
Södertörn University, Stockholm, Sweden

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_6

psychiatrization had on the way women seeking abortion were treated and how abortion requests were handled, including examining the discussion among doctors about psychiatry's increasing influence. This chapter additionally explores the corresponding decline in the number of legal abortions that occurred during the 1950s, as well as possible interpretations of women's contributions to the debate. The source material for this chapter consists of government committee reports, medical theses and articles, decisions on abortion requests, and to some extent popular fiction. The purpose of this chapter is to provide a tentative explanation for the role that psychiatry assumed in abortion cases in the Swedish welfare state during the middle of the twentieth century. In the present study, issues of gender are central, and notions of illness, weakness, and inadequacy will be linked to normative concepts of femininity and motherhood.

The psychiatrization of abortion can also be noted in other countries. For instance, in Denmark, most abortions in the 1950s were carried out on psychiatric grounds ("*belastningsneurose*") (Sander Esbensen 253). Similar developments also took place in the United States. US historian Leslie J. Reagan argues that while psychiatric reasons for abortion were seen as "ludicrous" at the beginning of the century, they had gained credibility by the 1940s and 1950s. A study of 60 hospitals in the United States showed that in the 1950s, nearly half of the abortions were carried out for psychiatric reasons (201, see also Rosen 82). Sociologist Ellie Lee cites studies that show a majority of abortions performed in Britain from the late 1950s to 1967 were carried out for psychiatric reasons (166).

Historical Context

The early twentieth century was a period of social and political change in Sweden. Universal suffrage was introduced in 1921, and in 1932 the Social Democratic Party took power and laid the foundations for the welfare state. The "People's Home," a society based on the principle of equality, was to be constituted through social reforms, including reforms on sexuality, reproduction, and women's health. Traditional and Christian ethics regarding sexuality were largely replaced by a modern, secular, and scientific outlook. Sex-reform groups, feminists, and radical doctors advocated legal abortion for poor, single, or unemployed women and for the so-called worn-out mothers—that is, women perceived to have too many children and in poor health. They also advocated access to contraceptives and the introduction of sex education in schools (Lennerhed, *Sex i folkhemmet*).

In 1938, abortion was legalized on medical grounds (if disease, physical defect, or weakness of the woman was a danger to her life and health), on eugenic grounds (if insanity, feeblemindedness, or other serious hereditary disease could be transferred to the child), and on humanitarian grounds (if a woman was pregnant after rape or incest) (*Betänkande i abortfrågan* 37). Abortion for what were considered social or economic reasons was prohibited, for example, if a woman was single, unemployed, or poor. Instead, social conditions were to be improved, or as the governmental Population Commission put it, "legal abortion on social indications would indicate that society is incompetent to deal with its own severe social ills" (*Yttrande i abortfrågan* 20). The same year, in 1938, the law that forbade information on contraceptives was repealed.

Centers with counselors, gynecologists, and psychiatrists—where women could apply for abortion—were established. Decisions on abortion requests were made by the social-psychiatric committee at the National Board of Health or by two doctors in collaboration. In the late 1930s and early 1940s, the number of legal abortions varied from 400 to 700 per year, while the number of illegal abortions was estimated to be much higher (Lennerhed, *Historier* 39). In 1946, the abortion law was amended to include a socio-medical indication of "anticipated weakness." After this change, the number of legal abortions increased, from over 2000 in 1946 to over 5000 in 1949 (*Abortfrågan* 13, 197).

Abortion on Psychiatric Grounds

Abortion statistics indicate a crucial change regarding the grounds for carrying out abortions in the 1940s. In 1940, just over 500 legal abortions were performed; more than 70% of these were for reasons of "disease" or "physical defect" and 3% because of "weakness." Ten years later, in 1950, almost 6000 legal abortions were performed, for reasons such as "weakness" in over half the cases, and "anticipated weakness" in 10%, while abortions performed because of "physical defect" or "disease" had dropped to 30% (*Abortfrågan* 81). That is, legal abortions increased tenfold throughout this period, and "weakness" and "anticipated weakness" became the dominant reasons for legal abortion. In contrast, the number of abortions performed because of "disease" or "physical defect" fell sharply. In this context, weakness meant asthenia (a medical term for loss of strength), psychasthenia, mental deficiency, or fatigue. Weakness was thus interpreted to be a psychiatric rather than a physical problem. Women

with other psychiatric diagnoses, such as psychosis or schizophrenia, could also be permitted abortion on grounds such as disease or weakness, while so-called oligofrenic (an older term for mentally disabled) women generally had abortions on eugenic grounds. However, women could have their abortion applications rejected if doctors believed that their "mental instability" was temporary or related to their pregnant condition and what was referred to as "physiological pregnancy depression" (*Abortfrågan* 85).

A further example of the psychiatrization of abortion is that women who applied for an abortion could be hospitalized for observation and investigation in psychiatric clinics. In the 1950s, the National Board of Health referred many applicants for abortion to psychiatric hospitals to get further information on their mental status. In 1958, 3% of all applicants were referred to a psychiatric clinic as part of the investigation. These women could remain in the hospitals anywhere from a few days to several weeks (Hultin, Ottosson).

Scientific theories regarding women's motives for abortion seem not very well developed. An analysis of how some abortion applications in Sweden were handled from the years 1956 and 1958 shows that theories about body types were common. In his widespread book *Physique and Character* (1921), the German psychiatrist Ernst Kretschmer tried to establish links between mental disorders and leptosomic, pyknic, athletic, and dysplastic body types, and the Kretschmerian categories were frequently used in Swedish abortion cases. For example, one physician characterized a woman applying for abortion in the following way: "Pronounced asthenic leptosomic, very lanky and lean. Bird profile, marked features, large nose" (Application for abortion 1956, vol E IV: 531). This woman was granted permission to have the abortion. In addition to body type, other aspects of women's appearance and clothing were noted. One woman was described as a "semi-elegant blonde, slightly vulgar and sloppy," another as "well-kept with long red nails," a third as a "shabby, colorless asthenic with no interest in her own appearance," while a fourth woman's underwear was commented upon as being "well-worn and soiled" (Application for abortion 1956 Vol E IV: 531, 532, 1958 Vol. E IV: 661).

In cases where women were believed to be of low intelligence, tests would be used to determine the individual's "intelligence age." Other descriptors used were "normal intelligence," "intellectually indifferent but not inferior," "diffuse and obscure, but not incoherent," or "leaves approximate or wrong answers to simple questions" (Applications for abortion 1956 Vol E IV: 531, 532, 1958 Vol. E IV: 661). In some cases,

supposed deficiencies regarding maternal or feminine qualities were singled out. One woman was described as elegant, superficially charming, modern, emancipated, sexually active, and seductive, as well as "cold and appearing to lack motherliness." This mother of two had become pregnant out of wedlock and was denied an abortion (1956 Vol E IV: 531).

Overall, these examples show that a psychiatric discourse on abortion was established. Psychiatrists obtained key positions in decision-making during this decade, both at the counseling centers for abortion applications and through the social-psychiatric committee at the National Board of Health. In addition, psychiatry's explanatory models—even though barely developed theoretically—formed the basis for the management of the majority of abortion cases.

Puzzled Psychiatrists

Physicians and politicians who had supported the introduction of legal abortion in 1938, as well as the amendments on socio-medical grounds in 1946, believed that these changes would be sufficient to meet the then current, and what they believed to be limited, demand for abortions. Instead, more and more women applied for abortions and for a wider range of reasons. For many psychiatrists this was a dilemma, and in articles and books they discussed how the situation should be interpreted and what could be done about it.

Yngve Holmstedt, a psychiatrist at the Stockholm County Council's Center, pointed to the pressures and dilemmas faced by doctors because abortion cases were different from others. When patients saw a doctor, they generally followed the doctor's assessment and treatment decisions, wrote Holmstedt in 1953. However, in abortion cases the situation was different. The woman was firm in her chosen course of action—a legal abortion—while the doctor was not always that sure. In abortion cases, the doctor's authority was challenged, according to Holmstedt. He supported women's access to legal abortion but he did not have any answers to how this new situation could be handled.

Thorsten Sjövall, psychiatrist and psychoanalyst at the Stockholm County Council's Center and board member of the Swedish Association for Sex Education (RFSU), raised concerns in 1953 about what he believed was a growing group of women seeking abortion—married women with one or two children who were physically and mentally fatigued. According to T. Sjövall, these women felt burdened, tired, and depressed. They were

either employed and felt inadequate in their maternal role, or at home with small families in modern apartments and felt lonely and unstimulated, or were experiencing marital problems. According to T. Sjövall, an abortion could symbolically be interpreted as a hostile act, directed first at the husband; second, against authority and society in general; and third, against the woman herself as a form of self-punishment. T. Sjövall supported women's access to legal abortion but believed this rarely solved their problems. However, psychotherapy could. Many women who sought abortion were, according to T. Sjövall, characterized by "a chronic state of malaise without any ostentatious symptoms" (257). T. Sjövall wanted to point out a problem, a new existential situation for women and their expectations regarding intimate relationships as well as uncertainty concerning their role in a welfare society. His solution was not to reduce access to legal abortion, but to take preventive measures: to promote birth control and give economic and social support to women and children.

While a psychiatrist like T. Sjövall called for prevention of unwanted pregnancies and abortions, other psychiatrists emphasized the need to limit women's access to abortion. The psychiatrist Martin Ekblad from Karolinska Hospital showed in his thesis, *Induced Abortion on Psychiatric Grounds: A Follow-Up Study of 470 Women* (1955), that very few women regretted their abortions, that mental disorders such as guilt, self-blame, or depression occurred in a minority of women but were transient, and that nearly a third had become pregnant again after the abortion (a majority with the same man as in the previous pregnancy and with no intent to have more children). Ekblad concluded that a new group of women had emerged to seek out legal abortion after 1946, namely married women in harmonious marriages. He believed that many of these women ought not to have been allowed legal abortion. Rather, he thought that they should have overcome their problems and difficulties and been forced to give birth. According to Ekblad, legal abortion was exclusively for the so-called worn-out mothers, and sterilization should be considered after the operation (51, 98, 103, 114, 160).

As a female psychiatrist, Elisabet Sjövall was an exception in the otherwise entirely male-dominated debate (Lennerhed, "A difficult person"). E. Sjövall was a gynecologist but had then embarked on psychiatry, and in the 1950s, she was the director of the city of Gothenburg's counseling center for women seeking abortion. She was also politically active and represented the Social Democratic Party first in Gothenburg's city council and then as an MP in Parliament's lower house from 1957 to 1968.

In addition, E. Sjövall was involved in sexual politics and was RFSU chair from 1961 to 1964.[2] She devoted most of her professional life to the abortion issue, as doctor and politician. She also wrote the novel *Barlast* ("Ballast," 1946) and the play *Fyra människor* ("Four People," 1951), two works of fiction that revolved around relationships and abortion. For E. Sjövall the abortion issue was complicated. As a fiction writer, she portrayed women's life choices between work, children, and marriage, and abortion was depicted as a reasonable but hardly simple solution. In a private letter to a friend, she wrote ironically and ambiguously about her own three abortions, which "never worried me, which is clearly a lie" (Letter from E. Sjövall 1954). As a doctor and politician, E. Sjövall argued that women's right to legal abortion for certain reasons was vital, but that too little was being done by society to prevent abortions. In sex education writings and articles from the 1950s, she returned to the argument that abortion was a bad solution. She described abortion as an "unbiological phenomenon" and that "no happy and healthy mother wants abortion" (E. Sjövall, "*Abortfrågan*").

Holmstedt, T. Sjövall, Ekblad, and E. Sjövall were all key persons in the abortion debate, and their statements (as well as those by many other psychiatrists in the 1950s) show that they found themselves in a new situation where a large number of women were applying for abortion, not because of physical illness or poor economic circumstances, but for other reasons, including fatigue and depression. These psychiatrists had differing views on what should be done, but none of them stated that simply accommodating women's wishes might be a solution.

The Art of Persuasion

Physicians often described women applying for abortion as "bloody minded" or "stubborn," and concluded that it was very difficult to persuade them to change their minds (Holmstedt 270, Schlaug 104). However, there was a strategy used by counselors and doctors in an effort to so do. In counseling, they were told to wait and think their situation

[2] Elisabeth Sjövall was chair of RFSU from 1961 to 1964 and replaced by Thorsten Sjövall, who was the organization's president from 1964 to 1972 (they were not related to each other despite their surnames). The conflicts were many, since E. Sjövall saw it as one of her main tasks to curb the influence of psychoanalysts including T. Sjövall and others in RFSU. E. Sjövall was elected to Parliament in 1957 and was the only social democratic female Member of Parliament who was not a member of the party's Women's Association.

over in the hope that their "maternal instinct" would awaken. Abortion applications could take several weeks to process, and the delay appears to have been an intentional strategy. Karin Malmfors, an abortion counselor at the Stockholm County Council's Center, wrote in 1953, "After talking to a counselor and a doctor, the woman needs this time for psychological reasons to fully understand herself and her situation" (60). Malmfors did not like the expression "persuasion to give birth" because she believed that a woman who completed her pregnancy had made a decision that was hers. However, Malmfors wrote, "some interference from outside" could sometimes help the woman to come to terms with her pregnancy (77). Although some women were perceived as having legitimate reasons for choosing to abort, many other women were described as fixed in false and distorted thinking. The role of the counselors and doctors was to show women that their difficulties could be overcome.

Concerns for women who became mothers against their will, or for the future of unwanted children, were seldom expressed in the debate. The lack of discussion on unwanted motherhood can most likely be attributed to the widespread belief that motherhood was a woman's natural and primary goal in life. The housewife ideal was strong at the time. The idea that a woman's place is in the home was not new, but it was reformulated. The 1950s housewife should be modern, using modern working methods in the home and raising her children in accordance with modern theories. At the same time, the 1950s, as historian Maria Björk has shown (Björk 41–42), was a time when it was noticed that neuroses and fatigue were a growing problem, especially among women. Holiday rest homes and home-support personnel were introduced to relieve exhausted housewives. In both the abortion debate and the general social debate, "the exhausted housewife" was a recurring discussion in the 1950s. Nevertheless, there were very few who mentioned that women could have roles other than as mothers and spouses.

At the same time as psychiatrists were discussing the abortion situation in Sweden, practices were changing. In the 1950s, the number of legal abortions declined to less than half, from more than 6000 in 1951 to less than 3000 in 1960 (*Abortfrågan* 40; *Familjeplanering och abort* 31, 117). This decline was not caused by any change in legislation. One explanation is that the National Board took a firmer grip on the determination of abortion applications. In 1940, it was common for two doctors in collaboration to adjudicate abortion applications. Ten years later, however, the National Board decided most cases. The National Board rejected an

increasing number of abortion applications. In addition, fewer applications were sent to the National Board, which may have been the result of stricter gatekeeping among the counselors and doctors at counseling centers. It is possible and likely that the intense and polarized abortion debate itself paved the way for an increased restrictiveness, that is, that the debate established a new norm. It was dominated by physicians, mostly psychiatrists and gynecologists, of different opinions but from a shared viewpoint that abortion was a problem. Women may have been influenced by the many comments critical of abortion. However, it may also have been the case that women assumed that it was not worthwhile seeking legal abortion because they would almost certainly be rejected.

An obvious question is whether psychiatry's increased influence over the processing of abortion applications contributed to the increased restrictiveness, but this is probably not the case. A common assumption within the Swedish medical debate in the 1950s was that psychiatrists were more willing than gynecologists to accept applications for abortion (Holmström, T. Sjövall). The disagreement could even be described as a "war" between gynecologists and psychiatrists (Holmström). Examples from other countries show similar differences of opinion. In his study of abortion in England in the 1960s, historian John Keown refers to psychiatrists as supporters of extensive reform, while gynecologists wanted limited reform (87). Reagan describes American psychiatrists in the early 1950s as reformers, and states that they "responded sympathetically to the emotional distress of pregnant women" (218).

Women's Voices

More women were heard in the political debate on abortion than in the medical one, and a key figure here was Inga Thorsson—Social Democratic Member of Parliament, president of the Social Democratic Women's Association in the 1950s, and a member of the government committee on abortion founded in 1950. During the 1950s, Thorsson took on the role of defending and explaining the abortion law's place in Swedish society. In a public speech in 1954, Thorsson claimed that every abortion, legal or illegal, is a "social failure" (2953). At the same time she rejected the claims that there were too many abortions and that they were not always carried out for compelling reasons—views which, among others, were expressed by many physicians. Abortions carried out since 1938 had, according to Thorsson, been necessary, but they were "black marks" for a society that

wanted to be "a progressive social community." Thorsson claimed that Sweden and Denmark were the two countries in the world to have chosen "the only morally defensible way" to handle the abortion issue (2954).

Thorsson wanted to see an increase in social and economic support for women, personal counseling, and measures aimed at preventing unwanted pregnancies. Thus, society would give "the positive desire for children, which exists in every woman living in acceptable conditions, a fair and reasonable chance to blossom" (2963). Thorsson's words can be interpreted as a strong criticism of a society that, despite its socio-political aspirations, was not supportive of women. Although Thorsson put women and motherhood in focus, she did not find access to abortion emancipatory for women. With a well-developed and woman-oriented social policy, unwanted pregnancies and abortions could be prevented and the role of women as mothers could be brought to fruition. Thorsson was far from alone in taking the motherhood stance in policies on women and abortion. As we have seen, the doctor and politician Elisabet Sjövall shared this viewpoint. The notion of motherhood as women's natural role and main goal in life was not new, but during the 1940s and 1950s it was particularly strong and it was also incorporated in the modern Swedish welfare project.

If we look at fiction written by female authors, we find a similar idealization of motherhood and problematization of abortion. In the novel *Ta hand om Ulla! Ett ungt äktenskaps historia* ("Take Care of Ulla: A Story of a Young Marriage") (1945) by Ebba Richert, Ulla becomes pregnant, and her husband Gunnar persuades her to turn to an abortionist. Several of the young women in the office where Ulla works have had (illegal) abortions one or more times. After the abortion, Ulla becomes infertile and feels great sorrow and anguish at never being able to have a child. Similarly, Rut in Birgit Tengroths *Törst* ("Thirst") (1945) argues that something dies in a woman after an abortion. However, her bitterness is directed not against men, but against feminists. Rut says that feminists do not understand that abortion scars for life since they have not seen the blood or the "executioners" with their sharp knives. Guilt and regret were the themes of Ingrid Beije's novel *Saliga äro de ofruktsamma* ("Blessed Are the Barren") (1955). "There was one thing in life that Nina Falkner found particularly difficult to forgive herself…," reads the opening sentence in the book (9). Fifteen years earlier, when her marriage with self-obsessed womanizer and artist Mikael broke down, her despair had driven her to have an abortion. But the memory lives on, and the situation becomes acute when Nina,

now remarried to Hans, a doctor, wants to "give him a son" (182) but discovers that the abortion has made her infertile. Nina believes that her infertility is her fault, and the novel ends with her taking her own life. Inga Lena Larsson told the old story about the backstreet abortionist in *Vide ung* ("Willow Catkin") (1951). Vera, a young naïve orphan, moves to the big city, gets pregnant with a man who abandons her, gets an illegal abortion for a dollar and a bottle of brandy, ends up in hospital with a fever and severe hemorrhaging, but survives. During the 1930s, there were several examples of women writers who in their novels described women's abortions as justifiable and without negative consequences, but such messages were uncommon in the 1940s and nonexistent in the 1950s (Lennerhed, *Historier* ch. 4). Meanwhile, the National Board of Health received thousands of requests for abortions each year. The applications were not written by the women themselves but by abortion counselors after interviews with the women. The abortion applications therefore provide just indications of women's thoughts and wishes. But they can, simply through being made, be interpreted as votes for women's right to abortion.

Conclusion

The late 1940s and 1950s was a period that witnessed the introduction of the welfare state in Sweden. For example, the state introduced an allowance for every child to ensure a minimum standard of living. Health improved in conjunction with better access to health care. Contraceptives became more available. Nonetheless, women continued to terminate their pregnancies, which, for the Swedish welfare state, was a challenge. The many abortion applications from exhausted and depressed women, and the many illegal abortions as well, were seen as signs of problems that society has failed to solve. Reforms had been implemented to safeguard and protect the notion of good motherhood. The large number of abortions and abortion applications showed that a significant number of women did not want any more children or to become mothers at all.

This is where psychiatry came in. In the 1940s and 1950s, abortion and mental health were closely linked. Women's demand for abortion was referred to as a psychiatric issue and explained by factors like mental insufficiency. The abortion law was seen as a law of last resort and not a right. Abortion was socially acceptable under emergency conditions for women who were sick, exhausted, and "worn-out." But the "maternal instinct" was seen as natural, and many women who sought out abor-

tions did so, it was believed, because of external factors such as socio-economic status, marital status, sexual problems, or what was referred to as the physiologically induced but passing depression of early pregnancy. The wish to have an abortion was also linked to a woman's personal failing. Some women were believed to be selfish and lazy, while others were described as weak and fatigued. The diagnoses on women seeking abortion in Sweden in the 1940s and 1950s can thus be interpreted as a disciplinary process.

The doctors mentioned in this study worked either at the country's psychiatric hospitals or at centers for abortion applications in the 1940s and 1950s. Their views varied, from supporting the abortion law and abortion care, to demands for greater restraint and warnings of a growing "abortion mentality." Doctors regularly characterized the women who applied for abortions as adamant, fixated, and unreasonable. In response, doctors and counselors frequently tried to persuade women to give birth.

Women were seldom heard in the abortion debate. At this time, neither the women's movement nor the sex-reform organization RFSU advocated for extended access to abortion or liberalization of the abortion law. However, in the early 1960s, movements called for the abolition of the application process and the transference of the "right to decide" to the women (Lennerhed, *Frihet*; Lennerhed, "Sherri Finkbine's Choice"). This new political line was initiated by liberal and social democratic student and youth organizations, while women's organizations, RFSU, and others followed years later. Abortion on demand, it was argued, was fundamental for women's freedom and self-determination. Significantly, these young liberals and social democrats downplayed the importance of motherhood for women. Women were said to be capable independent individuals who could pursue an education, careers, and maybe children, but motherhood was not identified as the sole purpose of a woman's life. In this context, abortion was regarded as a rational choice, something a woman could choose without being mentally insufficient. Abortion on request was introduced in Sweden in 1975.[3]

[3] In practice, abortion on request was introduced before the change in the law. During the late 1960s and early 1970s, over 90% of all abortion requests were approved, most of them on the socio-medical indication of "anticipated weakness," and the number of legal abortions increased: in 1968, 10,940 abortions and in 1971, 19,250 abortions (Swärd, *Varför Sverige* 47).

PART II

Abortion Politics

CHAPTER 7

"It Is Not Your Personal Concern": Challenging Expertise in the Campaign to Legalize Abortion in France

Jennifer L. Sweatman

The 1975 Veil law decriminalized "therapeutic" abortion in France for a trial period of five years and was renewed with some revision in 1979. The 1975 law required consultation with a social worker, a waiting period, consent of a parent or guardian for minors, and medical control over administration of the procedure; it also greatly expanded the notion of "distress" as justification for abortion. By 1982, the costs for abortions were reimbursed with state funds in France (Latham 2002). The 1975 law emerged from a national campaign to challenge Article 317 of the French criminal code. Article 317 of the penal code evolved from the 1920 law against the circulation of information about, and the use of, abortion and birth control and the 1939 Family Code that penalized abortion as a crime, yet also allowed abortion in exceptional cases such as when the woman's life was at risk. By 1975, Article 317 was hotly contested, as Great Britain's legalization of abortion in 1967 and more accepting atti-

J.L. Sweatman (✉)
Department of History, Washington and Jefferson College, Washington, PA, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_7

tudes toward birth control and sexual freedom undermined the state's ability to enforce the law consistently.

This chapter examines the transcript of a trial of four women which took place in the Paris suburb of Bobigny in 1972, for procuring and performing an abortion. Defense attorney Gisèle Halimi crafted a legal strategy that went beyond a typical defense of her clients' actions. Instead, Halimi indicted the law, and by extension, society itself. Halimi's use of testimony from "expert" witnesses who ranged from respected physicians to working-class single mothers succeeded in exposing the injustice of the status quo and expanding the notions of "expertise" and the "facts of the case" in ways that promoted feminist discourses about women's rights to control their bodies. Her female witnesses' assertion of their own expertise as deriving from their status as women and her own identification with her clients as a woman brought a radical feminist epistemological paradigm directly into the courtroom. The Bobigny case was not only about the defendants and their (illegal) actions. It was also about all women's experiences as women living in a patriarchal culture and their struggles to be free and self-fulfilled.

In 1971, Gisèle Halimi founded an organization called Choisir (To Choose) to campaign against Article 317 and to offer legal defense for women accused of violating the law. Halimi and her organization believed the lack of adequate education about contraception and poor funding and implementation of the 1967 Neuwirth law that legalized birth control meant that many women were still ignorant of contraception, leading them to seek illegal and clandestine abortions (Halimi 1977). Building on the success of the Manifesto 343, a statement published in 1971 that was signed by 343 well-known female writers, celebrities, and other public figures who proclaimed that they had procured, or themselves undergone, abortions, Halimi called a number of celebrity witnesses at the Bobigny trial who testified to the injustice of the law and used themselves as living examples of the law's class bias. Under oath, they announced that they had undergone abortions and helped others procure them, directly challenging the prosecutor to indict them.

In the first trial held in October 1972, Marie-Claire Chevalier, then 17 years old, was acquitted by the juvenile court, Tribunal de Grande Instance de Bobigny, most likely due to the fact that sex with her friend Daniel had been coerced. Marie-Claire told the juvenile court that Daniel, a friend of hers, forced her to have sex with him and that he threatened to "run her mother down with his car" after Marie-Claire asked him to

"take responsibility" for the child. Marie-Claire argued in her defense that she "did not want the child of a hooligan," that she was "not ready to bring up a child," and that her "child would have been looked after by Public Assistance and would have been unhappy" (Choisir 1975, pp. 4 & 5). The court, perhaps in sympathy with her plight, acquitted her, citing her ignorance and "pressures of a moral, family, and social kind that she was not able to resist" (Choisir 1975, p. 7). In November, a more drawn-out and controversial trial was held. At this trial, Marie-Claire's mother, Michèle Chevalier, along with two of her coworkers, Renée Sausset and Lucette Duboucheix, and Micheline Bambuck, a secretary who performed the abortion, were charged with violating Article 317 of the penal code.

Instead of civil servants and politicians dominating the debate, this trial brought together a specialist discourse on birth control, abortion, and women's sexuality that had been expanding since the late 1950s with an increasingly public discourse among activists about women's oppression in French society. Importantly, the successful defense strategy at Bobigny "exploded the French model […] where all decisions were made within the relatively closed political and administrative class" (Turenne 2007, p. 239). Halimi described her strategy as one of "address[ing] the body of public opinion" and going "over the heads of judges [to] argue from the particular to the general, go beyond the facts themselves, [and] put on trial a law, a system and a policy […]" (Halimi 1977, p. 52). In this, she brilliantly succeeded as the discourse on abortion during the Bobigny trial spilled over into the public sphere, creating a national debate on the issue.

Gisèle Halimi viewed her professional and activist identities as reinforcing her commitment to challenging oppressive laws, in this case, the law against abortion. Halimi successfully undermined a liberal legal practice that limited court testimony to narrowly defined "facts" of a case and treated defendants as atomized individuals. At Bobigny, the defendants represented all women, and a comprehensive critique of French familial and gender norms came to embody the "facts" of the case. The impact of her strategy was evident in the *Conseil de l'Ordre des Avocats*' response to the trial. This French equivalent to the American Bar Association criticized Halimi for "denouncing" rather than simply "applying" the law and for putting her female identity at the center of the defense (Valenti 2010, p. 161).

However, Halimi's strategy opened a space in which a wide range of discourses on women's sexuality and reproductive choice were brought into the courtroom and, due to the press coverage of the sensational case,

into the mainstream press. This opening of the conversation to include such a wide variety of opinion that converged in opposing the status quo facilitated not only the eventual reform of the law, especially an enlargement of the concept of "distress," but also the enhanced visibility of feminist discourses on women's sexuality.

The Campaign to Legalize Abortion in France

Recent historical studies of the French women's liberation movement have emphasized the key role that sexual politics and bodily liberation played in feminist discourse in the 1970s. Taking their cue largely from Simone de Beauvoir's maxim that "women are made and not born," such feminist activists and authors followed de Beauvoir in asserting that women's control over their bodies, and especially their ability to limit births, was essential to any authentic vision of women's liberation. Earlier, feminist and women's organizations, such as *Maternité heureuse* (Happy Motherhood)—founded in 1956 by Dr. Marie-Andrée Lagroua Weill-Hallé and Evelyne Sullerot—sought to reform repressive birth control laws based on their repressive nature, arguing such laws were difficult to enforce and out of sync with a modernizing society (Pavard et al. 2012). In 1959, *Maternité heureuse* joined the International Planned Parenthood Federation, and in 1960, it changed its name to the *Mouvement française pour le planning familial* (MFPF, or French Family Planning Movement). MFPF's goals shifted from professional to advocacy for effective contraception, rather than legalization of abortion (Weill-Halle 1959, 1962, 1967). However, between the 1960s and the 1970s, the MFPF's approach to family planning shifted from stressing "respectability" and family life to sexual education for the masses in the early 1960s and then to the idea of "sexual liberation" and the "right (of individuals) to pleasure" in the late 1960s (Pavard 2012, pp. 113, 110, 106). This shift within the MFPF was, in part, a response to a broader reconfiguration of the French left, especially in the aftermath of the student protests of 1968, which ushered in a period of more systematic critique of sexual repression and gender norms (Ross 2002; Bertaux et al. 1998; Gilcher-Hotley 1998; Reader and Wadia 1993). In the 1970s, the *Mouvement de Libération des Femmes* (Women's Liberation Movement, MLF) "made free and accessible abortion a condition for women's liberation," dramatically shifting the terms of the debate from family planning to reproductive rights (Pavard 2012).

The MLF stressed the notion that women's liberation required individual woman's control over her body, and it privileged the notion of "coming to speech," or articulating one's experiences as a woman oppressed in French patriarchal culture, as a kind of expertise (Garcia-Guadilla 1981; Picq 1993; Duchen 1986; Albistur and Armogathe 1977; Valabrèque 1970). Thus, the individual woman's experience was linked to women's universal condition and served as the basis for a claim to certain rights, abortion among them, seen as necessary for freedom and self-fulfillment (Pavard 2012). In the aftermath of Bobigny, the extreme left embraced totally free access to abortion as well as sexual education as key goals; such groups included the Movement for the Freedom of Abortion and Contraception (*Mouvement pour la Liberté de l'Avortement et la Contraception*, MLAC), founded in April 1973, and the Health Information Group (*Groupe Information Santé*), originally founded in the 1960s by doctors in response to the wars in Indochina and Algeria (Pavard 2009).

While Halimi successfully adopted certain elements of the MLF's discourse on women's rights and sexual liberation, she stopped short of openly endorsing the most radical arguments in play on the abortion issue at the time, such as those that proposed to remove physician involvement in the procedure. Instead, Halimi's strategy relied on the support and intervention of male physicians and well-known feminist activists like Simone de Beauvoir to expose and undermine the law. As a result, MLF militants often criticized Halimi's approach at Bobigny (Halimi 1977; Pavard et al. 2012; Valenti 2010).

Gisèle Halimi's Strategy at Bobigny: Opening Discursive Space for Radicalism in the Courtroom

Halimi called several prominent male physicians and leftist politicians to the stand whose prestige helped destabilize the boundaries between acceptable and unacceptable testimony, creating a discursive space in which radical feminist ideas could be expressed openly. Since none of the expert witnesses actually knew the "facts" of the case, the judge, in deferring to the expertise of the male physicians, put himself in a position in which he had to allow the testimony of other expert witnesses, like Claude Servan-Schreiber and Simone de Beauvoir, whose competency was defined in terms of their activism and personal interest.

Halimi's defense strategy brought "civil disobedience" into the court and turned a criminal act into "a gesture of moral or political protest" that "exploit[ed] the contradictions of a repressive system …" (Turenne, 5, pp. 225, 226). Her retrospective analysis of the trial's outcome is particularly revealing, as she admits that "we were not gentle with our judges … we did not make their task easy; we insisted we were guilty …" (Halimi 1977, p. 70). Judge Graffan, presiding at Bobigny, struggled to determine the "limits" of rights and legal norms, and his inability to limit testimony purely to the "facts" of the case aided Halimi's strategy of civil disobedience (Turenne 2007, pp. 8, 14). At Bobigny, Judge Graffan embodied "judicial reticence," a judge's veiling of his or her interpretations and attempt to appear non-partisan, as he simultaneously denied the admissibility of the defense witnesses' evidence and legitimated it. While continually challenging their expertise, he also opened several dialogues with the witnesses that allowed them to speak at great length. In the process, he affirmed the "difficult" nature of the Bobigny case and the repressive nature of Article 317. The judge became an important, though perhaps accidental, interlocutor for feminist ideas since, "for all observers, the accused was no longer Michèle Chevalier but the law of 1920[.]" (Turenne 2007, pp. 201, 226).

Despite the trial judge's best efforts to maintain decorum and limit the testimony to established definitions of the "facts" of the case, the various witnesses Halimi called exposed the hypocrisy of the law against abortion. In particular, the defense called three types of witnesses who deployed several arguments against the law. First, members of Halimi's association Choisir, and other feminist activists who had signed the Manifesto of the 343, brought a radical feminist paradigm into the courtroom as they exposed the law's hypocrisy. Witnesses like Claude Servan-Schreiber, Simone de Beauvoir, Françoise Fabian, and Delphine Seyrig practiced a form of civil disobedience when they admitted, under oath, to having had abortions themselves and challenged the prosecutor to arrest them. Second, Halimi attacked the social injustice of the law that disproportionately impacted working-class women and used primarily male scientific expertise to support her position that the law was fundamentally unjust. Here, the male physicians' prestige, testifying as men of science, served to open a discursive space in which the judge, perhaps unwittingly, helped the defense incorporate information that could not strictly be considered to be "facts" of the case. The judge's curiosity about their testimony and respect for their status as physicians and scientists led him to interrogate

them further, taking the court deeper into the various social, physical, psychological, and ideological defects of Article 317. Finally, the convergence of the various witnesses' testimonies, including the two working-class, single mothers who testified, produced a notion of "distress" that justified abortion as a "therapeutic" measure based on social and psychological, rather than only physiological, bases.

The "Facts" of the Case: What Is an "Expert" Witness?

Halimi and her expert witnesses brought radical feminist ideas about women's sexuality and a radical feminist epistemological paradigm into the courtroom. Radical feminist practice stressed that private matters like sexuality and familial life were political; thus, the experiences of one individual woman were connected to the experiences of all women living in a patriarchal society (Reineke 2011; Chaperon 2000). This feminist epistemology, a theory of knowledge that stressed women's shared sisterhood and common condition, was particularly evident during the testimony of journalist and Choisir member Claude Servan-Schreiber. Immediately after Servan-Schreiber took her oath, Judge Graffan challenged the witness by asking, "You know nothing of the matter? Of the actual facts[?]" (Choisir 1975, p. 78). It was both a question and an accusation, and it was one the judge continually posed as the trial progressed.

Servan-Schreiber insisted that her membership in Choisir meant that she did "know the facts," while Halimi insisted that the witness's expertise derived from an article she had published in *Elle* about her previous abortion. Rather than submitting the article to the court, as the judge requested, Halimi insisted that her witness be allowed to speak. This insistence provoked an extended scolding from Judge Graffan in which he assured counsel that he was "willing to go great lengths to ensure that everyone can speak for himself or herself, but there are certain limits that must be observed …" He then relented and instructed the witness to "give us your personal view, even though this is somewhat irregular … Let us know about your experience. But it is not you who are on trial; it is not your personal concern[.]" Not to be intimidated by this mild scolding from the judge, Servan-Schreiber responded, "It is the concern of every woman." The judge's riposte warned, "If you bring every woman along we shall still be here at the end of the year." The trial transcript records

that this comment provoked "murmuring" in the courtroom in response, no doubt, to the judge's sarcasm (Choisir 1975, p. 79). Most of Halimi's witnesses were only familiar with the defendants and the case due to its coverage in the press and were not witnesses in the strictly legal sense. However, the entire defense was based on such "extraneous" information calculated to challenge the law rather than the defendants' guilt. The exchange with Servan-Schreiber was one of several incidents during the trial in which the judge challenged Halimi's expert witnesses' "expertise."

Halimi called a range of witnesses, some of whom were well-known, powerful politicians, others prestigious physicians, and still others prominent female activists, like Servan-Schreiber, and ordinary women from working-class backgrounds. In so doing, Halimi rejected the MLF strategy of only allowing female witnesses and highlighted the "social tragedy of the trial"—its class bias (Halimi 1977, p. 57). She sought to launch an assault on Article 317 from multiple points of view, turning the public trial into a "political trial" in the broadest sense (Halimi 1977, p. 51). The order in which the defense witnesses were called indicated the important "convergence" between different discourses on abortion that had been circulating in the public sphere since the early 1960s. Michel Rocard, socialist deputy who had sponsored a bill to reform abortion law, took the stand just after Marie-Claire Chevalier, making him the first of the "star" witnesses called. Several prominent physicians, including the foremost expert on sterility in France, Dr. Palmer, took the stand after Rocard (Pavard 2012). They were followed by Simone Iff, who was also vice president of MFPF, Nobel Prize laureate Dr. Jacques Monod, and Dr. Paul Milliez, whose testimony resulted in a motion of censure from the *Conseil de l'Ordre des Médécins* (Council of the Order of Physicians) (Pavard et al. 2012). However, the last defense witnesses were, significantly, women with little direct claim to "expertise" in the traditional sense. They included two actresses, Françoise Fabian and Delphine Seyrig; two unemployed single mothers, Claudette Pouilloux, who had to relay her testimony via letter as she was too ill to attend, and Claire Saint-Jacques; and Choisir members, journalist Claude Servan-Schreiber and well-known intellectual Simone de Beauvoir. While opening with male witnesses, the last word belonged to women.

Significantly, Halimi presented several respected male authorities first. This allowed such respectable witnesses to challenge the judge's standards for admissible evidence and create space within which subsequent (more politically inspired) witnesses, such as Claude Servan-Schreiber, could become increasingly more assertive in their challenge to the law.

The presence of so many male physicians also chipped away at the *Ordre des Médécins*' (equivalent to the American Medical Association) intransigent stance against abortion, which dovetailed with the Catholic Church's opposition to reform of the law (Simon 1979). At the beginning of Deputy Rocard's testimony, Judge Graffan tried to limit the witness to the "facts as he knows them" and reiterated the court's definition of a witness, as a person who "has knowledge of the facts or of the persons accused" (Choisir 1975, p. 35). Subsequently, Rocard admitted that he did not know the accused before the crime in question, but met her afterward. However, Rocard continued to deliver his opinion of Article 317 through several "personal comments," which led Judge Graffan to remind the defense, "[W]e are not judging a law here; we are judging facts and the people who, unfortunately for them, are here before us. So we must not forget them" (Choisir 1975, p. 36). Rocard's response provided discursive space for denouncing Article 317, which Rocard considered an unjust law; Rocard countered the judge's attempt to limit his testimony by saying, "I am far from forgetting them" (Choisir 1975, p. 36).

Special Treatment for Male Physicians Redefines the "Facts"

The judge's treatment of the male physicians was particularly revealing of his inability to limit the case to the "facts" of the case as he initially attempted to do with Deputy Rocard. When Halimi called her next witness, she mildly scolded the judge by asking, "May I point out that the witness is a gynecologist[?]" (Choisir 1975, p. 38). In putting the professional knowledge of a male gynecologist at the forefront of her defense, Halimi sought to play upon his status in order to persuade the judge to allow information initially defined as extraneous to be heard. While the judge tried to limit these witnesses at the start of their testimonies, as they spoke, he became more deferential to their authority as physicians and even posed questions to them and engaged them in extended dialogue.

For instance, when Halimi called Professor Raoul Palmer, a gynecologist and president of the Society for the Study of Sterility and Fertility, the judge asked her if the "questions (were) going to be put in a precise manner[?]" (Choisir 1975, p. 45). Halimi chastised the judge by reviewing her own role as an attorney, who had a right to "put questions" to witnesses freely (Choisir 1975, pp. 45–6). She essentially accused the judge of irregular procedure, a dangerous practice that would call into question his own

professional status and claim to objectivity. Despite the judge establishing that Professor Palmer only knew about the case from the newspapers, the judge went on to involve himself directly in the supposedly "irrelevant" delivery of a witness's personal opinion by asking Palmer about psychological trauma from clandestine abortions as well as at what stage in a pregnancy he considered an abortion justified. Therefore, instead of minimizing the witnesses' opportunities to confuse the "facts" of the case, narrowly defined, the judge actually encouraged such respected physicians to speak at length about the dangers of clandestine abortion, their own assessments of Marie-Claire's predicament, including their willingness to help her if she would have appealed to them, their knowledge that the laws against abortion were regularly violated by doctors, and their overall opinion of the law (Choisir 1975).

Similarly, when Dr. Milliez—a practicing Catholic, member of the *Association nationale pour l'étude de l'avortement* (National Association for the Study of Abortion), and distinguished physician—began his testimony, the judge actually asked if he thought women should be allowed to decide whether to have an abortion or not. When Dr. Milliez said "Doctors [do not] have the right to decide for the woman," the judge went further afield from the "facts" of the case, asking him his opinion about a woman remaining childless (Choisir 1975, p. 41). Milliez recommended contraception and sexual education, pointing out that "the majority of Frenchwomen only have recourse to abortion" due to ignorance of birth control (Choisir 1975, p. 42). Interestingly, it was the judge's own intervention, in which he asked questions of Dr. Milliez that were seemingly irrelevant to the facts of the case before the court, that allowed this information to be voiced during the trial. What began as the judge's impatience with the introduction of extraneous information ended with the judge actually legitimating such information as being essential to the case and supporting Halimi's position that Article 317 unjustly targeted working-class women.

Later, the judge's exasperation with his struggle to maintain his judicial reticence is palpable. His frustration reveals how thoroughly the defense's strategy had dislodged the traditional definition of the "facts" of the case, exposing the law's hypocrisy and injustice toward women. By the time Dr. Jacques Monod—professor at the College de France, director of Pasteur Institute, and Nobel Prize laureate for Physiology and Medicine—took the stand as the 9th of 14 expert witnesses, the judge sarcastically interjected, "I suppose this witness is an expert witness who doesn't know the

actual facts themselves[?]" (Choisir 1975, p. 64). This was a largely futile gesture since, as Dr. Monod gave his testimony, the judge again became engrossed in the discussion. Monod, like Palmer before him, also knew of the case from press coverage and claimed it was "public knowledge" that hospitals performed abortions and that the law was "unenforceable" (Choisir 1975, p. 65). Monod went further than other physicians in asserting that a fetus is not a "human person," at which point the judge became directly involved in an exchange with the witness, asking, "Can you determine at what point the fetus becomes an individual[?]" (Choisir 1975, p. 66). During a lengthy dialogue between the judge and the witness, Monod estimated that a fetus does not develop a central nervous system before the fourth or fifth month, which led to a discussion of the limits after which abortion could not be performed. Instead of limiting what was admissible, the judge's desire to interrogate the expert witnesses allowed the defense's strategy of civil disobedience to develop with little real impediment beyond occasional verbal chastisement about decorum.

Feminist Activists Push the Boundaries of Expertise

This enlarged discursive space was particularly apparent in the testimony of the female witnesses and feminist activists, many of whom had signed the Manifesto of the 343, where they admitted to either having had abortions or helping others procure them. Several women who had signed the Manifesto 343 testified at the trial, including Françoise Fabian, Delphine Seyrig, and Simone de Beauvoir; they all admitted under oath to having had abortions. During Fabian's testimony, Halimi insisted that her intention was not to "shock the Court or anyone here" but only to illustrate the "discriminatory" nature of proceedings; Halimi then queried, "What is holding back the Public Prosecutor from taking the necessary steps[?]" (Choisir 1975, p. 70). Perhaps attempting to undermine the defense's attack, the judge asked the clerk of the court to note the admissions made by the witness, but Halimi was not to be deterred. During Seyrig's testimony, after she related her own experiences of having abortions, the judge asked, "What conclusions do you draw from this?" Halimi responded by saying, "I would like the Public Prosecutor to draw his own conclusion. Why is Mme Chevalier there in the dock and not Delphine Seyrig[?]" (Choisir 1975, p. 72). Halimi challenged the class bias of the law, which severely punished working-class women like Chevalier, but ignored the actions of middle-class and well-known women like Seyrig. At this point,

Seyrig interjected that her abortion "was a purely personal choice" and went even further, saying she "is an accessory to abortions every day" and just helped with one "the day before yesterday" (Choisir 1975, p. 72). This was the boldest confrontation with the law thus far, occurring, as it did, in the court that was then trying four women who had broken this same law. Halimi taunted the prosecutor, saying, "I would rather be in my shoes than in yours[!]" (Choisir 1975, p. 72). The judge had lost all control of the exchange at this point, and Seyrig's testimony ended with her boasting that she "felt very relieved" after her abortions and that other women did too. Besieged by this more direct interjection of radical feminist ideas into the proceedings, the judge said only "That will do[.]" (Choisir 1975, p. 72).

The exchange between defense counsel, the judge, and Simone Iff is exemplary of Halimi's strategy of bringing feminist demands into the courtroom. When Iff took the stand, the judge told her to "be brief," an intervention Halimi challenged, saying, "If you wish to show that some people are guilty, we must first find out if anyone made it possible for them not to be guilty[.]" (Choisir 1975, pp. 52 & 53). Iff began her testimony discussing the inadequacy of sex education among the youth and reported on a recent meeting she had held with several teachers' unions, in which they had refused to alert students to the services MFPF could provide. Thus, the law, and not the defendants, was at fault.

After her testimony established that government officials and civil servants were opposed to educating the youth about their legal right to access contraception, Halimi introduced another element of her defense strategy when she drew attention to the fact that Simone Iff was the first female witness and announced that "it would be interesting to ask her if she has had an abortion and what she thinks about the right to have an abortion[.]" Iff admitted to having had an abortion, at which point the judge again sought to impose limits on witness testimony by saying "That is not the question before us[.]" (Choisir 1975, pp. 54 & 55). Not to be deterred, especially so early in the proceedings, as Iff was the fourth witness called, Halimi replied, "On the contrary, it is fundamental to the problem. It is women who are charged here[.]" The judge reiterated that Iff's actions were "not of interest to us," while Halimi maintained her position that such actions were, in fact, "the whole issue. The issue is abortion[.]" (Choisir 1975, p. 55). The judge's scolding was, in this case, slightly different than it had been when he attempted to impose limits on

the male witnesses, as he insisted, "This frankness is unseemly. It is out of place here[.]" Halimi began to sound like an activist from the MLF when she contested this judicial intervention; she asserted, "It is time we finished with hypocrisy." The judge was not intimidated and interrupted Halimi to reassert his right to place limits on the type of testimony that was admissible when he said, "I am the one to ask the questions. I think the display of personal experiences is unnecessary[.]" (Choisir 1975, p. 55). Thus, he restricted Simone Iff to describing other women's experiences rather than her own since that expertise derived from her professional work and not from her own personal beliefs. The judge's victory was short-lived as, at the end of Iff's testimony, Monique Antoine, defense counsel for Sausset, asked the witness if she performed abortions. When Iff said yes, the prosecutor requested that her statement be recorded. By admitting in court to having had an abortion and to performing abortions for other women, Iff could have been prosecuted. Iff's testimony was a projection of the Manifesto of the 343 into the court, a clear incidence of civil disobedience, and was the first testimony to assert a feminist argument and perform an act of feminist solidarity with the defendants.

Interestingly, Simone de Beauvoir's admission of having had an abortion and of helping others procure them was treated slightly differently, perhaps due to her status as a well-known philosopher and award-winning novelist, as well as her advanced age (she was 64 at the time) during the trial. The judge posed philosophical questions to her, asking whether she really believed in the principle of absolute freedom. Arguing by analogy, he questioned whether her position that "everyone should have the freedom of his own body" extended to the "liberty […] to take drugs[.]" Attempting at first to deflect the question as irrelevant, de Beauvoir quickly recovered and said she would allow such freedom, provided "they were given comprehensive information about drugs …" (Choisir 1975, p. 84). This was a brilliant ending as it returned to the initial issue Halimi and Iff had raised about the lack of adequate information about birth control that forced young people like Marie-Claire to seek dangerous, illegal abortions. de Beauvoir connected knowledge and availability of information to the exercise of liberty, especially individual bodily freedom, in a way that challenged the hypocrisy of the law rather than the hypocrisy of the prosecutor; perhaps that is why the judge concluded her testimony with the phrase "The court thanks you" rather than drawing a red line as he did with Seyrig, to whom he said simply "That will do."

Enlarged Notions of "Therapeutic" Abortion: Gender Oppression as "Distress"

At the end of the defense testimony, two unemployed, single mothers—Claudette Pouilloux and Claire Saint-Jacques—testified to the ways women's educations were interrupted by pregnancy as well as to how humiliating state services for single mothers were at the time. Saint-Jacques claimed single mothers were treated like "whores" when "confined" at special hostels for single mothers (Choisir 1975, p. 76). Moreover, they suffered enormous pressures to give their children up for adoption. Such women's testimony highlighted the poverty and disenfranchisement women suffered that often increased with single motherhood.

Although coming at the end of the trial, the women highlighted the notion of "distress" that was used to justify not only the rather lenient sentences handed down in the Bobigny case but also the change in the abortion law that occurred with passage of the Veil law in 1975. Expert testimony at Bobigny and in other forums drew attention to the "distress" brought on by poverty and psychological trauma that justified abortion. Dr. Milliez would not go so far as to endorse a broad notion of "distress," but he did justify the recourse to abortion in Marie-Claire's case, which intimated that he believed her to be "distressed." He went further in describing a surgeon colleague of his who did not allow anesthesia to a woman who had a clandestine abortion that required subsequent hospitalization because "she ought to remember the occasion" (Choisir 1975, p. 40). This testimony exposed the punitive attitude of some doctors toward women suffering unplanned pregnancies and their underlying criticism of the women's sexual behavior. As such, Milliez's inclusion of this information lent further credence to the feminist argument that a form of gender injustice was occurring under the cover of Article 317. Another expert witness, Dr. Gerard Mendel, a neuropsychiatrist, actually testified that the law against abortion "worked against the civic concept," by denying to women "power over the thing that is most personal to her—namely, her own body," a "powerlessness (that) inevitably brings in its train a crippling of the personality[.]" (Choisir 1975, p. 58). Together, these two witnesses created a medical basis for defining "distress" as women's subjection to gender injustice and oppression in a patriarchal culture. Halimi's wide range of witnesses, especially the male experts and working-class women, legitimated an enlarged concept of distress that reinforced the radical feminist demand for women's right to control their bodies.

Broader Impacts of Bobigny

Radical feminist epistemology was also legitimated in Halimi's own comments during and after the trial as she emphasized that her own position as a woman was crucial to her legal strategy at Bobigny. In the process of making her closing remarks, Halimi revealed that, for her, the normal "prescription of distance between the advocate and her client" broke down in the Bobigny case. In her speech, Halimi highlighted her "fundamental solidarity" with the defendants and "with all the others (women) [.]" She denounced the "law … (as) the touchstone of the oppression that degrades women[.]" (Choisir 1975, pp. 125, 126). Her own identity as a woman came to the fore as she moved from describing women's condition from a position of distance to using the first-person plural, the collective "we." Halimi insisted on the sexist nature of the law in which "four men" were to judge "four women" for abortion and rejected the idea that "*we* (are) incapable of being in control of *our* own bodies …" (Choisir 1975, pp. 140–2). This assertion of a collective "we," referring to all women, was one of the distinctive features of the "imagined sisterhood" that the MLF popularized in the early 1970s, and it was inherently connected to an assertion about how women's condition should be understood and transformed (Reineke 2011).

While preserving his judicial neutrality through chastising witnesses who lacked knowledge of the facts, the judge also facilitated a process in which feminists gained maximum publicity for a "collective consciousness raising" around the injustice of the law against abortion (Turenne 2007, p. 226). The trial forced the *Conseil d'Ordre de Médécins* (Council of the Doctors' Order) to take a more public stand, albeit an anti-abortion stand, which it did in April 1973, when it rejected recognizing a right to abortion (Mossuz-Lavau 1991). At the same time, a new umbrella movement called the *Mouvement pour la liberté de l'avortement et de la contraception* (MLAC, movement for the freedom of abortion and contraception) formed that brought together a diverse range of activists and political parties for free and reimbursed abortion access (Pavard 2012; Mossuz-Lavau 1991). The Bobigny trial aided the feminist project of "lifting the taboo which pressed very heavily on the question of abortion […]" (Pavard et al. 2012, p. 102). In particular, in galvanizing a national debate on abortion, it put tremendous pressure on the government to act, prompting a debate on a draft bill in the National Assembly in May 1973. While that bill failed, Minister of Health Simone Veil was tasked with proposing a new bill in 1974, which finally succeeded in 1975 (Mossuz-Lavau 1991).

Debate on the initial bill revealed a new discourse in the National Assembly that overlapped strongly with the defense's discourse at Bobigny. While a systematic analysis of that discourse is beyond the scope of this particular chapter, it is revealing of shifting attitudes in the aftermath of the Bobigny trial. During the debate on the first law proposed to legalize abortion, Nicole de Hauteclocque, Member of Parliament from Paris and 1 of 8 women out of 490 deputies, explained her own participation as being a function of her gender in two ways: there were "so few women seated in this assembly" and "the decision we take interests all women[.]" Likewise, when Brigitte Gros, senator from Yvelines, wanted to express her support for Veil's project, she said, "Thank you in the name of the great majority of French women […] the near totality of them […]" (Pavard et al. 2012, pp. 97 & 26). Simone Veil too drew attention to her position as a woman when she began her speech in support of the law bearing her name by emphasizing the "double quality of [her position] as a woman and a judge" (Pavard et al. 2012, p. 137). In all three cases, these women drew special attention to their own position as women influencing their special interest in the debate on the abortion law and the connection between their own individual womanhood and the concerns of all women. Discursively, this was radical feminist epistemology in action. Laws regarding abortion were, as Servan-Schreiber had testified, "[their] personal concern."

While two of the defendants in the trial, Chevalier and Bambuck, were found guilty of violating the law, Halimi's strategy was effective as their sentences were suspended. In rendering the verdict in the Bobigny case, the judge cited Chevalier's "close family ties" to Marie-Claire and undue influence by "prominent people of the more privileged classes, demonstrated by a document called the 'Manifesto of the 343' widely publicized in the press" in explaining the "mitigating circumstances" in her case. After Bobigny, it was clear that the law against abortion was in complete disarray as subsequent trials (in Angers and Strasbourg) applied the law unevenly. The arrest of Dr. Ferrey-Martin in May 1973 for assisting a young woman with an abortion exposed the uneven application of the law at the provincial level as Dr. Ferrey-Martin claimed that her Grenoble-based MFPF group had been performing abortions for "nearly a year […]" (Pavard et al. 2012, p. 83). Her arrest did not impede access to abortion, however, as local activists organized trips abroad to secure abortions and practiced the Karman method on French soil. In a nation whose

legal system privileged universality and neutral application of the law to individuals, such a situation could not continue.

This uneven application of the law revealed an evolving public attitude toward abortion and toward women's sexuality more broadly. In public opinion polls carried out in the early 1970s, a growing public acceptance of reforming abortion laws was evident, with the number of French people supporting liberalization of abortion law growing from 22% in 1970 to 55% by 1971 (Mossuz-Lavau 1991, p. 84). This shift occurred in the context of the Manifesto of the 343 (women who had aborted) in April 1971, the Manifesto of the 252 (physicians supporting a reform in abortion law) in May 1971, and the Manifesto of the 220 (gynecologists expressing support for the 252 physicians) by the end of the year (Le Naour and Valenti 2003). Press coverage of these manifestos facilitated a public debate on the question of sexual liberation, liberalization of abortion law, and women's condition more broadly (Isambert and Ladrière 1979; Gouaze et al. 1979). Those in support of liberalization were emboldened by the trial at Bobigny, and the defense counsel's strategy of using the trial to indict the law was repeated at several more trials, such as in Angers and Lyons (Turenne 2007).

The impact of the unique legal strategy Halimi deployed was to significantly broaden not only the debate on the issue of abortion but also the definition of distress, a discursive process carried out during a negotiation between the judge and the various experts the defense called to at Bobigny. The defendants' rather courageous decision to allow Halimi to turn their criminal defense into a political trial that showcased civil disobedience not only aided them in the short term but precipitated a significant change for French women. In allowing so many male experts to speak for women and in stressing the class bias of the law, Halimi's strategy had failed to secure a law that privileged women's rights above social considerations. However, the notion of "distress" has been understood rather broadly as a "subjective appreciation of the state of distress, evaluated by the woman herself" so that "politically, the Veil law represents a victory for personal freedom …" (Turenne 2007, p. 230). While physicians control the actual practice of abortion, it is the "economic, social or moral situation of the woman," evaluated by the woman herself and not by the physician, that defines "distress" (Turenne 2007, pp. 223, 232). Therefore, Bobigny did gain a legitimate place in French law for a woman's own, independent, evaluation of her needs, desires, and quests for personal fulfillment. In this paradigm, the views of the woman herself are paramount.

CHAPTER 8

Feminism, Foetocentrism, and the Politics of Abortion Choice in 1970s Australia

Erica Millar

In the 1960s, a surge of abortion activism affected much of the Western world. Several groups—including civil liberties organisations, medical doctors and the nascent women's movement—joined forces to successfully campaign for abortion law reform. The UK Abortion Act (1967) expanded the definition of therapeutic abortion to explicitly allow medical doctors to perform abortion on the grounds of a woman's psychological (in addition to physical) health. Law reform in Britain helped ignite a trend for the worldwide liberalisation of abortion law. Between 1967 and 1982, 40 countries had liberalised their abortion laws (and only 3 had introduced more conservative abortion legislation). New laws in Australia, New Zealand and Canada were modelled on the UK Abortion Act. In the United States of America, a Supreme Court decision of 1973 resulted in more radical reform, conferring upon women the right to early abortion under the grounds of privacy (Francome 2004, p. 1).

As a consequence of campaigns for abortion law reform and the intense politicisation of abortion that began to take shape in the 1970s, abortion began to be spoken about in public forums on a scale not previously wit-

E. Millar (✉)
Gender Studies and Social Analysis, The University of Adelaide, Adelaide, SA, Australia

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_8

nessed. The language of "choice" became central to communicating liberal abortion politics. This chapter examines political struggles over the meaning of choice in two contrasting movements for law reform in 1970s Australia. It outlines the civil liberties approach to abortion, which framed abortion as a matter of individual conscience, and the women-centred language developed by the Women's Liberation Movement (WLM). It then considers how these competing frameworks of choice entered political vocabulary in the decade. I argue that in the 1970s the choice of abortion was increasingly normalised. By the end of the decade, politicians and the general public largely accepted that women should have the choice of abortion in many instances, and medical doctors commonly interpreted the criteria of psychological well-being broadly, leading to a de facto practice of referring women for first trimester abortions on request. Yet the incorporation of the language of choice into public discourse on abortion coincided and did not conflict with a morality that understood abortion to singularly entail the cessation of human life. Abortion was integrated into the discursive framing of pregnancy decision-making as an exceptional choice, and one absented from the radical gender politics of the WLM. The exceptional status of abortion restated the norm of motherhood for women generally and for pregnant women most acutely. The incorporation of the "awfulisation" (Boyle 1997, pp. 30–31) of abortion into a pro-choice framework is essential for historicising a contemporary paradox, where the abortion choices of women are simultaneously accepted as necessary and admonished as morally dubious (Pollitt 2014).

The Choice of Illegal Abortion

Australian states adopted abortion legislation from the United Kingdom, which criminalised women who intended to unlawfully procure a miscarriage and individuals who intended to unlawfully administer one with a penalty of five to ten years' imprisonment (*Crimes Act* 1958 (Vic) ss 65–6). The criminalisation of abortion encouraged secrecy surrounding the practice in public forums, with the print media, for example, euphemistically referring to abortion as an "illegal operation" (Gregory 2005, p. 123). Despite the overall taboo and secrecy of abortion, there were two prevailing stereotypes of women who had abortions: the "good," "aborting woman as victim," and the "bad," "selfish and pleasure-seeking" woman (Baird 1998, p. 163). The aborting woman as victim—of male licentiousness (single women) or poverty (married mothers with several

children)—was a working-class body, associated with the dangerous figure of the "backyard" abortionist (Baird 1996). The selfish aborting woman was implicitly middle class, refusing her maternal instinct as well as her duty to reproduce the nation (Baird 1998, p. 144).

The abortion taboo did not stem from concern about the foetus—as it arguably does today—but the taboo and secrecy surround sex and sexuality (Luker 1984, pp. 128–129). The foetus became a major actor in abortion discourses in the late 1960s as a direct consequence of the push for abortion law reform, which in Australia began in the mid-1960s, accelerating quickly after the UK Abortion Act of 1967. Leading to the period of liberalisation, the Catholic Church and the nascent anti-abortion movement established the "foetal rights" perspective as the only moral position on abortion (Luker 1984, pp. 128–129). The ascendency of a foetocentric abortion morality coincided with the reconfiguration of pregnancy as a medical (as opposed to "woman's") condition involving two autonomous patients, with the foetus as its primary subject (Kevin 2003, pp. 80–115).

Supporters of law reform did not represent abortion as a choice that should be available to women (Kevin 2003, pp. 80–115). Rather, they responded to foetocentric morality and claims of women's selfishness by inferring that women only had abortions in desperate circumstances, usually because they were unmarried and/or could not financially support a child. Activists also argued that doctors should have autonomy over what they framed to be a medical procedure. Support for law reform was certainly not based on the presumption that abortion was a social good. Rather, reformers argued that abortion was an inevitable consequence of a range of factors, including poverty and inadequate access to effective contraceptive devices; thus, rather than being unregulated and dangerous, the procedure should be safe and monitored by medical doctors. Abortion law reform would further end police corruption and illegal abortion rackets, themes that also dominated the media (Gregory 2005, pp. 132–137).

Freedom of Conscience

At the turn of the 1970s, agitation for abortion law reform amongst civil liberties groups, the medical profession, the media, some churches, and within the major political parties culminated in law reform across several Australian states (Gregory 2005, pp. 121–175). The Abortion Law Reform Association (ALRA) was a major agitator for change, and contin-

ued its activism after the medicalisation of abortion. Named after its British counterpart, ALRA emerged in Australia from civil liberties organisations in several states in the years immediately following the Abortion Act 1967 (UK); this providence, in addition to the strong influence liberalism holds in Australian legal traditions (Sawer 2003, pp. 2–5), ensured that classic liberal political philosophy played a key role in its activism.

The guiding principle of ALRA's activism was that legal prohibitions on abortion represented an unwarranted incursion of the state into the conscience of its citizens. ALRA's framing of abortion as a matter of private conscience involved two interrelated assumptions: that abortion was primarily a moral (rather than a political or social) issue, and perhaps more importantly, that the moral issue involved was whether or not the foetus constituted human life—"[t]he most complex and emotive aspect of the abortion reform debate" (ALRA 1970b). ALRA (1970b) contested claims that the foetus was objectively knowable—by religious tenet or scientific fact—and instead argued that one's opinion regarding foetal life rested on their broader "personal values and beliefs." Abortion morality was therefore variable and subjective, and in imposing a minority, Catholic morality onto the entire population, restrictive abortion law undermined the ability of individuals to act according to their individual consciences. ALRA initially emphasised the consciences of doctors, whose medical judgement was obstructed by laws that set guidelines as to when abortions could be performed. Yet in 1972, the association began placing equal emphasis on women's consciences and changed its name from the Abortion Law *Reform* Association to the Abortion Law *Repeal* Association to reflect its new campaign for the complete repeal of statute laws criminalising abortion (ALRA 1972a).

A striking aspect of ALRA's politics was its depiction of abortion as "unpleasant" (McMichael 1972b) and the recurring idea that, in the words of one of the association's presidents, "[n]o-one actually likes the idea of terminating pregnancies" because of "a natural respect for life in **any** form" (McMichael 1972c, p. 5). As noted above, abortion law reform had not been achieved in Australia, or elsewhere, through the rhetoric that abortion presented a social and moral good—rather, safe, legal abortion, so reformers argued, presented a better alternative to illegal, unregulated "backstreet" operators. ALRA continued to legitimate abortion by presenting it on a sliding scale of desirable options. Abortion, it argued, was more desirable than the birth of unwanted children—"every child should be a wanted child," so a leading slogan exclaimed.

ALRA reproduced scientific studies demonstrating that unwanted children experienced greater levels of emotional and physical abuses than did wanted children, and they frequently became "social misfits," "inadequate parents," and "deprived and inadequate citizens" (1970a; 1970c; 1970b). This was the closest the association came to advocating for abortion on eugenic grounds, a rationale that plagued the birth control movement transnationally since its initiation in the early twentieth century (Ziegler 2013). Although more desirable than the birth of unwanted children or unsafe "backyard" operations, ALRA considered abortion less desirable than other modes of contraception, placing a moral obligation on women to prevent unwanted pregnancies. Its leading slogan in the early 1970s was "Abortion: A Right. Contraception: A Responsibility." This slogan differentiated abortion from other modes of contraception while also privileging one over the other; ALRA (1972b) termed abortion the "second best" method of birth control and "the last resort" after contraceptives had failed (McMichael 1972a, p. 39). The framing of abortion as an issue involving the status of foetal life—one that should be granted a "natural respect," at least in some form—prevented it from depicting abortion in positive terms.

ALRA's repeated presentation of women who had abortions as, in the words of leading reformer Bertram Wainer (1969), being in a state of "anguish" and "desperation" enhanced the negative terms with which it discussed abortion. The association generally assumed the women who had abortions were unmarried and required an abortion to avoid the stigma of unwed motherhood, or married with several children, living in poverty and often in volatile, abusive relationships. Of the three case studies of women seeking abortion presented in its 1972 publication *Abortion: The Unenforceable Law*—written by a social worker, psychiatrist and general practitioner—all three women were married with children, two accounts dwelt on the woman's financial hardship, and two women had abusive husbands (Boas 1972; Gold 1972; Wynn and McMichael 1972). Aborting women generally figured as distressed victims of unfortunate circumstances beyond their control. ALRA, thus, relied on a trope that activists had deployed in their campaigns for law reform of the late 1960s—that of the "desperate aborting woman." The circumstances that ALRA believed led women to seek abortion implicitly circumscribed the conditions under which women were believed to mother effectively: being middle class and in a stable relationship. Such characteristics constituted the stability ALRA evoked in its description of law reform as

amounting to "willing mothers, wanted children, [and] stable families" (ALRA 1974).

Some aspects of ALRA's politics were undoubtedly progressive for the time: the demand for abortion with no legal restrictions is a goal yet unrealised in most of the world. The non-judgemental assertion that single women should have access to abortion also represented a morality that broke with the then prevalent ideology of female sexual purity (Reekie 1997). Yet in the main, ALRA argued for the decriminalisation of abortion by integrating the practice into the dominant social and political values of the time, values that reaffirmed abortion as a negative practice and motherhood as the normative and only unproblematic outcome of pregnancy. Abortion was viewed as a deviant choice—an undesirable, yet necessary procedure required when other forms of contraception had failed. There was no doubt a political expediency in adopting a position that did not freely condone abortion, yet it also infused anti-abortion sentiment into the very idea of abortion choice—in regard to both ideas about what the choice entailed (the failure of contraception and cessation of a life that should be granted "natural respect") and the women who made this choice (desperate victims of circumstance).

Towards a Women-Centred Abortion Morality

Although a foetocentric morality underpinned the most prominent articulation of ALRA's politics, a women-centred morality was increasingly visible alongside this. In a radio interview transcribed in *Abortion: The Unenforceable Law*, Germaine Greer—an Australian feminist who had achieved international acclaim with the publication of her *The Female Eunuch* (1970)—criticised the medicalisation of abortion for forcing a woman "to claim that she'd go off her rocker if she had a baby … We've got to argue … as idiots—as moral cripples, who are not able to make decisions for themselves" (Greer 1972). Here, Greer was drawing on nascent feminist critique of the staunch paternalism embedded in laws that medicalised abortion. By permitting abortion only in cases where women were medically (and, more often than not, psychologically) "at risk," the law reinforced a gendered binary that constructed women as "irrational" victims and doctors as "rational" saviours (Sheldon 1997). Greer and other liberationists argued instead that abortion should be recognised in law as a rational decision made by psychologically stable women.

Abortion politics were central to the renewed feminist politics that swept much of the Western world in the 1970s. Feminist intervention into abortion politics, in turn, significantly altered the terms of the abortion debate (Siegel 2014). The WLM viewed legal prohibitions on abortion—and the system of values that upheld such laws—as an exemplary example of the patriarchal system whereby men indirectly (through social mores) and directly (through laws) controlled women's lives for their own benefit.

In Australia, the WLM established a single-issue campaign for the repeal of all abortion laws in 1972, the Women's Abortion Action Coalition (WAAC). Australian liberationists believed they were part of an international struggle with "our sisters overseas" against patriarchy and specific issues, such as abortion. WAAC was a conscientiously global movement. Its political slogans, including "Women unite: abortion is our right," and the title of its magazine, *Abortion Is a Woman's Right to Choose*, were echoed through Western Europe and North America. Activists also shared campaign strategies. These included consciousness-raising activities, such as mass demonstrations, "speak outs" and "self-incrimination" campaigns. Inspired by the Manifesto signed by Simone de Beauvoir and hundreds of other well-known French women confessing to their abortions, for example, in 1973, Melbourne activists marched to the police headquarters demanding they be arrested for breaking abortion laws (Gregory 2005, pp. 255–256).

Liberationists believed that abortion rights translated into nothing less than "the right to control their own bodies and lives" (WAAC 1974a). WAAC's newsletter, *Right to Choose*, was a major forum for WLM's critique of the "image of a mother who is always giving … who never puts herself first" (WAAC 1979, p. 5). Restrictions on abortion, activists argued, ensured women's attachment to the twin institutions of marriage and the family, "which make women inferior to men—which make women the possession of men—which keep women from being free" (WAAC 1978b). Without access to abortion, women remained "in biological bondage and tied to the nuclear family" (WAAC 1975c, p. 10); they were mere "child producing units" (WAAC 1974b, p. 4), imprisoned in "a twenty-year sentence of enforced motherhood" (WAAC 1977). The coalition insisted that women "cannot be free to use their talents and skills fully unless they know their lives will not be interrupted by unplanned pregnancy and child rearing" (WAAC 1975d, p. 9). Women's inability to completely control

their fertility compromised their educational achievements, provided justification for employers to keep women in low status and low-pay careers (WAAC (1978d)), and formed a psychological barrier, preventing women from seeking fulfilment outside the roles of wife and mother (WAAC 1975b, p. 5).

WAAC asserted that men controlled every aspect of abortion: Catholic priests framed abortion as a moral issue based on foetal life; male politicians and judges delineated its legal position; and laws on abortion, in turn, gave the abortion choice to male medical doctors. *Right to Choose!* was littered with images of gagged pregnant women, exhausted mothers with demanding children at their feet and passive pregnant women, standing in judgement before men in their roles as doctors, judges, politicians and priests. Alongside slogans such as "Get your rosaries off my ovaries" and "Not the church, not the state, women must decide our fate," such images forcefully depicted women's lack of voice in decisions with profound implications for their lives.

WAAC (1973) maintained that the dominant view of abortion as a moral tragedy derived from "the reactionary media, churchmen and politicians who daily intimidate women into believing they have no right to control their own bodies." The male-oriented representational system defined women as mothers and compelled women to view abortion as a shameful, guilty secret they had to hide from others (WAAC 1975a). WAAC insisted that mainstream abortion morality was a "club to beat us [women] with" (1978d, p. 2). The campaign insisted that abortion was not a moral issue centred on foetal life or contraceptive failure, but "about political power, power over women's lives" (1978c, p. 5). Although WAAC campaigned for safe, free and widely available contraceptives, it also warned women of the health consequences of many contraceptive devices and aimed to reframe contraception as a woman's choice rather than obligation (1977, p. 21). When contraception was framed as a woman's responsibility—as it was in ALRA publications—women who sought abortions would be compelled to feel "embarrassment at having 'failed' with their contraception" (WAAC 1978a, p. 3). WAAC aspired to abate abortion shame and stigma by reconceptualising abortion as a common experience to women. In order to "overcome the terrible stigma attached to abortion," WAAC believed it was "necessary for women to get up in the streets and state they have had abortions and that they believe that it is every woman's right to decide" (Schnookal 1974).

The WAAC, therefore, represented abortion to be a moral good and social necessity, an essential precondition for the ability of women to live

as free, independent subjects, outside the shackles of compulsory motherhood. The autonomous, liberated subject of the abortion choice in WAAC publications was a direct challenge to ALRA's "desperate aborting woman"; she was a subject seeking to define her own life path and, in so doing, assert her own wishes and desires in a world that too readily conspired to define these for her.

Limitations of Choice

The WLM's focus on abortion rights as a means of liberating all women is exemplary of a broader failure to properly acknowledge the gross inequalities that exist between women and to address the concerns of women who fell outside the heterosexual, white, middle-class norm (Burgman 2003, pp. 141–147).

The focus on the law as the major or even sole obstacle to abortion obfuscated inequities that differentially determined, and continue to determine, women's access to abortion. The importance of considering class-based inequities in accessing abortion services was brought home to activists after the US Hyde Amendment of 1976 cut federal funding to abortion services. A bill introducing similar legislation (the Lusher Motion) was introduced, only to fail, in Australia in 1979. In response to threats to the state provision of abortion, many WAAC members pushed to replace the slogan "right to choose" with "free abortion on demand." Even if women secured the legal ability to choose abortion, they argued, abortion needed to be readily available and affordable before women could exercise this choice (WAAC 1976, p. 16).

During the 1970s, lesbians and women of colour presented staunch critiques of WLM's focus on patriarchy and compulsory motherhood as key sources of women's oppression. In proclaiming that "there is hardly a woman alive who has not been faced with the problem of an unwanted pregnancy" (WAAC *Right to Choose!* 6 February–March 1975), for example, liberationists reinforced the assumption of women's heterosexuality, one that works to marginalise other sexual identities. In contrast to the regime of compulsory motherhood, the motherhood of women of colour was (and continues to be) routinely denigrated—images of the "good mother" have historically centred on whiteness—or prevented through impelled regimes of foster care, adoption and programmes of forced sterilisation (Roberts 1997). In response to such critiques, the WLM in Australia and elsewhere included the demand for "no forced sterilisation" alongside its call for abortion rights. Since the 1970s, the

fight for reproductive rights has also expanded to a justice framework, with activists and scholars working to support the capacity for women to have children as well as decide when and whether to do so (Silliman et al. 2004).

In the Australian context, Aboriginal women were at the forefront of critiquing the whiteness inherent in Australian feminism. WLM's framing of pregnancy choice in relation to women's capacity to choose abortion disregarded the primary political demands of Aboriginal women, which, in stark contrast to WLM's aim to delegitimise the norm of the family, was *to be* recognised as legitimate mothers and *to keep* their families and communities together. Racist state policies in Australia tore Indigenous communities apart, separated children from their mothers, and medical doctors sterilised Aboriginal women without their knowledge, let alone consent.[1] By focusing on patriarchy as the explanatory framework of oppression and power, WLM was unable to account for why one of the biggest obstacles to white women's reproductive choice was abortion, when for many Aboriginal women it was the ability to avoid sterilisation and keep their children after birth. WLM needed to consider the discriminatory effects of colonisation and race to comprehend this contrast. The movement failed to do this because, as many Aboriginal women have argued, it would have entailed recognition of white women's role as oppressors of Aboriginal women. The irony of the campaign to "stop forced sterilisation on our black women … while white women campaign for the right to abortion" was not, however, lost on Aboriginal activists (cited in Vashti Collective 1973, p. 15).

Increasing demands within feminist activism and scholarship to think of gender as it intersects with race and class caused a further fracturing of discourses that, together, would come to be called "pro-choice" by the end of the decade. The movement thus contained several different strands of talking about the choice of abortion, the women who had abortions, and the necessity of women's access to abortion. As we shall see, these multiple meanings were narrowed in the broader political discourse on abortion, and the importance of gender to abortion politics diluted in the process.

[1] In her landmark critique of the whiteness inherent in Australia's women's movement, Aileen Moreton-Robinson discusses the use of the harmful contraceptive depo-provera—banned in the United States of America in the 1960s and not approved for use in Australia—in Indigenous communities in the 1970s (Moreton-Robinson 2000, p. 171).

Degendering Choice

As early as 1975, WAAC warned that many women "have been lulled into a false sense of security–and apathy" regarding their lawful access to abortion (WAAC 1975d, p. 6). Rebecca Albury—at that time a committed socialist feminist and member of WAAC—echoed this concern towards the end of the decade. Albury claimed that the increasing availability of abortion and broad support for women's choice—particularly from liberal feminists, who supported capitalism, and leftist men, who benefitted from patriarchy—severely compromised the movement because it threatened to remove feminism from the politics of abortion (Albury 1981, p. 22). Albury's comments were prescient in many ways. The choice of abortion was discursively abstracted from gender politics the more it became available and "normalised" in Australia. I examine this process through the language politicians used to support or oppose women's access to abortion in three Commonwealth measures relating to abortion in the 1970s.

The first Commonwealth debate concerning abortion in the 1970s was a pro-abortion bill sponsored in 1973 by Tony Lamb and David McKenzie, two ALRA members and MPs elected for the first time with the victory of the progressive Labor government led by Gough Whitlam in 1972. The McKenzie-Lamb Bill sought to remove legal restrictions on abortions performed by medical doctors to the 23rd week of a woman's pregnancy in the Australian Capital Territory. Lamb and McKenzie forwarded the bill to begin a national discussion on the issue of abortion. If adopted, the bill would have resulted in the most liberal abortion law worldwide at that time, and, indeed, it proved too progressive for the government and failed decisively. The debate over the bill did, however, lead to the establishment of a Royal Commission on Human Relationships, which reported in 1977 (Albury 1981, p. 22). A Royal Commission is the highest form of Commonwealth inquiry into matters deemed to be of public importance; thus, its establishment reflected government acknowledgement that social mores in regard to abortion were changing and this may require some policy or legislative response. The establishment of the Lane Committee in the United Kingdom was a major impetus behind its formation, and the final report drew heavily on its British counterpart. Unlike the Lane Committee, which recommended retaining laws that medicalised abortion, the Commission recommended that abortion be regulated like any other medical procedure until women

were 22 weeks pregnant, the point at which foetuses were assessed as viable (Evatt 1977, v1, pp. 105). This recommendation did not, however, lead to any Commonwealth or state action on abortion. Instead, in 1979, Stephen Lusher—an anti-abortion Catholic and member of the socially conservative Country Party—moved a motion to cease Commonwealth funding for abortion except in cases where a medical doctor certified that the aborting woman was suffering from a "pathological condition" or the abortion was required to save a woman's life (Stephen Lusher, cited in Australia 1979a, p. 693). The Lusher Motion represented the first anti-abortion intervention into Australia's formal politics. Unlike the US Hyde Amendment (1976) upon which it was based, the motion failed by an overwhelming majority (Stringer 2006).

The Royal Commission on Human Relationships authoritatively affirmed that the abortion debate hinged on "whether the life of the foetus should be protected by the criminal law [and whether] society [can] condone the destruction of the foetus without at the same time diminishing the value of human life" (Evatt 1977, v3, p. 147). This description of the abortion issue foreclosed WLM's alternative view, which centred on a pregnant woman's willingness to remain pregnant and become a mother. The Commission asserted that abortion was an "issue of serious concern to everyone" because it "brings that new life to an end" (Evatt 1977, v3, p. 149)—as opposed, for example, to an issue that has particular bearing on women. Yet it also concluded that foetal life was of "different quality" to life after birth, a conclusion informing its recommendations to decriminalise most procedures (Evatt 1977, v1, p. 54).

Parliamentarians debating the McKenzie-Lamb Bill and Lusher Motion reinforced an abortion common sense that viewed abortion through the lens of a foetocentric morality. The idea that the abortion debate hinged on the moral status of foetal life was built into the very structure of the debates, where parliamentarians were granted the ability to vote according to their individual consciences, rather than party affiliation. Conscience votes are rare, and usually extended to members when debating issues involving moral questions of life and death (Warhurst 2008). The narrowing of the abortion debate to "one's assumption or otherwise that a foetus becomes a human being at the time of conception" was noted by one Member of Parliament (Richard Klugman, cited in Australia 1979a, p. 1004). Parliamentarians who supported women's access to abortion argued that the value one ascribes to foetal life was "a matter of conscience … primarily for the woman and her doctor" (David McKenzie, cited in Australia 1973, p. 1963). Anti-abortionists argued that foetuses were the

moral equivalent of born humans and, as such, pregnant women were not autonomous subjects under the law: "another person is involved in this question of choice—the unborn child" (Peter Shack, cited in Australia 1979b, p. 1104).

Parliamentarians and the Royal Commission unanimously presented abortion to be a profoundly disturbing and undesirable practice. McKenzie claimed that his bill was "not a matter of whether one agrees with abortion—I do not, and very few people do" (David McKenzie, cited in Australia 1973, p. 1964). The Commission referred to abortion as "repugnant … to the conscience" (Evatt 1977, v3, p. 153), and an opponent of the Lusher Motion asserted that "I do not believe that any honourable member believes that abortion is morally a good thing" (Neal Blewitt, cited in Australia 1979a, p. 1113). Parliamentarians who supported fewer or no restrictions on abortions performed by medical doctors emphasised the need for contraception and social welfare services to alleviate the need for abortion: a clause in McKenzie-Lamb, for example, required doctors to provide women having abortions with contraceptive counselling (David McKenzie, cited in Australia 1973, p. 1963). The Commission was similarly directed to investigate how education and contraceptive services could reduce the number of abortions (Evatt 1977, v3, p. 153). "Pro-abortion" politicians viewed abortion as "the lesser of two evils" when placed alongside its alternatives: not forced pregnancy and motherhood, but dangerous, "backyard" abortion practices and the birth of unwanted children (Harry Jenkins, cited in Australia 1979a, p. 982). As choice, therefore, politicians accepted abortion as an exceptional and awful one. They nevertheless pled for "people who are so loud in their criticism to show real compassion for women" who were forced to make this "terrible choice" (David McKenzie, cited in Australia 1973, p. 1968). The object of their compassion was the desperate aborting woman and the related figure of the neglected, unwanted child, or, in the words of one MP, "the tired and overworked mother of a poor man's clutch of children" (Clyde Cameron, cited in Australia 1979a, p. 988).

The use of the term "pro-choice" to describe a politics that, in the 1970s, the media and parliamentarians usually termed "pro-abortion" was not commonplace until the 1980s. Rickie Solinger notes of the American context that activists increasingly adapted the liberal principle of choice to avoid condoning abortion as a social or moral good (Solinger 2001). The same, I argue, is true of Australian activists and politicians. The emphasis on choice stemmed in part from the discomfort many advocates for abor-

tion law reform had with the practice of abortion itself and the accompanying sentiment that "I do not know anyone who is pro-abortion" (Ian MacPhee, cited in Australia 1979a, p. 1081). A "pro-choice" position enabled individuals to support liberal abortion laws without also, explicitly, supporting abortion. The anti-abortion movement capitalised on the ambiguity of the "pro-choice" yet "anti-abortion" approach, arguing that individuals must either be for or against abortion.

Women-centred arguments had little impact on political debate in the 1970s.[2] Rather than being an issue of particular concern to women, parliamentarians generally argued that abortion was "one of the most sensitive and controversial issues facing the Australian community" (Phillip Lynch, cited in Australia 1973, p. 1979). The framing of abortion as a "community issue" rather than "women's issue" legitimated a range of social actors—including journalists and politicians, almost exclusively male—to speak authoritatively about the issue, foreclosing the idea that women held a particular or primary speaking position in the debate.

Freedom to Choose

In 1975, a journalist reported that "it is now possible for any Australian woman to obtain a safe, legal abortion if she wants one," a finding reiterated in the Royal Commission of 1977 (Dale 1975; Evatt 1977, v1, p. 154). The majority of parliamentarians, the media and the general community held Lusher's defeat to settle the issue of how the state should regulate abortion. Abortion would remain technically illegal and administered by doctors, whose broad interpretation of the mental health risks of continuing with unwanted pregnancies ensured that first trimester abortions were virtually available upon a woman's request (Savulescu 2004, p. 202). The Australian community largely supported the ability of women to choose abortion in many instances by the end of the 1970s (Betts 2004). During the 1970s, the notion of abortion choice gradually entered into the public vocabulary. Yet as it did so, the meanings given to the choice of abortion were narrowly circumscribed. Abortion was normatively framed as the death of a foetus, and the women who had abortions were stereotyped as either selfishly refusing their maternal duties or desperately seeking relief from circumstances that compromised their capacity to mother effec-

[2] Some politicians did express discomfort, however, in debating a "women's issue" with no female participants (see, for example, Harry Turner, cited in Australia 1973, p. 1987; Keppel Enderby, cited in Australia 1973, p. 1979; Tom Uren, cited in Australia 1979a, p. 978).

tively. The ascendency of a foetocentric framing of the abortion choice in the 1970s was the consequence of a political struggle, primarily over the centrality of motherhood to women's identities. When parliamentarians and activists spoke about abortion, they were, regardless of whether they explicitly acknowledged it, discussing whether pregnant women were already mothers, whether they should be compelled to become mothers, and, frequently, which women made the best mothers.

ALRA incorporated abortion choice into the existing moral order that sacralised foetal life and sanctioned the selfish mother. The association asserted that aborting women were desperate rather than selfish and required abortion in order to alleviate their suffering. ALRA also emphasised abortion as a means of preventing the birth of children to overburdened and potentially negligent mothers, subtly recentring the figures of the child and the "good mother" in debates about abortion. ALRA framed all abortions as undesirable and largely preventable, unwittingly confirming the shame surrounding abortion as a sign of irresponsible contraceptive use (Millar 2015). WAAC's women-centred approach was a reverse discourse. The coalition argued that a male-centred representational system produced the foetocentric morality of abortion, which infused abortion with shame in order to bind women to the mothering role. The comparison of ALRA's and WAAC's politics presented here begins to unravel the ready association of choice with freedom. The concept of choice can carry quite specific and diverse political aspirations and, as individual capacity, can construct its subjects in precise yet varying ways.

WAAC's activism was influenced by liberalism's privileging of the autonomous subject and individual rights. The reification of individual freedom through the language of personal choice has, in the subsequent decades, proved problematic. The presumption that abortion is a woman's autonomous choice, for example, removes abortion—and, by implication, motherhood—from the sociocultural realm to that of individual responsibility. Although focused on choice and the aspiration of women's autonomy, WAAC also deployed the language of choice and rights in judgement about "whose rights wrong whose rights" (Ahmed 1998, p. 42): that is, to emphasise that a woman's right to abortion is paramount, exceeding the rights of foetuses or doctors. WAAC insisted that genuine abortion choice entailed more than simple law repeal: it involved securing women's access to abortion, social support services and rethinking the sociocultural schemas through which the abortion choice and femininity more generally are given meaning in the broader community.

Lawful access to abortion is crucial to women's reproductive freedom. Although they did not achieve this goal, ALRA and WAAC improved and transformed women's access to abortion and ensured that the reformed laws that medicalised abortion were applied as liberally as possible (Gregory 2005, p. 278). *But a lawful choice does not equate to a legitimate one*. In the 1970s, the politics of abortion was incorporated into the existing normative frame of abortion, with the consequence that abortion was represented as a fundamentally illegitimate choice, requiring justification in reference to women's desperation and, implicitly at least, their status as potentially unfit mothers. In campaigning for lawful access to abortion, mainstream pro-choice politics reified the social and political values that produced abortion anew as a deviant and problematic choice for pregnant women. Thus, the exceptionality of abortion was written into the rhetoric of choice from the moment it became attached to abortion. The ambiguity of abortion I have historicised here—in its simultaneous acceptance that women will have abortions and derision of abortion as an imperfect and undesirable choice—is at the heart of contemporary abortion politics and manifests in what scholars call the stigmatisation and "awfulisation" of abortion. The profound negativity attached to abortion has material effects, including a lack of government investment in ensuring women can access to abortion (Baird 2013). This chapter thus contains an implicit warning: political expediency can result in an abortion politics that is in many ways counterproductive to its aims.

CHAPTER 9

We Are All Feminists Now: How to Pass an Anti-Abortion Law in Australia

Kate Gleeson

Australian women have been described as coming closer to the "radical claim for 'free abortion on demand' than women in most other liberal democracies" (Albury 1999, p. 11). In the 1980s, Australia was internationally feted for its feminist policy machinery, its generously subsidized women's services and its pioneering of an internationally influential model of bureaucracy "compatible with feminist philosophy" (Sawer 1990, p. xv). The perception of Australian feminists' success in abortion policy relates to their engagement in effective "venue shopping" between levels of government, exploiting the multiple access and veto points of local, state and federal policymaking, when they have been denied participation in decision-making arenas or when one venue's rules have proven to be "biased in favor of their opponent" (Pralle in Chappell and Costello 2011, p. 635; Fenna 2009, p. 158). Domestic abortion provision in Australia is governed by state and territory criminal and health laws, while the federal government is responsible for funding rebates for abortion procedures and associated counseling, the authorization of abortion drugs and the

Research for this chapter was supported by an Australian Research Council Discovery Grant DP0986934. Many thanks to Rebecca Albury, for invaluable advice on this chapter, and to Kate Barnsley, for research assistance.

K. Gleeson (✉)
Macquarie Law School, NSW, Australia

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_9

development of Australia's foreign-aid policies concerning family planning, including abortion.

Recent evidence suggests that the Australian model of federalism has been particularly amenable to feminist lobbying relative to Canada and elsewhere (Fenna 2009, p. 158) and has produced more innovative and experimental women's policies than have centralized governments (Chappell and Costello 2011, p. 635). Proponents of federalism identify one of its most valuable attributes as the possibility of vertical and horizontal "contagion" and policy learning (whereby innovations in one jurisdiction influence polices in another, across and between levels of government), which Australian feminists have successfully exploited between states, territories and the Commonwealth as part of their "venue shopping" strategy (Chappell and Costello 2011, p. 635). Nevertheless, as certain Australian anti-abortion policies indicate, feminist authority is vulnerable to exploitation within this system, particularly at times of conservative rule. "Venue shopping" is also used by anti-abortionists to target different aspects of abortion policy through more or less sympathetic governments, as these change over time, also with the aim of a national "contagion" in policy outcomes. When successful, such tactics support the orthodox criticisms of federalism that "the tyranny of the majority is replaced by the tyranny of the minority" (Chappell 2001, p. 60), as Australian opinion polls consistently indicate widespread support for safe and equitable abortion access (Betts 2004).

While there have been no outright abortion "bans" in the Australian states and territories, in 1996 the federal government passed a number of significant, enduring anti-abortion measures, including preventing domestic use of the abortion drug RU486 and prohibiting the funding of international abortion services (and some family planning programs). These reforms marked the beginning of 12 years of conservative rule in Australia, with apparent contradictory outcomes for abortion. Anti-abortionists had few conclusive successes replicating the 1996 federal anti-abortion policies in the states and territories. But, to extend the contagion metaphor, a new national culture was contracted at this time in which abortion was publicly reframed as an experience "that is contrary to, rather than consistent with, women's health and well-being" (Baird 2013, p. 245). Hence, while abortion has remained available in Australia (with some limitations incurred in certain jurisdictions and lifted in others), authors such as Barbara Baird argue that during the period between 1996 and 2007, the mainstream

political image of women changed to that of "being particularly vulnerable to being harmed by abortion" (Baird 2013, p. 245).

Most remarkable about this discursive shift was its legitimization by the conservative appropriation of *radical feminist* rhetoric and research characterizing abortion as dangerous and detrimental to women, such as that formulated and aired at the landmark fourth International Conference on Population and Development (ICPD) in Cairo in 1994. The Cairo ICPD is significant for marking a turning point of acceptance of liberal feminism in regard to reproduction within the international community. But it also signified the first overt, concerted program of appropriation of radical feminism by conservative religious organizations, such as the Vatican, at the United Nations. While this strategy had few demonstrable outcomes for the Vatican at Cairo, its use domestically in countries such as Australia has been significantly more effective. Promulgating the belief that "abortion harms women" is a well-documented strategy of the Christian Right. What has not been examined in Australia, however, is the role that the appropriation of radical feminism played in supporting anti-abortionist "venue shopping" to create a political culture of fear for women and abortion, and what the outcomes of this have been for feminism.

As this chapter suggests, while the authority of radical feminism was invoked to support political arguments that abortion harms women, parliamentary proponents of liberal feminism ultimately resisted this analysis, overturning the federal anti-abortion bans in 2006 and 2009. "Pro-choice" politicians (and lobbyists) are today ostensibly liberal feminists, and the discursive space for radical feminist critiques of abortion has closed, both in Australia and in the international community. While the predominant radical analysis blames liberalism for this closure, the consequences of the co-option of radical feminism by conservative Christians, and feminist cooperation with the latter, must also be examined. Such an examination in the context of Australian federalism forms the focus of this chapter, which aims to further analyze the vulnerabilities of federalism for women's policies, while highlighting the discursive arguments that anti-abortionists use and their effects on national culture and feminist movements. This chapter is structured as follows. First, it outlines the genesis of Australian abortion politics before outlining the "women-centered" developments in anti-abortion discourses in the 1980s and illustrating how these appeared to be mirrored by a nascent radical feminist critique

of medical abortion internationally. Finally, it explores the conservative appropriation of radical feminism at the Cairo ICPD and the effects of that strategy when deployed by anti-abortionists in the Australian parliament in 1996.

The Genesis of Australian Abortion Politics

In response to a series of corruption scandals involving Australian abortionists and police officials, as well as inspiration from the British *Abortion Act 1967*, a number of Australian states and territories reformed their repressive abortion laws after 1968. Through either the courts or the parliament, various jurisdictions clarified the circumstances in which doctors might lawfully perform abortions. National politics first became the focal venue of abortion lobbying during the 1972 election when the newly progressive Australian Labor Party (ALP) indicated it was amenable to "women's issues." Despite his party's lack of abortion policy, Prime Minister Gough Whitlam identified himself as supporting abortion on request and agreed to remove the prohibitive "luxury tax" on contraceptives. After members of his government tried and failed to enact prochoice legislation in the jurisdiction of the Australian Capital Territory in 1973, Whitlam pursued reform in the safety of the policy arena, including listing surgical abortion procedures in the new Medibank (now Medicare) public health rebates in 1974 (Gleeson 2014a). The Commonwealth inclusion of abortion in Medibank helped consolidate the legal, political and social legitimacy of abortion, and contributed to the perception of Australian women coming close to achieving "abortion on demand," especially when compared with the USA (Albury 1999, p. 11). No higher court judgment on lawful abortion has been delivered in Australia, but anti-abortionists challenged public funding and other federal parliamentary policy and legal initiatives in a variety of fora. Following the election of the Hawke ALP government in 1983, a bipartisan "quarantined" consensus was reached at the federal level whereby for 21 years the major parties declined to address domestic abortion policies, including funding (Maddox 2005, p. 103). The Hawke era is described as a period of "normalization of abortion and consolidation of abortion services" in Australia (Ripper 2001, p. 67). In response, throughout the 1980s and beyond, anti-abortionists changed strategies and venues, turning their attention once again to the states and territories, and Independent members of the federal parliament.

Developments in Anti-Abortion Discourses in the 1980s

As Rosalind Petchesky has documented, in the 1980s anti-abortionists worldwide made a "conscious strategic shift" away from religious discourses and authorities, to medico-technical ones centered on fetal images (Petchesky 1987, p. 263) that "effaced" women's reproductive bodies (Newman 1996, p. 625). A plethora of fetal images was complemented by melodramatic American "documentaries" of abortion procedures, such as the highly influential *The Silent Scream* (1984) and *Eclipse of Reason* (1987). The strategy was internationally influential in discursively positioning women as adversaries to their own pregnancies and fetuses (Newman 1996, p. 625), but it had no legislative consequences in Australia. On the contrary, in 1986 the abortion regime was *relaxed* in Australia's most conservative state, Queensland, by a ruling in the district court (*R v. Bayliss and Cullen* 1986). Australian anti-abortion campaigners experienced the unanimous jury verdict in *R v. Bayliss and Cullen* as a significant loss, which was followed two years later by a failed anti-abortion motion put to the NSW parliament. Leslie Cannold has documented the concerted shift in the activities of anti-abortionists in Australia and internationally around this time. In response to opinion polls indicating consistent widespread support for abortion access, even among those who believe that a fetus is a human being and/or that life begins at conception, anti-abortionists developed new "women-centered" campaigns (Cannold 2002, p. 172). Proponents of the women-centered anti-abortion approach—such as American David Reardon, author of *Aborted Women: Silent No More* (1987) and *Making Abortion Rare* (1996)—acknowledge the general failure of fetal-centered anti-abortion strategies to convert widespread beliefs about the fetus's humanity into lower abortion rates or heightened opposition to abortion (Cannold 2002, p. 172). Reardon and others connect this failure to the rhetoric of traditional anti-abortion campaigns condemning nearly all aborting women as "immoral, careless and or [*sic*] selfish murderers" (Cannold 2002, p. 172), which unsurprisingly many women resent. Contemporary anti-abortion activists using women-centered strategies "barely mention fetuses at all" and depict themselves as "having an agenda-less desire, grounded in their concern to protect vulnerable women's rights from being trampled by abortion service-providers" (Cannold 2002, p. 172). Reardon advises anti-abortionists not to acknowledge their goal of closing down the "abortion industry." Instead, he urges, "We

must always emphasize that our goal is simply to help and protect women. We may predict that our efforts will lead to the demise of the abortion industry, but that is not our direct goal—it is merely a byproduct of our legitimate concern to protect women's rights" (Cannold 2002, p. 173). In Australia, anti-abortion discourse involving the stigmatization of abortion providers as callously profiting from procedures was apparent by the 1990s (Ripper 2001, pp. 65–77).

The Radical Feminist Critique of Medical Science

The newly exploited distrust and stigmatization of abortion providers by anti-abortionists in the 1980s coincided with the emergence of a new strand of radical feminism critiquing scientific interventions in reproduction. Initially, radical feminists were most publicly associated with American and British anti-pornography and anti-sex-work campaigns such as the Take Back the Night marches led by Andrea Dworkin, Robin Morgan and others in the 1970s. Such campaigns identified sex as central to women's oppression and radical feminism as not one form of feminism among others but, in Catharine MacKinnon's terms, as simply "feminism unmodified" (Thompson 2001, p. 1). A proliferation of reproductive technologies in the 1980s prompted the expansion of radical feminist critiques to medical science, particularly in Europe and the UK.

Although feminists of different persuasions had long protested the medicalization of abortion, maternity and other aspects of reproduction, the birth of the first "test-tube baby" in England in 1978 and the subsequent development of international artificial reproduction technologies (ART) industries consolidated a dedicated strand of radical feminism suspicious of the medical science establishment. Treatises such as the 1984 *Test-Tube Women: What Future for Motherhood* (edited by Arditti et al. 1984) and the 1985 *The Mother Machine* (by Gena Corea 1985) exemplified the radical feminist quest to "shed light on what 'gifts' benevolent (male) scientists and doctors were ready to bestow on women worldwide" (Klein 2008, p. 157). From 1984, the European collective FINNRET (Feminist International Network on the New Reproductive Technologies), including founding member Swiss biologist and social scientist Renate Klein, debated topics such as the "death of the female" at the hands of medical science. In 1985, FINNRET changed its name to Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE).

FINRRAGE described itself as "an international women-centered network whose ultimate aim is to stop these dehumanizing technologies rather than regulate them because we believe that they are part of women's oppression and constitute violence against women and other nonhuman animals and plants" (Klein 2008, p. 157). FINRRAGE identified the promotion of ART in the West as an extension of the old reproductive technologies deployed in population policies in the developing world, and protested the "severe short and long-term adverse effects—including death—that women suffer from the procedures and drugs used in both the old and the new reproductive technologies through dangerous superovulation and egg harvesting" (Klein 2008, p. 158). Hence, FINRRAGE opposed the forced sterilization of women, chemical contraception (especially long-term methods such as Depo Provera and Norplant) and the failed vaccine against pregnancy, as well as chemical abortifacients such as the French abortion pill RU486.

In 1986, Klein immigrated to Australia, assuming an academic position in Women's Studies (Klein 2006) and establishing FINRRAGE (Australia). Klein's arrival (along with British radical feminist Sheila Jeffreys in 1991) provided fresh color to Australian feminist politics, which remained influenced by libertarian legacies such as that of Germaine Greer and contemporary liberal femocrats such as Anne Summers. The nascent, small Australian radical feminist movement of the 1980s came to be associated, generally, with the politics of FINRRAGE (Australia) and the publishing house established by Klein, *Spinifex Press*.[1] Klein and her collaborators staged some local campaigns against ART, but their Australian profiles were consolidated through opposition to RU486, although the drug was not available in Australia. FINRRAGE (Australia) identified its position on abortion in the following terms: "FINRRAGE (Australia) is a feminist organization and our focus is on the needs and interests of women rather than the fetus which we see as part of a woman's body. For these reasons we support abortion at all stages of a woman's pregnancy" (FINRRAGE (Australia) 1998). But Klein and her supporters identified RU486 and prostaglandin abortifacients as unsafe, with worryingly adverse effects, including, occasionally, death (Klein et al. 1991), and described medical abortion as the "new backyard abortion against which feminists in the 1970s campaigned" (Klein 2006). They advocated the "well-established"

[1] I note here that Denise Thompson and Sheila Jeffreys also promoted critiques of patriarchy. See Thompson, *Radical Feminism Today*; and Jeffreys, *The Lesbian Heresy*.

suction method of abortion with local anesthetic as representing international best practice (Klein and Hawthorne 2012).

In 1991, in response to an Australian tour by the drug's manufacturer, Renate Klein, Janice Raymond and Lynette Dumble published the report *RU486: Misconceptions, Myths and Morals* (hereafter *Misconceptions*). The authors detailed their concerns regarding the drug's safety and efficacy. Although their concerns about risks to women and the heightened medicalization of abortion appeared to mirror those promulgated by Reardon and his followers, the radical feminists implored, "There is an urgent need for more informed feminist discussion of RU486 but *not* on the terms of the anti-abortionists" (Klein et al. 1991, p. 3). Klein and Dumble presented the report's findings during a one-hour dedicated episode of a mainstream current affairs television program, where they criticized the drug and the heightened medicalization of abortion ("RU Ready"). This was an unusual coup for radical feminists, who, internationally, had begun to be marginalized and, in Australia, had experienced limited mainstream appeal.

In the USA in particular, by the early 1990s tensions between radical and liberal feminists had reached a breaking point around issues of pornography, ART and the RU486 campaigns. The liberal feminist stance on abortion promoting heightened choices, including medical abortion, had mostly prevailed within feminist circles across the West. This was evident in the 1993 affirmation of *Roe v. Wade* by American President Bill Clinton, and the outcomes of the Cairo ICPD, discussed below. While MacKinnon blamed the ascendancy of the liberal value of *privacy* for the decline of the radical American women's movement in the 1980s (MacKinnon 1990, p. 9), fellow American Raymond blamed the liberal feminist championing of *choice*, especially in regard to ART. In 1989, Raymond argued that contemporary liberal feminism was preoccupied with an agenda utterly fearful of any connotation that women were "victims" of men or patriarchy, to the detriment of a nuanced appreciation of the socialization of reproductive choices (Raymond 1989).

Raymond and her supporters characterized the liberal feminist position as ascending to the detriment of radicalism because liberal feminism is less oppositional and disruptive to the agenda of male liberals and the liberal establishment, including the ART industry (Raymond 1989). Similarly, Klein described liberal feminists arguing for contraception in the developing world as having been commandeered by the "population control forces" which emphasized false notions of women's "empowerment" to justify eugenicist and racist population policies, to the detriment of

radical analyses (Klein 2008). However, such arguments are simplistic in their failure to examine the co-option of radical feminism by conservatives, including conservative Christians, which has contributed to the decline in the mainstream authority of radical feminism. In 1991, British-based ex-patriot Australian Lynne Segal (of the libertarian feminist tradition) warned that feminists were losing control of the "setting of sexual agendas" to the conservative Christian Right, which, especially in the USA, had successfully appropriated the rhetoric and tactics of the feminist anti-pornography project to its advantage (Gleeson 2013a, p. 89). The anti-pornography feminist movement had never taken substantial hold in Australia. However, following the mainstream dissemination of the radical critique of RU486 in 1991, radical feminist arguments came to be appropriated by conservative Christians and used to enact federal anti-abortion laws and policies, contributing ultimately to the demise of radical feminist authority.

Senator Brian Harradine and the "Pro-Life Feminist"

In the 1990s, Australian anti-abortionists continued venue shopping, turning their attentions to the country's longest-serving senator, Tasmanian Independent Brian Harradine, and framing their arguments increasingly in terms of the appropriated discourses of radical feminism. Elected to parliament in 1975, Harradine was a traditional Catholic who believed that abortion was "an attack on the inherent dignity of every human being and their right to life" (Powell 1996, p. 11). Throughout his career, Harradine exploited numerous opportunities to raise abortion in parliament, including filibustering the debate on the Sex Discrimination Act 1984 by arguing, nebulously, that the act would legislate for abortion on demand. However, Harradine's approach changed once he came to be advised by Christian "pro-life feminist" and journalist Melinda Tankard Reist (Morton 2012), an Australian versed in the American conservative tactics of which Segal had warned. When studying journalism in the USA in 1987, Tankard Reist was affected by a screening of *Eclipse of Reason* (Tankard 1987) and developed her anti-abortion agenda in the traditions of Reardon and Feminists for Life (FFL)—an American organization formed by two women expelled from the National Organization for Women in 1972 for their anti-abortion views (Sweet 1985).

On her return to Australia in 1988, Tankard Reist championed the cause of FFL to little avail (Tankard 1989). The bemusement with which her arguments were met reflected the lack of an Australian "pro-life

feminist" movement, a peculiarly American phenomenon. Her invocation of traditional Catholic opposition to abortion gained her greater attention, however. In 1990, Tankard Reist participated with Pro-Life Victoria in the Melbourne Palm Sunday march, brandishing images of aborted fetuses under a banner quoting Mother Teresa, which read that abortion was "the greatest destroyer of peace." This action enraged other participants and saw Tankard Reist advised to leave the march (Tankard 1990, p. 8). Tankard Reist's appointment as Harradine's adviser in 1993 and her attendance at events associated with the Cairo ICPD appear to have focused her agenda. Since that time she has referred less frequently to "pre-natal terrorism" (Tankard 1990, p. 8) and more consistently portrayed abortion as necessarily coercive and a failure of liberal feminism. As she puts it, "something went wrong. A movement which claimed to seek peace resorted to violence; a movement which hated war and acts of aggression accepted cutting, scraping, poisoning and dismemberment within the wombs of women themselves" (Tankard Reist 1994a, p. 56).

Both of Tankard Reist's books, *Giving Sorrow Words* (2000) and *Defiant Birth* (2006), depict women who claimed they were pressured to abort. Her characterization of women who choose to terminate in less "coercive" circumstances has earned her suspicion among feminists, especially her comparison of abortion to cosmetic surgery—a long-time tactic of conservative male anti-abortionists (Tankard Reist 1997). Certainly, a number of prominent feminists of all persuasions have been ambivalent about abortion, with Naomi Wolf a leading example (Wolf 1995). Greer also presented a complicated position on abortion over time. The defining difference between feminist arguments such as Greer's and Tankard Reist's, however, is the associated critique of patriarchy. For Greer, the utter normalcy of penetrative heterosexual intercourse and the "invisibility" of vasectomy as a contraceptive practice in the West are central to understanding abortion (Greer 1984). Such an analysis is not apparent in the work of Tankard Reist and Reardon.

The Cairo ICPD

In 1994, Harradine attended the Cairo ICPD along with representatives of 179 member countries. Cairo is routinely described as a "milestone" by the international community, as it was the first ICPD to acknowledge population growth as a global concern, rather than as an issue for individual nations, and the first to attempt to "address the central problems facing

all humanity: to balance population, development and natural resources, while promoting choice, particularly for women, and human rights, all within the context of sustainable development" (Woolcott 1995, p. 2). The Australian committee reporting to the ICPD was headed by United Nations Ambassador Richard Woolcott and did not include one woman among its ten members. It reported that Australia was concerned that the number of people worldwide with no access to family planning services was greater than in the 1950s and acknowledged that providing women with "a choice of quality family planning methods, in culturally appropriate ways, is both more effective in limiting population growth than coercive approaches and more in keeping with democratic and status-of-women ideals" (Larmour 1994).

In preparation for Cairo, activists, including feminists from the developing world and Western FINRRAGE members such as Klein, met at a symposium in Bangladesh with the Bangladeshi organization Policy Research for Development Alternative (UBINIG). Tankard Reist attended the symposium, where she met Klein and other FINRRAGE members (Klein and Hawthorne 2012). Together, the members of the Bangladesh symposium issued "The Declaration of Comilla," a statement condemning all population policies as designed to "control the bodies, the fertility and the lives of women" (UBINIG 1996, p. 519). The declaration rejected that the reproductive practices of women in the developing world posed a threat to global development, stating, "There cannot be any feminist population policy because it violates and contradicts the basic premise of feminism" (UBINIG 1996, p. 519). It demanded the elimination of all demographic population targets, along with the provision of women's "access to safe contraception and legal abortion" (UBINIG 1996, p. 524) as a part of broader health-care initiatives.

Similarly, at Cairo, feminists testified about the dehumanizing and eugenicist nature of global population policies aimed at the developing world, while the Vatican and conservative Islamic leaders first joined forces to damn population policies. Feminist concerns were based on the rights of women to control their reproduction and direct their fate, while religious leaders were concerned with maintaining the family and opposing all "unnatural" contraception and abortion. The Vatican made repeated attempts to insert words into the Cairo Program of Action (PoA) emphasizing "the right to life or rights of the child" (Woolcott 1995, p. 4), while Mother Teresa faxed a statement to the conference describing abortion as "the greatest destroyer of peace in the world today" (Goldberg 2009,

p. 104). Numerous feminists found their arguments being appropriated for conservative religious ends. As Klein explained at the time, she and others at Cairo who opposed population policies but supported a woman's right to contraception and abortion resented the suggestion that "we are in alliance with the Vatican. The Vatican is only concerned with the sanctity of the family … The Right to Life have also taken and used our arguments … They are only concerned with the embryo, not with the harm done to women" (Bone 1994). Indeed, in an Australian book edited by Opus Dei celibate numerary Michael Cook, Tankard Reist wrote of the Bangladesh meeting she attended with "swelling groups of feminists" from the developing world opposed to target-driven population policies, while failing to note their arguments about the need for abortion and contraception (Tankard Reist 1994b, p. 89).

After protracted and volatile debate over nine days and nights, the Cairo ICPD produced a PoA informed explicitly by liberal feminism, thereby sealing what has been described as the "greatest diplomatic defeat sustained by the Vatican in the twentieth century" (Goldberg 2009, pp. 117–18). The PoA stated that "advancing gender equality and equity and the empowerment of women … and ensuring *women's ability to control their own fertility* are cornerstones of population and development-related programs" (Goldberg 2009, pp. 117–18, emphasis added). This emphasis on women's individual agency and choice was celebrated by many as a liberal feminist success: Woolcott described it as a "significant success" in which Australia "played an active, constructive and innovative part" (Woolcott 1995, p. 2). But radical feminists experienced Cairo as a diplomatic defeat. Klein and FINRRAGE dismissed the PoA as a "sad milestone in the increasing dominance of western liberals—especially from the USA—in the feminist debate about women's health and wellbeing" (Klein 2008, p. 164). This was because the PoA continued to promote population control and link global wealth and development to the reproductive practices of women in the developing world.

Cairo constituted a crucial moment of division between liberal feminists, promoting the centrality of "choice" to feminism, and radicals, who claimed that feminist language such as "choice" had been co-opted by international agencies such as the United Nations Fund for Population Activities (UNFPA) to legitimize racist, neocolonial population policies (Klein 1994). On her return from Cairo, Dumble invoked a feminist critique of patriarchy, which she said was wholly absent from the Cairo "liberal feminist" PoA, when she wrote that "women's reproductive rights

have become the catchwords to stake further investment in population control. Male reproductive responsibility seems to have escaped attention" (Dumble 1994, p. 18).

Radical Feminism in the Australian Parliament

Despite the dismissal of radical feminism, and the accompanying affirmation of women's liberal agency and human rights made at Cairo, upon his return to Australia, Harradine used the radical feminist position to secure a number of local anti-abortion measures. Earlier, in 1993, by delaying support for government legislation, Harradine had succeeded in freezing the Keating Labor government's A$130-million overseas aid family planning program, pending the outcome of an inquiry into links between population growth and economic development (Meade 1994, p. 5). The freeze was described by the then Chair of the Australian Medical Association as sending an "appalling signal to the international community … Only by using the review to dramatically increase our contribution to overseas fertility programs will we avoid continued international embarrassment" (Larmour 1994). Funding was resumed on the recommendations of the inquiry. Harradine then turned his attentions to RU486, after the drug's manufacturers withdrew an application for its marketing approval in Australia in response to anti-abortion campaigns. Following the manufacturer's withdrawal, Harradine believed he had secured an agreement with the Labor Health Minister not to allow the drug's registration. Nevertheless, in 1994, the new Labor Health Minister (and liberal feminist) Dr. Carmen Lawrence approved trials of RU486 to be conducted by Family Planning Victoria, with drugs imported from the World Health Organization in Geneva. Harradine believed his agreement was breached, and from that moment, RU486 returned to the agenda of the Christian Right (Kingston 1994, p. 17). In the Federal Court, Right to Life NSW launched a failed challenge to the legality of the trials and of abortion itself, while the Australian Catholic Bishops' Conference and the Archbishop of Sydney lobbied Lawrence to cancel the trials because RU486 "always poses a threat to human life" (Ewing 1994, p. 17). Lawrence bowed to pressure to stage an inquiry into the trials, which were eventually resumed.

In 1996, when Harradine secured the balance of power in the Senate, he was finally able to bargain for effective policy on both issues of foreign aid and RU486, and by this stage, he was well versed in radical feminism. Harradine initially made numerous (failed) demands of the government,

including cuts to domestic family planning, In vitro fertilization (IVF) programs and Medicare funding for abortions (Sweetman 1996), and to hold the first federal parliamentary vote on abortion (Chan 1996, p. 2). But the conservative Howard government agreed only to the two demands that had the least effect on domestic policy and generated minimal public debate.[2] First was the ban on the government's development agency AusAID funding overseas activities involving "abortion training or services, or research, trials or activities which directly involve abortion drugs," including the provision of information about abortion and restrictions placed on types of contraceptive and family planning programs that may be funded (Gleeson 2013b). This policy contradicted the Cairo PoA, to which Australia was signatory, and did not require parliamentary assent. It mirrored the "global gag rule" initiated by Ronald Reagan and successive American Republican governments since 1984, defunding the American Planned Parenthood Federation and the UNFPA, which Clinton overturned as one of his first acts in office. Harradine's newfound feminist rhetoric was persuasive in Australia. When explaining Australia's adoption of the global gag rule, then Foreign Minister Alexander Downer claimed the decision to cut A$3.5 million in family planning aid (Bagwell 1996, p. 17) reflected his "own conscientious concerns" about aid being used to "coerce" women of the developing world into having abortions (Brough 1996, p. 10).

Harradine's second successful demand was the conditions placed on the importation of RU486, still unavailable in Australia, but already in wide use in Europe. Harradine successfully moved an amendment to the Therapeutic Goods Act, stipulating that, unlike any other drug, the Health Minister must approve the importation, evaluation, registration and listing of the drug, and that any such ministerial approval must be tabled in parliament. Under these conditions, no drug company applied to register RU486, and no doctor applied for its Authorized Prescriber Status, ensuring it remained unavailable to Australian women. When tabling the amendment, Harradine secured bipartisan support by framing his arguments as concerns for women's safety at the hands of unscrupulous drug companies and citing the radical feminist concerns documented

[2] Harradine has also been connected to decisions of the Howard government related to appointments and research of the National Health and Medical Research Council, identified as motivated by an anti-abortion agenda. See Cannold, *The Australian Pro-Choice Movement and the Struggle for Legal Clarity, Liberal Laws and Liberal Access: The Extended Australian Report of the "The Johannesburg Initiative."* 2001.

in the 1991 *Misconceptions* report. Klein testified to parliament in support of the amendment (Klein 2006), and Harradine's office liaised with Dumble, who "naively" exchanged information on RU486 and related matters (Dumble 1997). But in parliament Harradine misrepresented or exaggerated the risks of RU486 and, to Dumble's shock, the parliamentary debate citing her feminist research "befitted a pro-life rally" as the anti-RU486 law was passed in the Senate (Dumble 1997). Inspired by Cairo, and advised at this time by "pro-life feminist" Melinda Tankard Reist, Harradine had achieved the most significant anti-abortion measures enacted by the federal government.

The appropriation of feminist rhetoric to condemn abortion as "men's oppression of women" has been a tactic of conservatives since the 1970s (McCormack 1978, p. 9), but with little demonstrable political effect. It is a testament to the widespread success and persuasiveness of feminism in Australia that by the 1990s these tactics were effective. By the 1990s feminism had well and truly come of age in Australia, allowing, ironically, for its appropriation as the authority for anti-feminist agendas. Whereas in 1983 Harradine had explained his anti-abortion objections to the Sex Discrimination Act in terms of his need to honor his commitment to "pro-life issues" (Harradine 1983, p. 3963), in 1996 he argued uncontroversially that "anyone who regarded the health of women as very important" would support the ban on RU486 (Harradine 1996, p. 578). So effective was this tactic that, unusually, neither coalition nor ALP members were afforded conscience (free) votes on the anti-RU486 amendment. The unquestioned authority of radical feminism in parliament was, in part, able to have effect due to a general ambivalence or ignorance within Australia about the international fractures in feminism. Although conservative Christian MPs enthusiastically described Harradine's amendment as exploiting a "split [in] the women's movement" over the desirability of RU486 (Nile 1994, p. 4803), the bitter and significant divisions between liberal and radical feminism of the era were mostly lost on the Australian population and parliament. The Australian feminist heritages of libertarianism, the New Left and liberalism had never accommodated the American radical feminist movements against pornography and sex work. European and American anti-ART campaigns also had little traction in the broader Australian feminist environment, where, relatively, there was scant appreciation for the significant schisms between liberal and radical positions internationally.

Conclusion

On Harradine's retirement in 2005, women parliamentarians from the cross benches worked together in an historic bipartisan agreement to pass legislation to return RU486 to the authority of the Therapeutic Goods Administration in 2006 and to be treated like every other pharmaceutical drug. It was not until 2012, however, that Marie Stopes International acquired a license to import the drug into Australia (Peatling 2012). A Senate Inquiry into the Therapeutic Goods Amendment (repeal of ministerial responsibility for approval of RU486) Bill 2005 received a large volume of submissions and testimonies, most in favor of the drug. Tankard Reist testified in her new role as director of the anti-abortion lobby Women's Forum Australia, telling the committee that abortion "resulted in demonstrable harm to women" and that it would be "dangerous" to expand its practice by way of medical terminations (Women's Forum Australia 2006). Klein continued to promulgate criticisms of RU486 and medical abortion, testifying that although she was "in full support of a women's right to have access to safe and legal abortion," RU486 was unsafe and undesirable, and hence, the 1996 Harradine amendment should be maintained (Klein 2006).

In 2005, however, the radical feminist critique of medical abortion was no longer persuasive in Australia. The moment for debate, such as when the 1991 *Misconceptions* report was publicly discussed, appears to have passed. The movement to have RU486 made available in 2005 was overwhelmingly understood as a *feminist* movement, indicating that the nuances between radical and liberal feminism have been extirpated from mainstream Australian commentary on this issue to the detriment of the radical position. Undeniably, international debate about RU486 has also evolved since 1991, whereby decades of widespread use of the drug in Europe proved its relative safety. Still, there is no denying the general marginalization and decline in radical feminism, whereby in 2005 radical feminist critiques of medical abortion essentially had no traction in the community or the parliament. Similarly, with the election of a new Labor government in 2007, the Parliamentary Group on Population and Development recommended as a first-order priority the abolition of the AusAID family planning guidelines enacting the global gag rule, which it described as "cruel and illogical" (Parliamentary Group on Population and Development 2007, p. 9). When the restrictions were finally lifted in 2009, this was also understood as a *feminist* victory, whereas Klein continues to refer to Western Aid programs in this policy area as "demeaning"

to women and a "form of re-colonization" (Klein and Hawthorne 2012). Radicals such as Raymond and Klein publicly blame liberal feminism for the marginalization of radical feminism, but the authors of the 1991 *Misconceptions* report today appear to be divided over the desirability of working with anti-abortionists to resist RU486 and associated technologies and procedures. Although at Cairo Klein criticized the appropriation of feminist testimony by Christian anti-abortionists, since 1996 she has continued to collaborate with Tankard Reist on a range of issues, including abortion and pornography. In contrast, Dumble has written bitterly about her experiences with Harradine's office and RU486 in 1996 (Dumble 1997).

One unfortunate outcome of this period in Australian history is the political ascendancy of the view that abortion is harmful to women, with no accompanying analysis of *patriarchy* or the *conditions of heterosexuality*, which radical feminism once offered. The vertical policy "contagion" afforded under federalism is apparent in three abortion reforms performed in the states and territories in the years following Harradine's federal amendments, as anti-abortionists again switched venues, undoubtedly buoyed by their successes in the federal arena. Between 1998 and 2001, the exceptional legal construct of "informed consent" and various other paternalistic measures were introduced to Australian abortion laws for the first time (Baird 2013, p. 245). Then in 2004, the Liberal Health Minister Tony Abbott broke 21 years of bipartisan consensus to pursue a public anti-abortion debate, culminating in funding for pregnancy counseling and instigating a "pregnancy counseling hotline" to advise women about options for pregnancy other than abortion (Gleeson 2011, p. 485). Both initiatives were premised on the idea that abortion harms women. Nevertheless, this ideological transformation of Australian law and politics was not accompanied by the ascension of any other aspects of radical feminist analysis.

Reforms initiated since the overturning of the RU486 ban in 2006 might also suggest the influence (contagion) of federal politics on state abortion governance. In 2007 Victoria decriminalized abortion, while in 2011 a Queensland jury took 30 minutes to return a unanimous verdict of not guilty in the case of a young couple charged with offenses related to self-supplying and self-administering RU486 (Gleeson 2014b). However, the 2009 arrest of this couple (and the resistance of the Queensland government to unequivocal pro-choice reform in response to their case) also highlights the peculiar political cultures of states and illustrates that the

"innovation" afforded states under federalism also harbors policy outliers. Indeed, studies of federalism indicate that perhaps territorial (not institutional) differences matter most of all to policy outcomes (Fenna 2009, p. 158). The example of the path of action chosen by the Queensland couple, to self-administer RU486 in apparent ignorance that abortion is regulated by the criminal law in Queensland, also brings into question the popular saturation of the "abortion harms women" discourse to which numerous politicians appear to be beholden (Gleeson 2014b). What is evident is that contemporary "pro-choice" politicians and lobbyists in Australia do not have the luxury of entertaining radical feminist analyses of abortion at any level of government because anti-abortionists have successfully commandeered these positions.

CHAPTER 10

A Provider's Right to Choose: A Legal History

Mary Ziegler

In the United States, the latest round of the abortion wars has prompted state and federal courts to determine what constitutional rights, if any, abortion providers have in the context of reproductive healthcare. When the Supreme Court decided *Roe v. Wade*, the justices adopted the medical framework advanced by movement pragmatists. In a move widely criticized by feminists, *Roe* emphasized the interests of physicians in practicing medicine as they saw fit. Contemporary abortion law seems to have come full circle, finally recognizing that women's interests in equal treatment are paramount.

This chapter unearths the lost history of how and why arguments for abortion providers' rights faded from American abortion law and politics. Historians have documented the evolving arguments made by American feminists connecting abortion and women's rights (Siegel 2007). In exploring the rise of these claims, feminist scholars have spotlighted the shortcomings of medical rights arguments similar to those advanced by the Supreme Court in *Roe* (MacKinnon; Ginsburg). More recently, legal commentators have further complicated the analysis, arguing that litigators and activists should better explain the public health benefits of legal abor-

M. Ziegler (✉)
Florida State University College of Law, Tallahassee, FL, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_10

tion (Hill; Lindgren). Just the same, these studies have mostly missed a crucial story about why providers' rights arguments lost influence. This chapter recaptures this history, drawing on a wide array of archival sources from competing advocacy organizations, abortion clinics, and providers' groups.

The study begins by tracing the origin of claims centered on rights of physicians and providers in the late 1960s and 1970s. This effort culminated in the *Roe* decision—an opinion focused heavily on the medical dimensions of abortion. Exploring feminist reasoning and anti-abortion strategy, the chapter turns next to attacks made on the medical framework in the 1970s and 1980s. This analysis sets the stage for an exploration of the marginalization of providers in the 1980s and 1990s. The chapter examines the reasons for the sidelining of providers in the period, including pro-life litigation tactics, abortion rights rhetoric, and a spike in violence against providers. Finally, the chapter illuminates the costs of this approach, particularly in the US Supreme Court. Foregrounding a line of decisions from 1976 to 2007, the study chronicles the transformation of the court's view of providers. While the Court once portrayed providers as rights-holders, American jurisprudence increasingly presents them as manipulators requiring state supervision. In order to effectively defend abortion rights, the movement need not resurrect the widely (and justly) maligned privacy frame set forth in *Roe.* Just the same, the movement will have to reconsider the constitutional importance accorded to providers. In the United States, the abortion right will mean little if providers are left out.

Remaking a Woman's Right, 1965–1980

Before *Roe v. Wade*, clashes within the abortion rights movement pitted feminists against physicians, and pragmatists worried that a women's rights approach would only undermine the progress of reform. Feminists like Nancy Stearns and Betty Friedan offered innovative accounts of how fertility control impacted women's interests in self-determination and equal rights (Siegel 2007). Friedan described abortion as a "civil right for women" (Friedan). Shirley Chisholm, the honorary president of NARAL (then called the National Association for the Repeal of Abortion Laws), described the founding of the organization as "an historic occasion in the arduous struggle of American women to free themselves from oppression."

Fearing that feminist arguments could alienate undecided voters, physicians, environmentalists, and other pragmatists insisted that a medical framework would better serve the movement's goals. NARAL put out literature explaining that abortion laws violated "the privacy of the doctor-patient relationship" and that legalizing abortion would allow doctors to "practice medicine in the best interest of [their] patients" (Executive Committee Meeting Minutes). Medical rights claims also played an important part in NARAL's litigation efforts. In explaining the organization's approach in a Michigan case, NARAL member Joseph Nellis explained that "courts would more easily strike down state anti-abortion laws if the test case were presented in terms of interference [with] medicine than if it were done on the basis that many women's rights groups have advocated" (Shanahan).

Framing abortion as a physician's right made the legalization cause more respectable. Instead of tying abortion to the still controversial women's movement, medical arguments presented the procedure as a matter of good clinical practice. For practical reasons, as Nellis's statement suggested, medical arguments often served as a substitute for more divisive women's rights claims, particularly in mainstream organizations. At the same time, pre-1973 conflict convinced feminists that a medical framework played down the importance of women's interests in fertility control.

Roe escalated tensions between those championing a medical framework and those promoting women's rights. Harry Blackmun's majority opinion described abortion as a right belonging jointly to the woman and her doctor. *Roe* and its companion case, *Doe v. Bolton*, struck down the vast majority of abortion regulations then in place in the United States. The *Roe* majority surveyed the medical history of abortion and highlighted the changing attitudes of medical leaders and professional organizations toward the procedure. The Court emphasized "the important rights of … physicians … to administer medical treatment according to their best professional judgment" (Outline and Redraft of *Doe v. Bolton*). *Roe* seemed to vindicate those who argued that a medical framework would most effectively advance reproductive freedom in the United States.

Women Versus *Roe*: The Medical Framework Under Attack

Over the course of the 1970s, abortion rights organizations gradually moved away from the medical framework advanced by *Roe*. In portraying women as the sole holders of abortion rights, pro-choice leaders responded

to feminist commentators worried that the justices (and perhaps the abortion rights movement) misunderstood what reproductive liberty meant for women. Importantly, as the anti-abortion movement moved women into positions of leadership and deployed new woman-protective arguments, champions of abortion rights increasingly drew attention to their own commitment to sex equality. Nevertheless, remaking abortion rights had unintended consequences, leaving women's constitutional protections vulnerable to later attack.

After 1973, demands for the redefinition of abortion rights intensified among feminist scholars who viewed *Roe*'s understanding of reproductive rights as inadequate and counterproductive. Feminist scholar Catherine MacKinnon argued that *Roe* and all "abortion policy" had "never been approached in the context of how women get pregnant; that is, as a consequence of intercourse under conditions of gender inequality" (MacKinnon 47). By mostly ignoring women's experiences of sex and abortion and by focusing on the needs of the physician, *Roe* "translat[ed] the legal right to privacy as a means of subordinating women's collective needs to the imperatives of male supremacy" (MacKinnon 47). Ruth Bader Ginsburg, a future US Supreme Court justice, also criticized *Roe*'s inattention to women's interests. Had *Roe* instead made a more convincing argument based on equal protection and sex discrimination, Ginsburg argued, abortion conflict might have diminished (381–82).

In the 1970s and early 1980s, early American feminist criticisms of *Roe* resonated with an abortion rights movement seeking to maintain women's support. Prior to the mid-1970s, many abortion rights organizations took for granted that women would support reproductive freedom. By mid-decade, however, pro-lifers made an unprecedented bid for female recruits, insisting that their cause advanced both women's interests and fetal rights. In the decade after the *Roe* decision, abortion opponents did more to appeal to women, selecting female leaders and forging a set of arguments explaining the supposed harm women suffered as a result of abortion. For example, Illinois activist Dr. Eugene Diamond told the *Chicago Tribune* that women who chose abortion were victims, manipulated by abortion providers (Colander). Pat Goltz, the founder of Feminists for Life, popularized claims that "an insidious form of enslavement to the Playboy's 'right to [have sex'] has no place in the women's movement." Such contentions became a part of the argumentative agenda of major groups such as the National Right to Life Committee, then the largest national anti-abortion organization ("National Right to Life

Committee Statement of Purpose"). Anti-abortion organizations further signaled their focus on women's concerns by raising a number of women to positions of power. Marjory Mecklenburg, who was sympathetic to sex education and family planning, created American Citizens Concerned for Life to offer a home to women with "pro-birth control, pro-sex education," anti-abortion positions (The National Organization for Women 1978). Nellie Gray, the founder and leader of March for Life, appealed to activists who brooked no compromise on abortion, even if a woman's life was at risk (Scheidler 41).

Over the course of the 1970s, as the opposition did more to recruit women, pro-choice activists put more women in positions of leadership: for example, Sarah Weddington became the leader of NARAL in 1975, and Faye Wattleton became the head of Planned Parenthood in 1978. With these new leaders in place, the abortion rights movement began putting greater emphasis on women's rights arguments inside and outside of court. For feminists who had finally obtained positions of leadership, foregrounding women's rights exposed the true relevance of safe and legal abortion. Women's rights arguments also had concrete strategic advantages for movement leaders seeking to firm up the support of the women courted by abortion opponents.

By the end of the 1970s, a new generation of feminist leaders had firmly established that abortion was a right for women. Only in the 1980s and 1990s did the hidden costs of this decision begin to become clear. Presenting abortion as a right for women became a convenient vehicle for abortion opponents intent on stigmatizing abortion providers and chipping away at access to the procedure.

Women's Rights and Anti-abortion Strategy, 1978–1992

As the anti-abortion movement returned to court, movement attorneys at least partly abandoned earlier rights-based strategies centered on the fetus, instead arguing that the *Roe* decision itself permitted a wide variety of abortion restrictions. In particular, these lawyers contended that states had significant leeway in restricting providers' ability to offer abortion care, since women, not providers, enjoyed constitutional rights to choose. Arguments of this kind first came to the fore during the litigation of *Harris v. McRae*, a case addressing the constitutionality of the Hyde Amendment, a federal ban on Medicaid funding for abortion. In

McRae, James Bopp, Jr., General Counsel for the National Right to Life Committee, the nation's largest anti-abortion organization, argued that *Roe* protected "the woman from *unduly burdensome* interferences with her freedom to decide whether to terminate her pregnancy" (Brief of Amicus Curiae National Right to Life Committee). By extension, Bopp argued that the court should scrutinize much less closely any restrictions that "merely make the physicians' work more laborious or less independent without any impact on the patient" (Brief of Amicus Curiae National Right to Life Committee).

The idea that abortion rights belonged only to women served two purposes for anti-abortion attorneys. First, arguments of this kind allowed Bopp and his colleagues to argue that *Roe* permitted any restriction that primarily impacted the physician. If, for example, a state prohibited a particular method of abortion, abortion opponents characterized that law as impacting only the provider's choice about how to proceed. Similarly, if a physician had to read a particular script about abortion, that regulation might inconvenience the provider but did not stop the woman from obtaining an abortion. For the anti-abortion movement, framing abortion as a right for women served as a foundation for efforts to narrow the protections offered by *Roe*.

Between 1980 and 1992, the mainstream pro-choice movement remained equally invested in the idea of abortion as a right belonging exclusively to women, albeit for radically different reasons. First, feminists still opposed the widespread use of medical justifications for abortion rights, believing that such contentions reflected blindness to the connections between sex equality, racial and social justice, and fertility control. Changes to the composition of the provider community reinforced its marginalization. As independent clinics offered a greater percentage of abortions and as physicians distanced themselves from violence and protests directed against abortion clinics, the provider community appeared less prestigious, smaller, and less influential. Showcasing the rights of women who might need abortion seemed wiser than spotlighting the rights of a group of providers increasingly under siege.

The Marginalization of Providers, 1985–1992

Outside of court, between 1980 and 1992, the pro-choice movement redoubled its efforts to present women as the true holders of abortion rights. In so doing, movement leaders drew public attention away from

discomfort with the abortion procedure itself. Consider two campaigns launched by NARAL in the period. As the organization explained in a strategy memorandum entitled "Abortion Rights: Silent No More," "the right to abortion was won in large part because women began to speak out, to say we are your mothers, daughters and sisters, and we are the ones having abortions." After *Roe*, the memorandum asserted, women no longer shared their experiences, and "the silence left [the abortion-rights movement] vulnerable to attack" ("Abortion Rights: Silent No More"). Its leaders envisioned "Silent No More" as a platform to make abortion more visible—to serve as a reminder of the fact that "the 1.5 million women who have abortions every year are much more than nameless, faceless persons" (Nanette Falkenberg to Members of the Media). NARAL encouraged members not "to focus only on the hardship cases" or to describe abortion as a tragedy. Instead, the program would legitimate the very idea of abortion, convincing the "American people that every woman who chooses abortion does so for reasons that are compelling" (Nanette Falkenberg to NARAL Leadership). Between 1986 and 1989, after conducting polls on which message would resonate most with voters, NARAL formulated a new campaign, "Who Decides," designed to draw out public concern about public interference with the abortion decision (Saletan 2004). Instead of emphasizing "the legality of abortion itself," the movement planned to focus on "whether the government [should] decide who can have one" (Dionne). As the then NARAL President Kate Michelman explained at a strategy session, the "key" idea was "individual decision-making" ("Notes on Messaging"). As these campaigns demonstrate, the mainstream abortion rights movement had strategic reasons for stressing the interests of the woman and the evils of state interference.

In the 1980s and 1990s, American reproductive politics reinforced activists' decision to play down providers' rights, as the opposition made abortion care appear less prestigious and more dangerous. Abortion opponents presented abortion providers as irresponsible profiteers rejected by other medical professionals. In commenting on a 1983 Supreme Court decision on reproductive rights, for example, Doug Johnson of the National Right to Life Committee asserted that the Court "defended the interests not of women, but of the assembly-line abortion industry" (Treaster). The demonization of providers foreshadowed the intensification of violence against abortion doctors and facilities. Between 1983 and March 1985, 238 clinics reported over 319 acts of violence, and in 1985, about one half of women seeking an abortion reported that they had experi-

enced some form of harassment (Faye Ginsburg 50). Later in the 1980s, organizations like Joe Scheidler's Pro-Life Action Network and Randall Terry's Operation Rescue expanded demonstrations outside of clinics, seeking to discourage physicians from performing abortions. In 1989, clinic operators in cities like Nashville reported to the *Atlanta Journal Constitution* that they had to fly in physicians to perform abortions since local doctors refused to participate (Perl). As Jane Shepherd, a spokeswoman for Operation Rescue, explained in 1989, "there is a direct relationship between not being able to find a doctor and the pickets" (Perl). Increasingly, physicians distanced themselves from the procedure, and abortion care fell to independent providers who did not enjoy the same cultural status as doctors. Whereas doctors performed 80% of abortions in hospitals in 1973, in 1996, 90% of abortions took place in freestanding clinics, and only 12% of obstetric-gynecological programs offered abortion training (Bazelon). As abortion providers found themselves isolated from the medical mainstream, advocacy groups had more reason than ever to identify their cause with women's rights.

When providers found themselves increasingly sidelined, their organizations took on a more ambitious agenda. One such group, the National Abortion Federation (NAF), formed in 1979 in order to offer providers support, political influence, and an opportunity to exchange information (Freedman 27). The National Coalition of Abortion Providers (NCAP) formed in 1990 under different political circumstances. Composed primarily of independent clinics, NCAP "was founded to address the concern that major abortion rights groups were not representing the unique interests of clinics" (NCAP Strategic Communication Plan 2000).

Provider organizations challenged advocacy organizations' turn away from arguments centered on those who performed abortions. Instead, in telling the stories of those who offered or received abortions, as provider groups argued, the movement stood a better chance of recapturing the moral high ground and connecting to real women who sought out reproductive healthcare. For example, the organization's treatment of grief counseling, a subject often discussed at NAF national conferences, testified to the complexity of real abortion experiences. Consider a case study examined at a NAF national conference. A former patient, Chris, had contacted providers approximately one year after terminating her pregnancy (Case Study: Morgentaler Clinic). Chris's sister had recently delivered a baby that Chris "wished … could have been hers" (Case Study: Morgentaler Clinic). After clinic workers spoke extensively

with her, however, Chris told providers that she did not regret her abortion and had been "feeling better" since attending church (Case Study: Morgentaler Clinic). Political and legal accounts of the abortion experience failed to capture this level of emotional complexity. Pro-choice activists tended to emphasize the relief most women experienced after abortion and deemphasized more complicated reactions to it or to the idea of fetal life. Abortion opponents presented the procedure as a uniformly scarring and traumatic experience, one that women very rarely chose when provided with full information.

Aware of this gap in the popular and legal debate on abortion, the providers' movement made some attempt to reshape the political conversation. In 1999, for example, in formulating a new strategic plan, NCAP asserted that after *Roe*, "the horrors of illegal abortion became a distant memory and conversations over abortion began to focus even more on the complex moral issues associated with the procedure" (Ron Fitzsimmons to Certain Abortion Providers). As NCAP members asserted, the pro-choice movement "remained relatively silent on the morality of abortion" (Ron Fitzsimmons to Certain Abortion Providers). As abortion opponents mobilized, the procedure became "highly stigmatized" and even its supporters sometimes described abortion as "a necessary evil" (Ron Fitzsimmons to Certain Abortion Providers). The organization explained, "It is time to lift the veil of secrecy and to engage in candid dialogue regarding the real life and death issues surrounding abortion" (Ron Fitzsimmons to Certain Abortion Providers). Groups like NCAP urged political activists to reconsider their reluctance to foreground providers and the work they performed.

The setbacks confronted by NCAP reveal how profoundly providers' rights in the abortion context had diminished since the *Roe* decision. Openly discussing the reality of abortion or the complexity of women's reactions to abortion promised to increase the controversy surrounding the procedure. This danger seemed more real after NCAP's leader, Ron Fitzsimmons, touched off a media firestorm about a particular late-term abortion procedure, intact dilation and extraction (intact D&E), that would become known as "partial-birth abortion" (Gorney). In a 1998 interview in the American Medical Association Medical News, Fitzsimmons admitted that he had "lied through [his] teeth" about the number of intact D&E procedures performed annually in the United States, and he suggested that the true number was considerably higher than he had originally indicated (Jacoby). Fitzsimmons's comments proved to be explosive.

Abortion opponents used his statements to suggest that members of the abortion rights movement were routinely dishonest (Johnson). A number of NCAP member clinics resigned or stopped making contributions to the organization ("So I Lied"). As veteran provider Merle Hoffman explained, "the most awful thing is it appears to have validated everything the antis have said about the abortion providers" ("So I Lied").

In the wake of Fitzsimmons's statements, NARAL and the mainstream movement returned to a tested strategy based on the danger of government interference with private choice. Similarly, NAF distanced itself from Fitzsimmons and his organization. During the drawn-out struggle about partial-birth abortion, the leadership of NAF primarily stressed that the law would undermine legal abortion itself. NAF leader Vicki Saporta argued that proponents of the federal partial-birth abortion law intended "to ban abortion in the United States" ("So I Lied"). Fitzsimmons's comments made some organizations suspicious of NCAP's proposals and concerned about the very idea of transparency in abortion care.

Between 1973 and 1992, the mainstream movement increasingly assigned the abortion right exclusively to women. Rather than framing abortion as a medical matter, the movement described abortion as an issue of sex equality. The benefits of this approach seemed clear. Politically and legally, however, rhetoric divorcing abortion from medical practice had its costs, particularly in the US Supreme Court.

Providers' Plight: The US Supreme Court, 1980–2007

By so exclusively stressing women's rights arguments, pro-choice activists left themselves vulnerable. In the US Supreme Court, the opposition narrowed abortion rights by convincing the justices that regulations were constitutional so long as they targeted only providers. The Court defined an increasingly capacious liberty interest governing women's control over reproduction—an interest touching on concerns including bodily integrity and sex equality. At the same time, the Court used a women's rights interpretation of abortion in upholding restrictions on providers' conduct and speech. The rationale for abortion rights in the United States pointed to an ever-broader reproductive liberty, even as the Supreme Court upheld an unprecedented number of abortion restrictions.

In the Court, the remaking of abortion rights began in 1976, with the decision of *Singleton v. Wulff*, a case addressing physicians' standing to

raise women's abortion rights. In concluding that the physicians did have standing, the appeals court had relied on the existence of a doctor's constitutional right to practice medicine. By contrast, the court made clear that what was "at stake" was "[t]he woman's exercise of her right to an abortion" (117). Indeed, the majority suggested that no prior precedent, *Roe* included, recognized a physician's right in the abortion context. Nonetheless, the *Singleton* court made clear that providers had a substantial say in the abortion decision. As *Singleton* explained, "[a] woman cannot safely secure an abortion without the aid of a physician, and an impecunious woman cannot easily secure an abortion without the physician's being paid by the state" (113).

In *Planned Parenthood of Central Missouri v. Danforth*, the Court again elaborated on what it meant that women, rather than physicians, held the abortion right. The opinion explained that "*Roe* and *Doe* [had] establish[ed] that the State may not restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy" (66). The Court insisted, however, that "the woman [was] the one primarily concerned" when abortion rights were at issue (67). Women's input mattered most because of the importance of making a decision to abort. Since "[t]he decision to abort is indeed often a stressful and important one," the state could intervene to assist the woman in exercising her right (67). The fact that abortion mattered most to women justified limitations put on the women's own decision making.

In dealing with a statutory definition of viability, however, the Court still preserved some role for providers in interpreting abortion rights. Viability, in *Roe*, marked the point after which states could advance an interest in fetal life. States had worked to narrow abortion rights by changing the definition of viability and by challenging the power of providers to define it. In *Danforth*, the Court criticized these efforts, asserting that it was "not for the legislature or the court to place viability, which is essentially a medical judgment, at a specific point in the gestation period" (64).

Between 1983 and 1989, the Court expanded providers' interpretive authority. The court began to rethink the provider's role in 1983, when the justices decided *City of Akron v. Akron Center for Reproductive Health* (*Akron I*). In striking down an informed-consent provision of the ordinance, the Court distinguished its opinion in *Danforth* and defined a much narrower sphere for state intervention in the relationship between the woman and the provider. As the *Akron I* Court suggested, the disputed informed-consent restriction was unconstitutional because it

intruded "upon the discretion of the pregnant woman's physician" (445). The abortion right again seemed to protect the provider's prerogative to share with the woman only that information that "in [the physician's] judgment … is relevant to her personal decision" (445). Moreover, under *Akron I*, the state could not provide nonmedical information designed "to convince women to withhold their consent altogether" (444). The provider retained her role as the interpreter of abortion rights, determining which information could be relevantly provided to the woman.

In 1986, in *Thornburgh v. American College of Obstetricians and Gynecologists*, the Court again broadly defined the provider's constitutional role. In analyzing a Pennsylvania informed-consent restriction, the court itself determined which state-specified information was "nonmedical" and therefore inappropriate for the woman to consider. *Thornburgh* created a larger medical sphere that was immune from state regulation. In *Danforth*, the Court had assigned to providers the power to define viability and, with it, the boundaries of the abortion right. In *Thornburgh*, the Court defined as medical and protected from state intervention "the privacy of the … dialogue between the woman and her physician" (762). The Constitution still offered some form of protection for "the physician's exercise of proper professional judgment," although the physician himself did not possess any abortion right. That judgment, under *Thornburgh*, enjoyed protection as part of a private dialogue, one that had to be controlled by the equality interests of the woman and the "professional medical guidance" of the provider rather than by any "state medicine imposed upon the woman" (763). The provider mattered, not just as an interpreter of women's rights but also as a protected participant in a constitutionally protected dialogue.

In the decades after *Roe*, however, the anti-abortion movement had consistently argued that women alone possessed abortion rights, justifying a broad variety of restrictions on provider's discretion. The Court gradually adopted a similar approach, emphasizing the importance of women's equality interests in the abortion decision while chipping away at abortion rights. This shift began in 1992, with *Planned Parenthood of Southeastern Pennsylvania v. Casey*. In theory, *Casey* represented the culmination of anti-abortion efforts to remake the federal judiciary. In 1980, Ronald Reagan, the first presidential candidate to endorse anti-abortion positions, had committed to nominating judges opposed to *Roe v. Wade*. After Republican presidents replaced four of the justices who had decided *Roe*, the Court's 1973 decision seemed in imminent peril. In reality, how-

ever, *Casey* did not deliver the overruling of *Roe* many observers expected. Instead, *Casey* fundamentally changed constitutional analysis of a provider's interest in abortion.

Without denying the secrecy ordinarily surrounding the relationship between a woman and provider, *Casey* insisted that the confidentiality of the dialogue between the woman and her physician justified state intervention. In *Casey*'s account, the provider could not be counted on to tell women the truth about the impact of abortion on the fetus, a matter that "most women" would consider "relevant, if not dispositive, to the decision" (881). Women were the ones who possessed abortion rights, and providers would not reliably interpret those rights or look out for those who held them. The state could introduce abortion restrictions to further "the legitimate purpose of reducing the risk that a woman may elect an abortion, only later to discover, with devastating psychological consequences, that her decision was not fully informed" (882). *Roe* and its progeny had assumed that providers had a special competence in medical matters and a profound interest in the patient's welfare. It was partly for this reason that providers had been given particular interpretive authority in the abortion context. *Casey* reversed these assumptions, describing the privacy of the doctor–patient relationship as a reason to limit providers' discretion.

Casey also provided the clearest articulation to date of providers' stake (or lack thereof) in the abortion right. "Whatever constitutional status the doctor-patient relationship may have as a general matter," *Casey* explained, "in the present context, it is derivative of the woman's position" (884). "On its own," *Casey* stated, "the physician-patient relation here is entitled to the same solicitude it receives in other contexts" (884). If the abortion right uniquely reflected the social standing of women, *Casey* explained, that right offered little protection for providers.

Indeed, under *Casey*, the fact that providers practiced medicine itself justified more, rather than less, state intervention. In analyzing the providers' first-amendment rights, for example, *Casey* described their speech as "part of the practice of medicine, subject to reasonable licensing and regulation by the state" (884). In 2007, in *Gonzales v. Carhart*, the court further downgraded providers' constitutional interests. *Carhart* has attracted criticism primarily because of its paternalism toward women (Siegel 2008). In *Casey*, the court had already begun to frame the privacy of the provider–patient relationship as a reason to be concerned about psychological harm to women. *Carhart* went considerably further, expos-

ing what the majority presents as the hidden truth about the intact D&E abortion procedure. Indeed, the court offered a morally charged narrative about the details of "partial-birth abortion" procedures.

Carhart lifted the veil of privacy surrounding the provider–patient dialogue. It purported to take the reader inside the abortion clinic, describing the probable conduct of the provider, the likely emotional response of the woman, and the details of an abortion procedure. This information was intended to have the same effect on the reader as on the woman: undermining support for abortion by presenting abortion as a woman's decision to allow "a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child" (159). *Carhart* stressed the importance of informing both the public and women about late-term abortions. The Court suggested that providers act to prevent the public and the women from acquiring this much-needed information. "In a decision so fraught with consequence," *Carhart* explained, "some doctors may prefer not to disclose the precise details of the means that will be used, confining themselves to the required statement of the risk the procedure entails" (159). At a minimum, providers could not be relied upon to inform women fully or to look out for women's interests. Indeed, providers could not necessarily be trusted, *Carhart* suggested, to protect the integrity of their own profession. Congress, rather than providers, was best qualified to advance an "interest in protecting the integrity and ethics of the medical profession" (160).

Carhart replaced *Roe*'s deference to providers' medical judgment with deference to the state's regulation of medical practice. Faced with uncertainty about the health benefits of a particular abortion procedure, *Carhart* attached weight to legislative judgments of scientific evidence. By contrast, as *Carhart* explained, "[p]hysicians are not entitled to ignore regulations that direct them to use reasonable alternative procedures" (157). *Casey* went far in recognizing women's interests in equal citizenship, self-determination, and bodily integrity. Nonetheless, because the Court presents providers as untrustworthy, recognizing women as the holders of the abortion right does not clearly lead to concern about state interference with their reproductive freedom. Even if women have profoundly important interests in the abortion decision, under *Casey* and *Carhart*, the state can intervene to protect women against scheming providers.

Carhart and *Casey* illustrate some of the costs of stressing women's rights while neglecting those of providers. As anti-abortion opponents

had long recognized, courts could pay lip service to women's autonomy and equality while still narrowing abortion rights. In *Casey* and *Carhart*, the Court has done so partly by eliminating any meaningful stake in the abortion right on the part of the provider. Without a clear constitutional account of why providers matter, abortion rights are on inherently unstable ground. Politically, the abortion rights movement has also made trade-offs by emphasizing women's rights claims to the exclusion of those involving providers. In particular, the movement's rhetorical strategies have not fully captured the unique voices, concerns, and claims of the provider community. For this reason, the pro-choice movement has no clear answer to anti-abortion descriptions, like the one adopted in *Carhart*, of the abortion clinic and the abortion procedure.

Health and the Rights of Women

A sophisticated scholarly debate tracks the evolution and relative advantages of American abortion arguments centered on rights of women. This chapter adds a new dimension to the discussion by uncovering the story of the ascendancy of women's rights arguments. These claims emerged from a series of contested tactical battles and political transformations. Prior to 1973, activists experimented with claims focused on physicians' rights. When *Roe v. Wade* emphasized doctors' needs, this strategy appeared to have paid dividends. Over the course of the 1970s, however, abortion rights activists found practical and ideological reasons for drawing attention to women's interests. The costs of this strategy began to surface during the 1980s and 1990s. In the courts, abortion opponents began to demand greater latitude, under *Roe*, to restrict providers' actions. In the political arena, these activists worked to denigrate providers and isolate them from the rest of the medical profession. While facing some resistance from providers' organizations, mainstream groups turned more and more often to claims involving women's autonomy and equality.

Offering a new constitutional justification for the abortion right has had powerful advantages. *Roe* itself obscured the importance of fertility control for women. In reality, as many scholars and activists have noted, abortion was as much a social issue as a medical one. Just the same, in developing a powerful rhetoric of women's rights, the movement did not account for the importance of providers to the abortion decision. By focusing so much on why women enjoy abortion rights, however, the

pro-choice movement has sometimes lost sight of the relevance of providers, both politically and constitutionally. As abortion opponents recognized, assigning abortion rights exclusively to women did not simply bring to light important concerns about sex equality. The Supreme Court's recent decisions testify to the dangers of ignoring providers' interests. By 2007, American abortion jurisprudence presented providers as untrustworthy actors with no rights of their own. By excluding providers, the abortion right has become weaker, smaller, and more vulnerable to attack.

There are a number of paths available to the movement if it seeks to reinsert providers into the constitutional politics of abortion. The movement could do more to frame abortion as an important part of reproductive healthcare. By focusing on abstract notions of autonomy and equality, advocates have not always done enough to explain how abortion figures into women's healthcare. Moreover, in dodging discussion of a controversial procedure, activists have not fully countered opposition claims about what abortion involves and how women experience it. Drawing on arguments like those set forth by providers in the 1990s would make for a more transparent, direct, and morally sophisticated response for pro-life claims about providers' work. In particular, activists will have to develop a clear account of providers' work and women's experience of abortion.

Constitutionally, reframing abortion as a part of women's healthcare will encourage the courts to defer once again to physicians' and providers' judgments about issues from the need for certain techniques to the time of fetal viability (Lindgren). Rhetorically, such arguments provide a better counter to anti-abortion efforts to undermine providers' credibility. When addressing pro-life contentions about late-term abortions, for example, activists should assert not only that the state can trust women to make good decisions but also that government can rely on most providers to safeguard women's interests.

The history of arguments for providers' rights shows that it is more critical than ever to explain how abortion represents one of several important and inextricably linked health interests. Reclaiming rights of providers may allow the abortion rights movement to carve out broader constitutional protections for abortion-related care. Convincing the public of the value of abortion care also has the potential to reverse opposition efforts to stigmatize the procedure. Without an established right for providers, women's reproductive freedom will mean far less.

CHAPTER 11

Abortion Politics in a State in Transition: Contesting South Africa's 'Choice Act'

Rebecca Hodes

Abortion, the 'Culture Wars' and South Africa's Democratic Transition

On 10 June 2013, the *Daily Sun*, South Africa's most widely read daily newspaper, published a front-page story entitled 'House of Abortion Horror'. The newspaper described the arrest of an illegal abortion provider, known as Professor Kute, after the boyfriend of a client reported him to the police. The police had arrived at Kute's rooms just in time to stop the 19-year-old woman from swallowing the 'killer pills to abort her five-month-old fetus' (Nkhwashu 2013, 1–2). An accompanying photograph showed a dishevelled room, described as a 'fully-functioning surgery.' Kute, characterized 'as a so-called doctor from Uganda', was due to appear in court for contravening the Medicines Act.

Read in conjunction with the comments section on the *Daily Sun* website, the story reveals much about the politics of abortion in post-Apartheid South Africa. It illustrates how abortion functions as a symbolic catch-all

R. Hodes (✉)
AIDS and Society Research Unit, Centre for Social Science Research, and Department of Historical Studies, University of Cape Town, Cape Town, South Africa

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_11

for an array of perceived social problems and public anxieties—including the sexual irresponsibility of young women, the inefficacy of regulations to protect public health, and the criminality of foreign nationals in South Africa.[1] Readers interpreted the story of a teenager seeking an abortion for a late-term pregnancy and her assistance in this by a 'foreigner' as a threat, not just to the woman's health, but to the realization of democracy. In this instance, South Africa's nationhood was equated with fetal survival, and abortion understood as a violation of both. The story also illustrated many of the medical realities of abortion in present-day South Africa. The woman was young, her pregnancy was unwanted, and her gestational length precluded access to legal abortion within the formal healthcare sector except under exceptional medical circumstances. Despite the legalization of abortion in the mid-1990s, accessing abortion in the public sector remains impossible for many. Rates of illegal abortion remain high, with up to half of all abortions occurring nationally procured in the illegal sector (Hodes 2016; Saving Mothers 2011–2013).

This chapter explores the judicial, political and moral controversies that have surrounded South Africa's legalization of abortion. It investigates strategies used by pro- and anti-choice advocates to improve, or eliminate, access to abortion in the public health sector. Findings are based on over four years of primary research with abortion providers and patients within five public health facilities, together with interviews with government officials, policymakers and activists. These interviews and observational data were combined with a review of parliamentary minutes and government documents pertaining to the Choice Act, and with an analysis of popular media coverage about abortion. I argue that, despite the legalization of abortion, its moral freighting as taboo and as a transgression, among healthcare workers and patients, continues to preclude public access. I describe the ambivalence felt by healthcare workers towards providing abortions, together with the pain and trauma experienced by patients. I explore the ethical challenges of documenting this ambivalence, and of conducting research on the complexities of abortion experience more broadly.

[1] For a discussion on xenophobia in post-Apartheid South Africa, see Michael Neocosmos, "From 'Foreign Natives' to 'Native Foreigners'. Explaining Xenophobia in Post-Apartheid South Africa: Citizenship, Nationalism, Identity and Politics." Dakar: CODESRIA, 2006.

Historical Context

Since the 1970s, abortion has been the focus of fervent and acrimonious debate, perhaps the single most inflammatory issue at the core of the globalized 'culture wars'. Abortion is unique in its ubiquity and persistence as a form of reproductive control (Kumar et al. 2009, 625). Historically, however, abortion was treated largely as a private matter, beyond formal regulation. Abortion emerged as a public issue at the heart of various moral movements in the mid-twentieth century, alongside social and technological developments. Advancements in anaesthesia and infection control, combined with the formalization of medical education, meant that abortion became a safe procedure when practised by trained providers under sterile conditions. Second-wave feminists reimagined the social role of women, challenging their primary identity as mothers; and fears about the 'population explosion' gathered momentum in new discourses of development. Between the 1950s and 1970s, despite intense opposition from religious organizations, most affluent nations legalized abortion within certain gestational limits, revealing how advances in medical technology blended with changing social norms to radically redefine the parameters of reproduction. The issue has remained at the forefront of 'moral movements', in which participants regard abortion not as a single issue, but rather as the core constituent of a particular worldview that informs beliefs about matters as fundamental as sexuality, the family, and the nature of personhood (Luker 1984, 2).

During the decades in which abortion attained such prominence as a moral and political issue, South Africa remained largely outside of global abortion debates. The Apartheid government restricted access to legal abortion except under very limited circumstances (Cooper et al. 2004, 71). While a group of pro-choice advocates lobbied for legalized abortion from the 1970s onwards, they never established a wide support base for their advocacy. Popular resistance to apartheid abortion laws was rife, but assumed a very different form to political lobbying, manifesting in the widespread practice of illegal abortion. By the early 1990s, approximately 120,000 women in South Africa were inducing abortions outside the formal health sector every year (Jewkes et al. 1997, 417). In 1985, more legal abortions were performed on South Africans aged 15–24 in England and Wales (368) than in South Africa (320). By 1988, South Africa had been the UK's leading source country for abortions, outside of Europe, for over a decade. The demand for abortion by affluent South African women in

the UK by the 1980s was substantial enough to warrant the creation of a for-profit abortion service. South African women would fly to London, where they would be met at Heathrow, and then helped to procure, and recuperate from, a legal abortion. A few days later they would return to South Africa after a 'holiday' (Interview 6, 15.06.2011). A doctor who worked in the Netherlands during the 1970s recalled providing abortions for a number of young Afrikaans women who had travelled there specifically for the operation. However, the women who were able to afford these trips represented only a sliver of the total number who sought to end unwanted pregnancies. The majority of these women resorted to clandestine abortion providers, presenting in the formal health sector only if side effects were severe or if the illegal provider had initiated but not completed the procedure.

Throughout the 1970s and 1980s in Apartheid South Africa, the admission of patients with incomplete abortions in public health facilities was so commonplace that healthcare workers developed a nomenclature to chronicle their care. Patients who presented with complications from an illegal abortion, for instance, were termed 'incompletes'. Doctors working within obstetrics and gynaecology departments at public hospitals dealt with such a high volume of these patients that their shifts routinely included 'clearing the evac slate': performing uterine evacuations in sufficient number to fill a day's surgery schedule. Thus, while the state prohibited legal abortion except under extraordinary circumstances, it was unable to avoid the medical consequences of illegal abortions, revealed in related rates of morbidity and mortality (Rees et al. 1997, 432–437). By the mid-1990s, a range of illegal abortion techniques were in use, most commonly the injection of detergents into the cervix or the ingestion of herbs and chemicals believed to have abortifacient properties. A study of women who had procured abortions illegally, and then presented in the public health sector, showed that many regarded the role of health workers as to 'finish the job' (Jewkes et al. 1997, 418).

During the years of South Africa's democratic transition, leading political figures and organizations in the anti-Apartheid movement began to plan the transformation of South Africa's health sector. After the elections of 1994, the democratic government set about redrafting its population policy, including its commitments to reproductive healthcare. Public submissions on the revised population policy were invited and many hundreds were made, indicating high levels of public investment in the governance of fertility. In September 1997 the White Paper on Population was tabled

in parliament. It replaced the Apartheid focus on fertility reduction with a broader approach to sexual and reproductive health. The exhaustive consultation layered into the new government's population policy points to its recognition of reproductive rights as fundamental to democratic transformation.

In the early 1990s, various interest groups began lobbying for stronger 'pro-choice' components to the forthcoming South African health legislation. Foremost among these groups was the Reproductive Rights Alliance, a coalition of 30 organizations established in 1995 to advocate 'acceptable, accessible, affordable, cost-effective and user-friendly termination of pregnancy services for women… integrated into comprehensive health services' (Cooper et al. 2004, 76). Within the 'pro-life' faction, the Christian Lawyers' Association and Doctors for Life lobbied against the liberalization of abortion laws.

During the years in which the laws were under review, the Reproductive Health Research Unit, based at Wits University (Johannesburg, South Africa), conducted a study of gynaecological emergencies in 56 randomly selected public hospitals, spanning all of South Africa's provinces. The study measured morbidity and mortality associated with incomplete abortions (Rees et al. 1997, 432–437). One of its investigators, and a later author of the national protocol on the termination of pregnancy, recounted how many of the women in the study 'were severely sick, severely septic, and how many died… It was a very powerful bit of research and we actually took it to the parliamentary Commission' (Interview 5, 29.03.2011). The study found that the management of unsafe abortion placed considerable strain on health resources, and recommended 'a re-evaluation of the clinical management, including the introduction of appropriate technologies, so that access to services can be improved' (Rees et al. 1997, 437).

In response to the use of epidemiology to support pro-choice arguments, those healthcare workers opposed to the legalization of abortion also framed their arguments in relation to public health. While the benefits of legalized abortion had been established in reduced adverse health outcomes from illegal abortions, anti-choice advocates focused on weaknesses in health systems—particularly human resource shortages—to argue that the Choice Act was doomed to fail. In his submissions to the Constitutional Assembly and to parliament's Portfolio Committee on Health, Dr. Harvey Ward, an obstetrician and gynaecologist, wrote: 'It would be an impossible task to identify the need and adequately train the large numbers of personnel required for the performance of abortions in

even the secondary level of healthcare facilities… There are probably not enough facilities, and not enough trained or willing personnel currently employed by the state who are willing or even able to cope with the anticipated influx of women who would wish for and be eligible for an abortion under the proposed legislation' (1996a).

Healthcare workers feared that the legalization of abortion in South Africa would result in a rapid escalation in demand, with a number of participants drawing parallels between South Africa and Romania (another state in political transition during the 1990s). In Romania, public demand for abortion had spiked and remained comparably high after anti-abortion laws, tantamount to enforced fertility, had been abolished. Such arguments ignored the fact that restrictions on legal abortions in South Africa had not historically prevented them, as high annual numbers of patients presenting with incomplete abortions in the public health sector had shown. South Africa's culture of illegal abortion thrived under Apartheid, with the state largely unable, or unwilling, to intervene. Notable exceptions involved cases brought by the Apartheid state against select young white women (Hodes 2016; Klausen 2014).

Another argument made by anti-choice activists was that the South African polity was opposed to the liberalization of abortion laws, and that these changes were being pushed through by a political elite out of touch with public morality. In the weeks leading up to the tabling of the Choice Act in parliament, three theologians made a public call for an 'open vote' to allow parliamentarians to vote as individuals rather than along party lines. Executive leadership of the African National Congress (ANC), the political party with an overwhelming parliamentary majority, rejected this call. It announced that its members would vote as a bloc, thereby ensuring the passage of the bill through parliament.

To diffuse internal opposition to the legalization of abortion, the ANC's *Parliamentary Bulletin* (1996) published a communiqué on the Choice Bill, outlining objections to its content and providing detailed rebuttals with reference to ANC ideology and policy. The bulletin framed abortion principally as a health, rather than a moral, issue, citing 'compelling medical reasons' for the Bill's introduction. Under the section on 'Objections and Answers', it stated:

> This is not a morality Bill, but a health Bill… The Government has not taken a moral position, but has introduced this Bill on health grounds alone, although it respects the moral and religious views and convictions of all in society. The Government must carry out its duty to protect its citizens.

In subsequent discussions, key figures within the ANC used the findings of the epidemiological study on the health impacts of incomplete abortion to defend the Choice Act (Mhlanga 2003, 117). The fact that all 425 deaths in the study were of black women demonstrated decisively that this group bore the disproportionate burden of unsafe abortions as a result of their social and economic marginalization. This underscored the necessity of improved health provisions for this population, including comprehensive reproductive services.

On 6 October 1996, in an effort to increase support among ANC parliamentarians, President Nelson Mandela announced his personal support for the Choice Bill. On 31 October the National Assembly passed the Bill, with 209 votes for, 87 votes against, and 5 abstentions. Over 50 parliamentarians absented themselves on the day of voting. Opposition to the Choice Act was later mounted through a succession of legal challenges. In 1998, the Christian Lawyers' Association of South Africa brought a case against the Minister of Health to the Transvaal High Court on the basis that the Constitution protected the right to life and that the Choice Act violated this right. The Christian Lawyers' Association lost the case when the Court ruled that the word 'everyone' in section 11 of the Constitution, describing bearers of the right to life, excluded a foetus. In 2004, the Christian Lawyers' Association brought a second case against the Minister of Health, arguing that the Choice Act allowed women younger than 18 to terminate their pregnancies without the consent of parents or guardians, without mandatory counselling, and without time to reflect on the decision before the procedure. The Association lost again when the Court ruled that, so long as a woman was capable of giving informed consent to terminate her pregnancy, no further consent is required.

Abortion Rhetoric

In the struggle over the legalization of abortion in South Africa, proponents and opponents have used various rhetorical strategies to defend or criticize the Choice Act. Words used for the physiological processes of abortion imparted biological information while making moral appeals. Pro-choice authors sought to excise emotive terms and focus on the woman as the central figure, while anti-choice authors focused on the foetus. The following two paragraphs, both about the legalization of abortion in South Africa, reveal these juxtapositions:

> The 'Choice on Termination of Pregnancy' law has unleashed a holocaust of child killing across South Africa… By making the murder of pre-born babies legal, easy and taxpayer funded, this 'law' defies all logic. (Lues and Africa Christian Action 2012)

> The passing of this Act was in keeping with the South African Constitution and represented a major breakthrough for women's reproductive rights… The Act has increased women's legal access to safe abortion services, leading to a dramatic decline in morbidity and mortality associated with unsafe abortions. (Hoffman et al. 2006, 1056)

In the first quotation, legalized abortion has facilitated the mass killing of infants, while in the second, it has advanced reproductive rights and made vital improvements in women's health. The ideological weight of vocabularies is perhaps most clearly enunciated in different descriptors for the foetus: neonates, unborn babies and murdered children, versus zygotes, embryos and the 'products and conception' (van Bogaert 2003, 1140).

During the struggle over the Choice Act, pro-choice advocates pursued two key strategies. The first emphasized the public health benefits of safe, accessible abortions, measurable in reduced morbidity and mortality. The second framed the opposition to legalized abortion as a throwback to Apartheid-era discrimination, in which appeals to religious dogma justified the denial of reproductive rights. In an article written in defence of the Choice Act, Eddie Mhlanga, a pro-choice health official, and one of the authors of the Act, wrote: 'South Africa is a strongly Calvinistic country… Apartheid government influenced the church practices, and it was influenced by the church in its policies. The church also provided theological justification for the policies of South Africa. There is now a growing charismatic religious movement within the country, with varying levels of conservative persuasions with regard to reproductive and family health' (117). Mhlanga is a religious Christian, which he often mentioned when speaking publicly in support of legalized abortion. As a doctor who treated women for the adverse health effects of illegal abortions during the Apartheid years, Mhlanga also argued from a position of personal experience. Anti-choice activists also noted similarities between legalized abortion and the laws of oppressive political regimes, illustrating the dynamism of these comparisons. In a letter of objection to the Choice Bill, Harvey Ward, also an obstetrician and gynaecologist, described a draft clause regarding the possible imprisonment of a health professional for

'obstructing or failing to refer a woman eligible for an abortion' as exposing 'a deplorable, Nazi style attitude to people of conscience'.

A further criticism levelled against anti-choice activists in South Africa was that their work was funded and controlled by overseas organizations working to undermine reproductive rights. Anti-abortion pundits were depicted as local cogs in the global anti-choice machine, rather than as arbiters of an elevated morality. In response, anti-choice activists argued that abortion was unknown in pre-colonial Africa, and that, on this basis, it is fundamentally 'anti-African' (Turyomumazima date unstated).[2] As the work of historians has shown, abortion was common among both 'native' and 'settler' societies in South Africa prior to the twentieth century (Bradford 1991; Potts and Marks 2001). A pharmacopoeia of abortifacient remedies, emetics, and purgatives were in common use among diverse ethnicities in South Africa from at least the early nineteenth century. The range and popularity of abortion methods used in South Africa, 20 years after the official legalization of abortion and the formalization of its medical procedures, demonstrate a powerful continuum between the past and present.

Abortion After the Choice Act

Currently, there are two principal procedures for abortion in South Africa's public health sector. The first is medical abortion, in which a prostaglandin analogue is given to women in pill form. The second procedure, available only in a smattering of hospitals and clinics in the public health sector (Harries et al. 2009, 3), is the dilation and evacuation (D&E) procedure known as surgical abortion. A shortage of providers willing to perform surgical abortions in South Africa's public health sector has resulted in their outsourcing to a handful of private doctors (Harries et al. 2012). Medical abortion is therefore often the sole option available to women in the public health sector, and its procurement may also be prevented by an array of social, economic and clinical factors.

Women's health advocates have attributed expansive health benefits to medical abortion using Cytotec, including decreased severity of adverse health effects from clandestine abortions and positive changes in the attitudes of women and healthcare workers towards the abortion procedure

[2] Similar arguments are made regarding the alleged absence of homosexuality in pre-colonial Africa. These have been refuted by the historian M. Epprecht.

(Arilha and Barbosa 1993, 43–45; Hyman et al. 2013, 128–130). Because medical abortion requires less instrumentation and minimizes provider involvement, it may improve accessibility in contexts in which stigma and resource constraints remain prohibitive. However, due to the urgent need to expand the number of facilities in which abortion is provided, and to increase the number of trained healthcare workers, much of the focus of pro-choice advocates has been on access, rather than on quality, of care. Moreover, because of widespread opposition to abortion, an honest account of the difficulties that many healthcare workers and patients face in procuring abortions may strengthen moral appeals to restrict or to forbid access to abortion, rather than expanding the availability of abortion in public facilities. While medical abortion may improve access, there are ongoing problems with the procedure in South Africa, including the pain and trauma that women experience. A doctor with a long career of providing reproductive healthcare in South Africa's public sector, and a committed pro-choice advocate, recounted the experiences of medical abortion patients in their second trimester:

> They have to push the baby out. And this baby is born and it's a baby, it looks like a baby. It doesn't breathe, but it looks like a baby and it's quite something to go through. Then you have to have the placenta delivered and sometimes you have to have an evacuation of the uterus. So it's not an easy thing to go through… [S]ome of them get very little counseling. They are not well prepared for what they are going to go through and it can be very traumatic. (Interview 1, 26.01.2011)

The Choice Act mandates counselling and support to offset the psychological impacts of abortion, and analgesia to mute its effects. But these palliative measures remain in scarce supply in the public health sector. This lends to the claim made by anti-choice advocates in the mid-1990s, but equally applicable two decades after South Africa's legalization of abortion: that health systems are too weak, clinics too overloaded, and healthcare workers too resistant, to implement the Choice Act (Ward 1996b).

The withholding of pain blockers to abortion patients was reported by a number of healthcare workers and abortion patients in this study. As one healthcare worker stated: 'The women are in a lot of discomfort… [T]hey should be giving them pain medication, but it doesn't always happen' (Interview 7, 30.03.2011.) In the most comprehensive epidemiologi-

cal study of second-trimester abortion in South Africa to date, investigators found that only 20% of patients were given pain medication of any kind (Grossman et al. 2011, 5). Informants described how healthcare workers may withhold analgesics to punish abortion patients for having the procedure, and to discourage them from seeking 'repeat' abortion in the public health sector. One recounted 'I do think that the pain medication, the analgesia, is not optimal… If you, if you make it too comfortable, then people are going to come back… It's like wanting to offer a disincentive as if an incentive exists' (Interview 7, 30.03.2011). Another healthcare worker, with decades of experience in treating medical abortion patients, explained: 'The women don't get pain medication. They abort at home, they abort on the way [to hospital] or they abort while waiting there' (Interview 11, 15.05.2012). Healthcare workers sought to adapt national health protocols to improve the experiences of abortion patients. But shortages in equipment to ensure the quality of care—including bulbs for surgical lights, and beds in patient recovery rooms—rendered the experience of abortion more painful and more difficult for many women in this study.

In many South African clinics and hospitals, first-trimester medical abortion patients are given misoprostol pills and then leave the clinic to abort elsewhere. This may afford women greater secrecy, as there is little privacy in the waiting and recovery rooms of public abortion facilities.[3] It may also help women to offset the costs of multiple clinic visits and time away from work (waged or not). Medical abortion has been heralded for its positive effects on improving access to abortion and on decreasing the negative health effects from clandestine abortion (Hyman et al. 2013). However, in the struggle to improve access to medical abortion, both as a benefit for public health and reproductive rights, the experiences of patients have often been left undocumented. Because any recognition of suffering or pain due to abortion may serve as a concession to the anti-choice lobby, the negative experiences of patients often remain undisclosed. In South Africa, while medical abortion has certainly improved access, the experience of abortion—for both patients and for providers—is frequently traumatic. Even in healthcare settings that are regarded as

[3] The ethical issues that arise in violations of medical confidentiality within South Africa's health sector have received relatively little attention (Benatar 59). In the case of abortion in South Africa's public health sector, the breach of confidentiality enacted by the architecture of the waiting and recovery rooms requires further exploration and analysis.

models of best practice in South Africa, an abortion counsellor recounted how patients frequently wept throughout the procedure, because 'they are feeling that pain' (Interview 15, 12.10.2012).

The negative experiences of healthcare workers in this study were not the result of personal opposition to abortion. Out of 15 healthcare workers with direct experience of either providing abortion in the public health sector, or supporting access through working for health advocacy organizations or counselling abortion patients, 13 were explicitly pro-choice. However, every one of these informants spoke of the difficulties in providing second-trimester surgical abortions, from the perspectives of both patients and healthcare workers. These acknowledgements ranged from casual avowals such as, 'Let's be honest, it's not a pleasant procedure' (Interview 7, 30.03.2011), to more detailed accounts of the trauma that healthcare workers and patients endure in terminating pregnancy. An obstetrician explained how many healthcare workers:

> [H]ave a deep abhorrence of performing abortion. There's a lot of emotion around abortion. They feel like they are murdering a baby… I find it distressing. It really is distressing. It is really not 'a nothing thing' for the health professional to go through. (Interview 01, 26.01.2011)

Responses such as this presented an ethical quandary in this research. Is describing the pain felt by both abortion providers and patients, documenting the visceral and emotional difficulties of their experiences, worth the risk? Should the concern that this information may benefit anti-choice advocacy outweigh the need to recognize the difficulties that doctors and patients face, and, through this recognition, to conceive of their potential amelioration? These are questions with which researchers of reproductive rights grapple, particularly if they hope to strengthen the evidence base for improved abortion access.

In South Africa, the personal politics of many healthcare workers remain profoundly at odds with the legal commitment and the public health imperative to provide comprehensive reproductive healthcare, including abortion (Wood and Jewkes 2006, 116). One result is a critical shortage of healthcare workers who are willing to either provide or assist in abortions, to play any role in the procedure whatsoever—from taking a patient's temperature, to providing her with prostaglandin pills, to supporting her through the procedure. The dearth of abortion providers undermines women's access to safe abortion services, and has serious implications for

the continued reliance on clandestine abortion providers (Grossman et al. 2011, 6; Harries et al. 2009, 1). One informant described how, at rural clinics in three South African provinces—KwaZulu Natal, Limpopo and Mpumalanga—the nurses 'are not offering any second trimester terminations of pregnancy. Only first trimester. And they report very difficult staff who don't do them [abortions]' (Interview 05, 29.03.2011). The resistance of healthcare workers to providing abortions is fervent and widespread. But the mere acknowledgement of this raises ethical concerns about bolstering claims that abortion is fundamentally at odds with public morality and that policies mandating its provision are guaranteed to fail.

In 1997, a year after the passage of the Choice Act, approximately 50,000 legal abortions were performed annually in South Africa. However, a similar number of 'unsafe' abortions were also performed in this year (van Bogaert 2003, 860). Findings from the Confidential Enquiries into Maternal Deaths in South Africa, combined with numerous studies on abortion provision since the Choice Act, indicate continuing and comparably high rates of illegal abortion, with concomitant negative health effects (Saving Mothers 2015). The South African government has identified 'septic abortion' as among the most common causes of female death (Office on the Status of Women 2002). Public health researchers have explored two reasons for high rates of illegal abortion (Dickson et al. 2003): the continuing stigmatization against abortion—both by healthcare providers and by communities—and the uneven distribution of abortion services, due primarily to the opposition of healthcare workers to performing abortions.

According to indicator data by the National Department of Health, the percentage of facilities designated to provide termination of pregnancy which were actually functioning rose from 31.5% in 2000 to 61.8% in 2003. However, the perception of both proponents and opponents of the Choice Act by the mid-2000s was that healthcare workers' opposition to abortion was mounting. Numerous studies documented the punitive attitudes of doctors and nurses, and their obstruction of abortion access to patients. In response to repeated complaints by health workers and women's rights advocates that the Choice Act was not being fulfilled and that abortion remained inaccessible for many, the Choice on Termination of Pregnancy Amendment Act was passed in 2004. It extended facilities that may provide abortions and allowed registered nurses with appropriate training to perform first-trimester abortions (in addition to doctors and midwives, as stipulated in the original Act). The Amendment Act was

challenged in the Constitutional Court, which found that parliament had failed to follow due process in consulting the public during the Act's drafting. The judgement was suspended for 18 months to allow parliament to consult further, but the media's coverage of the trial created confusion among health workers and the public about abortion's legality.

Conclusion

Abortion is among the most fiercely contested issues in global health and human rights. Research has been marshalled by both the 'pro-' and 'anti-choice' lobbies to defend their positions, and researchers themselves have become attuned to the potential political uses and misuses of their work. One response has been to adhere to one side of the debate, and to argue fervently for this position. Another has been less explicit but no less ideological: to structure studies and interpret findings according to a 'pro-choice' or a 'pro-life' perspective. In the context of South Africa—where the right to legal abortion has been realized relatively recently and where abortion remains a highly stigmatized practice—research that seeks to defend and uphold the need to expand abortion access may gloss over the ambivalence felt by healthcare providers and patients towards the practice and experience of abortion. This chapter confronts this ambivalence, exploring the ongoing challenges that healthcare workers and abortion patients face in providing and procuring abortion in the public health sector.

The legalization of abortion in South Africa has had a measurable public health impact. One study found a 91% decrease in abortion-related mortality between 1998 and 2001, attributable directly to the implementation of the Choice Act (Jewkes and Rees 2005, 250). Another study found massive reductions in both the number of women presenting with incomplete abortions and the number of deaths from abortion, as a direct result of the Choice Act (Mbele et al. 2006, 1198). Despite these findings, which lend empirical support to the health benefits of abortion provision in the public health sector, numerous deep-seated problems with abortion access remain. The prevalence of severe morbidity from illegal abortions in South Africa is persistently high. A study that examined the causes for this found that a lack of knowledge of the Choice Act, and where to access a safe, legal abortion in the public health sector, together with fear of mistreatment by healthcare workers and abortion-related stigma within communities, was the main reasons for the continued high rates of illegal abortion procurement (Jewkes et al. 2005).

Many thousands of South African women terminate their pregnancies every year, and have been doing so for decades—even centuries. This historical fact casts a critical light on the simplistic pro-natalism ascribed to black women in particular (Hodes 2013, 541). Although abortion rates convey that the practice is commonplace, this does not translate into public support for pro-choice advocacy or to changes in moral codes that define abortion as wrong—particularly among healthcare workers. Women continue to terminate their unwanted pregnancies *en masse*, but usually in ways that uphold the norms of silence and secrecy around the practice, including the choice to abort illegally, rather than risk the exposure and censure that public access to abortion often entails.

Abortion has been legal in South Africa for over two decades, but its social interpretation as a transgression and a marker of moral failing remains a powerful influence. As the clinical observations and expert interviews in this study revealed, pain and humiliation among abortion patients are so normalized within the healthcare system that they are understood to be an inevitable part of the clinical transaction. The law mandates that abortion should be a safe medical procedure that forms an integral part of comprehensive healthcare in South Africa. Nevertheless, through obstructing its access and rendering its legal procurement a conduit of punishment and suffering, it remains a source of pain, enacted within South Africa's public health sector, against the women whose health it is meant to protect.

CHAPTER 12

Quiet Contestations of Irish Abortion Law: Abortion Politics in Flux?

Joanna Mishtal

Abortion is banned in Ireland,[1] unless the woman's life is in danger, and even then the law is unclear. The reality of thousands of Irish women traveling to the UK for abortion services since 1967, when abortion was decriminalized there, constitutes common knowledge in Ireland, but is protected by a code of silence. The terms and the extent of discussions about reproductive health and rights have long been shaped by the Irish Catholic Church. In political discourses, the complex power dynamics between the Church, the state, and medicine converge on women's bodies as the "gatekeepers" of Irish Catholic nationhood, and maintain particular meanings of reproduction, sexuality, and family (Smyth 2005, *Abortion and Nation*). National debates in Ireland also include anxieties about declining birthrates—a phenomenon that is becoming global and is linked to dwindling social services and health provisions, which drive women to limit childbearing (Murphy-Lawless 2005, 229–248). Doctors' perspectives and their political role in abortion debates are significant for reproductive rights advocacy efforts, especially in Catholic settings (De Zordo and Mishtal).

[1] Ireland and Irish refer to the Republic of Ireland.

J. Mishtal (✉)
Department of Anthropology, University of Central Florida, Orlando, FL, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_12

In this chapter, I explore the perspectives of Irish doctors involved in reproductive healthcare provision about the current abortion policies. I consider the question: How do Irish healthcare providers, as the necessary executors of the current restrictive reproductive health policies, understand the policies, in particular the abortion travel abroad, in the context of medical practice experience? I frame my analysis with a historical overview of abortion politics in Ireland and the role of the Catholic Church in shaping abortion and family planning policies. I also examine how religiously defined bioethics shape discourses about, and access to, reproductive rights.

The Politics of Abortion in Ireland

Historically, the Church's dominance emerged in 1922, when Ireland achieved its independence from the British, and resulted from a long-standing consolidation of religious power within the state structure. The ongoing safeguarding of Irish nationhood and its Catholic character is the result of that recent colonial past (Oaks 1999, 150), as the Church began to provide nearly all public education, healthcare, and social services. All hospitals were Catholic and operated based on a religious ethos. Presently the Church continues to be a major administrator of state hospitals, especially maternity and gynecological facilities, where they decline to provide some services, especially sterilization and emergency contraception. In one of the hospitals in this study, religious ethos dictates that HIV/AIDS education must focus on abstinence, and therefore, brochures promoting condoms cannot be displayed in waiting rooms. However, in the quiet of a doctor–patient encounter such information is tolerated by the nuns, who increasingly "turn a blind eye," as one of the providers explained, due to requests by some providers to loosen the rules. But the majority who needs hospital privileges is quick to point out that they have nowhere else to go since most hospitals are Catholic, which limits their ability to challenge the prohibition of certain lawful procedures like sterilization.

Attention to the effects of religiously defined bioethics on access to healthcare and providers' views on this form of medical governance has been nominal. Bioethics is a cross-disciplinary area of inquiry, and for the purpose of this chapter, I follow Turner (85) in defining it as "constellations of moral theories and ecologies of social practice" with implications for healthcare provision and utilization. A recent review of bioethics definitions and models downplays religious influences as a force of the past, and

of limited use to clinicians, who grapple with decisions that must accommodate present-day moral pluralism (Gaines and Juengst). Anthropologist Margaret Everett (47) calls attention to the value of a social justice framework for the analysis of medical ethics, defining ethics as a distinct local discourse and practice embedded in relations of power and historically constituted, thereby highlighting questions that examine why, for example, certain medical services are cast or understood as ethical issues.

Building on these observations in the context of my research with Irish healthcare providers, I consider bioethics as a specific set of moral formulations and theories affecting access to healthcare and shaping health in/equity at the institutional level. The health equity and justice model is a useful theoretical lens in the case of Ireland, where religiously influenced policy banning abortion motivates Irish women to travel to the UK for the service and restricts doctors in referrals, even though abortion is one of the commonest and safest procedures sought by European women. This approach therefore gets at the dilemma present in the subjective experiences that underlie the morality discourses, which is fundamentally about limitations placed on access to wanted healthcare. More broadly, I position this chapter within the medical anthropology scholarship that addressed reproductive governance (Morgan and Roberts 2012). The analytic tool of reproductive governance illuminates "shifting political rationalities directed toward reproduction," that is, the ways in which mechanisms that produce and monitor reproductive behaviors are maintained, mitigated or reshaped (Morgan and Roberts 2012, 241, 243). These mechanisms have historically been deployed by a variety of actors, including the state, church, and nongovernmental organizations, through direct policies, economic influences, as well as moral and ethical claims. The reproductive governance framework also highlights the regulation of reproductive conduct as a national project of shaping citizens—an approach useful in the context of Ireland, where historically Catholicism and familism have been central in the way that Irish identity was constituted. Irish familism constructed women in maternal terms and highlighted the centrality of the family in everyday discourse (Oaks 1999).

The influence of the Catholic Church in Irish medicine, politics, and public life, beyond a religious presence, created what sociologist Tom Inglis (*Moral Monopoly*) refers to as the "moral monopoly" of the Church over matters of Irish public morality. This moral monopoly also created a code of silence among policymakers that prevents many from speaking openly, lest it be construed as challenging the Church (McDonnell

and Allison). The code of silence encompasses more than the politicians. Traditionally, the three institutions—the Church, the state, and the medical community in Ireland—have employed what scholars refer to as the politics of "semantic subterfuge"—the reluctance to engage in an open discourse about reproductive health policies—a practice that forecloses challenges to the laws, even as grassroots contestations are percolating, and maintains "an illusion of consensus to contain a widening dissensus" (McDonnell and Allison 819–820, 833). It furthermore maintains the image of Ireland as a "pro-life nation" externally in the eyes of the European Union (EU), even if internally the Church is battling new social movements led by the Irish Family Planning Association, Irish Doctors for Choice, and a growing gay and lesbian rights community. Moreover, the challenges come from ordinary women. Thousands of Irish women annually enact what is known as the "export script" as they travel abroad for abortion (McDonnell and Allison 825). Many more women and couples use contraceptives, including emergency ones. Juxtaposed against these contestations is a Church that continues to hold significant religious capital with the majority of the Irish continuing to affiliate with Catholicism.

The contrast of, on the one hand, these powerful and authorized discursive formations framing reproduction as a Catholic and patriotic imperative, and abortion and contraception as grave transgressions that have no place in Ireland, and on the other hand, the increasing forms of ambivalence toward the institution of the Church and overt forms of contestation manifest in the abortion travel raise questions for anthropological and feminist observers: What can be said to contest these religious assumptions? Specifically, to what extent can healthcare providers, normally the authoritative voice, be allowed to speak out publically against or about them?

Methodology

I draw on six-month fieldwork in Ireland conducted in 2009 and 2010 with 25 reproductive health providers, primarily general practitioners (GPs) and secondarily obstetrician/gynecologists (Ob/Gyns). I aimed to explore doctors' perspectives at the intersection of religion and medicine by examining how Irish doctors understand the influence of Catholicism and the Church in their medical practice in reproductive health. My approach was to include doctors' religious and medical trajectories and perspectives regarding reproductive policies and abortion travel. I recruited

doctors through three professional organizations which allowed me access to their email lists in order to present my study: the Irish Catholic Doctors Association, the Royal College of Physicians of Ireland—Institute of Obstetricians and Gynaecologists, and the Irish College of General Practitioners. As a result of the emails, 11 doctors volunteered to participate; they ranged from self-described orthodox Catholic to nonreligious providers, in terms of religiosity. These 11 seeds offered starting points for snowball sampling, which resulted in the sample of 25 doctors. The Irish GPs provide the majority of family planning, while Ob/Gyns offer services at maternity hospitals and in private practices, and therefore address fetal abnormalities. Both groups see women with unintended pregnancies and those seeking abortion abroad. The doctors' locations varied from urban and suburban areas of Dublin and Cork, to small towns and rural villages in the midlands, the west of Ireland near Limerick and Galway, and as far north as Dundalk on the border with Northern Ireland. All names are pseudonyms unless noted.

The Role of Bioethics in Reproductive Health Policies

The position of the Catholic Church on issues of bioethics acts as a religious and political framework that links religious tenets with reproduction. In some settings, the Catholic Church influences healthcare provision directly through the work of bioethics committees in addition to influencing policies—in Poland, for example, Catholic priests serve as ethics committee members in hospitals and state health institutions (Mishtal 2015, *The Politics of Morality*). The Vatican commonly engages in broader bioethics debates, including at the EU level, through documents which define Catholic ethical conduct in the domains of abortion, contraception, and in vitro fertilization (Mishtal 2014, "Reproductive Governance in the New Europe"). Specifically, The Charter for Healthcare Workers, released in 1995, and the "Instruction *Dignitas Personae* on Certain Bioethical Questions," released by Pope Benedict XVI in 2008 (Levada and Ladaria 1), argue that ethical conduct consists of objective truths that must be upheld regardless of individual circumstances.

This objective truths approach, present historically in a variety of bioethical models, has been critiqued as missing "the powerful constraints of real worlds," including social and economic structural constraints and dilemmas (Kleinman 48–49). The feminist bioethics movements of the

1960s likewise critiqued the abstract nature of objective/masculinist ethics paradigms and called for situating ethics in the particulars of real life (Sherwin). In Ireland, where medical ethics has been infused with religious morality, effects of the "objective truths" paradigm on reproductive policies have been significant. Abortion had been illegal in Ireland since 1861 under the general Offences Against the Person Act, but after the procedure was decriminalized in the UK in 1967, Irish women began to travel there for abortion. Despite a more explicit constitutional ban on abortion enacted in 1983, the travel continues. Abortion is illegal except to save the woman's life, as distinct from health, and cases of rape or incest do not warrant abortion. But doctors in this study could not recall a single case of a legally performed abortion to save a woman's life in Ireland. The law threatens life imprisonment for the doctor and the woman if an abortion was performed which was deemed, ex post facto, not necessarily life-saving—this degree of criminalization has a chilling effect on doctors, who decline to even assess women for abortion eligibility. In 2010, the European Court of Human Right declared in the ABC case that Ireland was guilty of not making the life-saving exception a realistic possibility based on a case of a woman with cancer who had to travel to the UK for an abortion, but should have otherwise qualified for one in Ireland. In 2012, this issue was highlighted by the death of Savita Halappanavar, who was denied a life-saving abortion while in an Irish hospital in Galway (O'Toole). This tragic case triggered a vigorous political debate about the ambiguity of the law, and finally resulted, in 2014, in a clarification that allows abortion when the life of the woman is at risk, including the risk of a suicide. It remains to be seen how this clarification is tested in future cases.

The state acknowledges that approximately 4000–7000 Irish women travel each year to the UK for abortions—a substantial number for a population of only 4.5 million people (Best). The ability of Irish women to openly obtain abortion information, including addresses of clinics but not actual referrals, is a relatively recent change spurred by the feminist movement when in 1995 the Abortion Information Act was implemented. It is unclear how many travel for abortions as the estimates account only for women who offer Irish addresses when presenting in UK clinics.

Encroachment of the EU into Irish reproductive politics is highly significant. Scores of feminist politicians in the EU are calling for the right to abortion as a fundamental human right, one that would override national laws (Rossilli). EU's role has also been perceived by some as threatening

to the sovereignty of member states. Irish scholar O'Carroll argues that the 1983 constitutional amendment to protect fetal life was already back then sparked by just such anxieties, in particular, fears of "alien ideas" from the EU. By 1991, the Irish state had negotiated an agreement with the EU stipulating that Ireland would retain its sovereignty on matters of "public morality," and therefore remain independent of EU's position on abortion policy.

Fears of EU's intrusion spill into the wider European space. Due to recent liberalization of abortion laws in Spain and Portugal, the Vatican intensified calls to Catholic physicians to use conscientious objection to circumvent the new laws. Discussions at the EU about family planning as citizenship rights and gender equality fuel EU–Ireland tensions around the competing discourses of European citizenship rights and the protection of "Irishness" through the protection of the Irish unborn (Oaks 1999). The relationship of Irish identity to reproductive laws was vigorously, but briefly, debated for three abortion referenda in 1983, 1992, and 2002. Alternative views were marginalized when the political right successfully framed Ireland as "a pro-life nation" in a wave of manufactured (with the help of the press) moral panic at the prospect of "encroaching global liberalism" (Smyth 2005, *Abortion and Nation* 49–71). Likewise, the historically high birthrate was depicted as a national tradition that endured a recent colonial. True, Irish birthrate during most of the twentieth century was higher than elsewhere in Europe, but was it indeed a national tradition?

Historical Perspectives: A View from Healthcare Providers

The veteran doctors in this study, who have been practicing since the 1960s, believed that the "national tradition" of large families was mainly due to key historical structural factors rather than its national character. The 1937 Irish Constitution of President Éamon de Valera contained Catholic social principles that confined women to home and reduced their chances for economic, social or reproductive independence (Connelly 1999). De Valera, a devout Catholic who himself eventually had seven children, believed in the special position of Catholicism in Irish state, law, and society. His ban on married women's employment (repealed only in 1973) aimed to confine women to duties at home (Conrad). To protect the institution of marriage, De Valera delegalized divorce (the law stood until 1996). Under these restrictions, doctors saw the 1935 ban on the sale,

manufacturing, and import of contraceptives (in effect for 43 years until 1978) as detrimental to women's reproductive lives. For providers, the common recollection from that era was that of a female patient with multiple unintended pregnancies. Dr. Margaret Clarke, who had been practicing in Dublin since the 1960s, described how patients would grab her arm and beg her to "do something":

> In those days [1960s and 1970s] we had about 60 or 70 percent of the women having God knows how many children, very big families. I was terribly worried about women who were older and had serious health risks who couldn't get contraception because a lot of them were lined up for death on a subsequent pregnancy. A colleague said she wanted to run for the Senate and campaign to legalize contraception. I said of course I'd help her; I wasn't really from a human rights point of view or anything like that that. I felt contraception should be available. My concern was because of the women I was dealing with—they would be coming to me sometimes and I would think "This woman is so old, she couldn't be pregnant," and then she worked out to be 35 and have 10 children.

When Dr. Clarke presented her research paper about the association of high birthrate and maternal mortality in Ireland to the Royal College of Obstetricians in London in 1965, she was met with disbelief; she recounted: "When I got to talking about a woman of 47 who was on her 17th pregnancy, and add epilepsy into the bargain, and she died of a pulmonary embolism, I knew I lost the audience the way you do sometimes, because they thought 'Dr. Clarke is making this up, you know, this could not exist.' I saw them say, 'Oh, for God's sake.' It was dreadful, it was so dreadful." Women's experiences of suffering and the courage of many doctors and feminists in Ireland led to a series of legal changes. Since sterilization was not available, Dr. Clarke recalled she was heartened in the early 1970s by a group of doctors who began to provide family planning in Dublin—they avoided arrests by not *selling* contraceptives but giving them away. Two of these clinics are known now: one in Merrion Square and another on Pembroke Road, which became the Well Woman Center. Dr. Clarke would refer her patients, telling them euphemistically they "could get a bit of help there," even though three of the nurses on her staff told her once that "she had no business" referring women for family planning—an incident she still recalls with exasperation. Some doctors at these clinics obtained contraceptives locally as certain pharmaceutical companies received state permission to distribute the pill as a "cycle

regulator." Other doctors took weekend trips to the UK only to return with "suitcases filled with thousands of condoms," and when questioned by customs, claimed them for personal use—these stories became a subject of humorous narration by doctors during interviews.

The Irish feminist activists have also been helping women pursue abortion in the UK, although the groups worked quietly because of the inherent perception that helping women abort "would never be seen as a good cause" (Rossiter 87). In 1971, 47 feminists from the Irish Women's Liberation Movement (IWLM) openly organized the "contraceptive train"—a one-day trip from Dublin's Connolly station to Belfast. The women occupied two carriages, and a score of journalists came along to capture the event. Upon their return, the women chanted "The law is obsolete!" and the guards, in a gesture of support or disbelief, refused to confiscate the condoms and spermicidals (Coghlan). Mary Kenny, one of the founders of IWLM, recalled that the public talk of condoms when the train returned to Connolly challenged the norm as "anything touching sexual intercourse was protected by the greatest possible decorum" (Kenny). The contraceptive law was not changed right then, but the movement put a crack in the well-ossified taboo.

Despite the Church's opposition, the ban on contraceptives was finally lifted in 1978, but not entirely. The Irish Minister of Health, Charles Haughey, decided that even condoms should require prescription to let doctors establish if they are for a "bona fide" couple. This became known as the "Irish solution to an Irish problem," reflecting the double bind of Irish politicians: needing to reform laws in ways condemned by the Church, while simultaneously appeasing the Church (Fuller 51). Medicalization of condoms was the political solution to this double bind—it shifted the responsibility from politicians onto the morally trusted, but also bound by medical laws, authority of physicians. From the perspective of the Church, which cared strongly about restricting access to condoms, this was the next best thing: if a direct law could no longer limit access, then a law obliging physicians to limit access was what was left. All but two physicians in this study (liberal and conservative alike) criticized the burden of prescribing condoms, and generally found the law trivializing to medicine. The two providers who disagreed identified as orthodox Catholic. One saw the law as irrelevant to his work since he would never support condom use to begin with. The other argued that condoms promote promiscuity; therefore, he would allow them only for his married patients. Thus, in his view prescription was appropriate to control condom use.

Dr. Andrew Rynne,[2] whom I interviewed in his clinic in Clane, a rural town with a population of less than 5000 in County Kildare, was particularly proud of his opposition to the prescription law, and likewise he was frequently credited by others in this study with triggering a fallout. In 1983, he forced a legal showdown when he arranged the sale of ten condoms to a patient to force a prosecution, which followed. Dr. Rynne argued that the perspective of the medical community, which he believed generally opposed religious bioethics, was never elicited when the Minister of Health Haughey established the law requiring prescriptions for condoms and a "moral assessment" for their use:

> They never consulted anybody else, so we were landed with this piece of legislation whereby a doctor is supposed to interview people and give them a prescription—a doctor's prescription for condoms!—which was silly, and write down their names and approve them. And I argued, as a lot of people did, that we didn't go to medical school to prescribe toiletries or toothpaste or condoms, that's not our function in life, A, and B, our function in life is certainly not to make judgments about people's morality as to whether theirs is so-called bona fide family-planning.

As a result of these contestations, the Irish state liberalized contraceptive law in 1985 by removing the prescription requirement, but limiting condoms to adults over 18 years. Recalling these times, Dr. Clarke emphasized, and most other doctors in this study concurred, that the ban on contraceptives "was not a medical issue" but a particular moral/ethical position that was institutionalized in health policy. In practice, this moral ethos continues to be leveraged when doctors refuse dispensing contraceptives due to conscience-based objections. Scholars observe similar discourses deployed institutionally; for example, "[t]his is evident in recent events in which hospital ethics committees in several key Dublin hospitals refused to sanction cancer drug trial protocols that required the use of contraceptives in conjunction with treatment, on the grounds that it was contrary to a Catholic ethos" (McDonnell and Allison 829). Such incidences are generating doubts among providers about the appropriateness of Catholic bioethical guidelines in medicine, yet providers appear to be restrained by a kind of rhetorical paralysis regarding the abortion ban.

[2] This was a public case; thus, a pseudonym is not used.

Individualized Strategies, Quiet Contestations: "An Irish Solution to an Irish Problem"

"Most Irish Catholics are still born into the Church," argues Inglis ("Catholic Identity" 205) in his analysis of Catholic identity in contemporary Ireland, and given the control of the Church over most of the school system, it is the Catholic habitus and its distinct moral lens that dominates. But this research revealed significant points of contestation vis-à-vis the Church as a moral authority, therefore suggesting a question, Might abortion politics in Ireland be in flux? Doctors' narratives sketched a repeating story line that attributed the waning of religion to expanding education and economy. Ireland's entry into the EU in 1973 and the subsequent economic boom of the Celtic Tiger was a secularizing energy. The gravest reasons behind declining religious authority among this study's participants have been the abuse scandals and cover-ups in Ireland and abroad, in particular, revelations exposed in the Ryan Report in 2009, which shows physical and sexual abuses of children housed in Irish Catholic institutions (Ryan).

Public reaction to the report was powerful, and many doctors cited scandals as a significant factor in their wane in religiosity. One of them explained that nowadays the Irish Sunday mass cannot last longer than 20 minutes (versus an hour in Poland and Italy, and up to two hours for weddings and holidays) because people complain, and the Church is cautious not to put off any more of the faithful since "it's having difficulty keeping bums on seats" as it is. Some doctors explained their personal trajectory from deeply Catholic upbringings to a nonpracticing but Catholic-affiliated status, whereas others continue to attend Church, as one doctor put it, for the "spiritual nourishment of the community," but reject the Church's authority in moral matters.

Dr. Jenn Walsh, who qualified as a GP in the 1980s, completed most of her education in Ireland and now works in a large clinic in a working-class suburb of Dublin. She affiliates with Catholicism, although she no longer practices. She explained that requests from her patients for abortion referrals often presented "some moral conflict" for her, as her Catholic background produced "an ingrained personal preference for people to retain their pregnancies." She explained: "I had a very good, young experience with the Church in Ireland; extremely good, very comforting Church I found it. But then realizing that just so much was hidden and was going on has certainly influenced me." She observed that while the clergy's sexual

abuses seriously discouraged her faith, it was altogether another incident that affected her practice. Her view changed dramatically after she had an unwanted pregnancy herself: "and realizing that I really would prefer to have, I lost the pregnancy, I really would have preferred to have an abortion. And actually reaching that personal dilemma for myself, where I truly understood what it was like not to want another baby." Since then, she has been supportive of patients who pursue abortion. As our discussion turned to abortion travel, she explained further:

Dr. Walsh: Yes, women travel and we let someone else deal with it. I can understand how, I can understand that frame of mind because I can understand where allowing Irish women to get abortion elsewhere comes from, allowing that to continue. But it's clearly an anomaly and it's clearly unfair. And I think it's just that it hasn't really been discussed. I think we need a referendum on it and to decide whether we should have abortions provided within our country or not.

Author: What do you mean when you say you can understand it? What's under there?

Dr. Walsh: I can understand. What's under there is a little like my own mindset that on balance many, many people would prefer abortions not to be happening at all. But they just have this inherited thought through feeling. And a slight sense of a slippery slope that if we bring it in here more people will have abortions, it will be too easy. People will have them more available. And it [sending abortion abroad] is putting one's head in the sand a little bit, but it is about a group of people, I think, who haven't yet come to terms with this question and the complexity of it. I think the referendum on this will come up here in the future, I think it *must* come up here in the future, and that we could do with an open, honest debate about it.

Author: What would you like to see happen in a referendum?

Dr. Walsh: I think I would have to say that abortion should be provided here in this country so that women don't have to travel.

Dr. Walsh's position, similar to her clinic colleagues', challenges the position of the Church, but it is an individualized form of opposition enacted in one-on-one encounters as she quietly facilitates travel for her

patients. Dr. Fiona Gallagher, a GP who has been in practice for over 20 years and runs a busy clinic in Dublin, echoed Dr. Walsh's assertions, saying: "Well, okay, we do accept what goes on [abortion travel] and it's an odd solution. It's as though we don't want to actually have anybody, doctors, nurses and so on, have anybody really be inconvenienced here in Ireland." She added, "But at the same time we don't want to hear that it's going on. Really, it's just shutting your eyes and just saying you don't want to see."

Both doctors saw export of healthcare as problematic, yet, Dr. Walsh's identification of her own concern, and a concern among the general public, of a "slippery slope" is one that resonated with other doctors—it is described as a sense of anxiety about "giving an inch" and potentially allowing for abortion to be provided for "on demand" reasons. "On demand" abortion was depicted as less legitimate and conjured poor contraceptive habits and irresponsibility on women's part. Thus, while many physicians were in favor of greater abortion access, there were clear limits of comfort, beyond which questions of judgment, morality, and conscience were central. Sending women abroad for abortions was considered most problematic in cases of fetal abnormalities which were seen as "legitimate." Dr. Orla Flanagan, an obstetrician in Cork area who qualified in 1985, explicates: "We have Irish solutions to Irish problems. Yeah, we actually get around it without actually having to kind of abolish something or make a huge big deal of it, we get around it. So if I can't sterilize my patients I send them to a friend [in the UK] who can. That would be the same thing with termination of pregnancy." As an obstetrician, she was especially concerned about women who have been given diagnoses of severe fetal abnormalities and were dropped from the system: "We would pick it up on scan at 12 weeks that there's something seriously wrong with the baby. And the baby is maybe incompatible with life and if they wish to terminate the pregnancy then they have to go to the UK. If the law was otherwise, I would do them [abortions] here personally." But Dr. Flanagan drew the line at what she called "social abortion" but added that "if it's just not convenient at the moment for me to be pregnant so I would like to end it, I'd have difficulties with that. Now that's part of my culture, part of the way I've been brought up, you know, so I think many of my colleagues would feel the same. But clearly women go to the UK because we have that easy out, there's never been any real pressure on the law to change it. It's a very strange mentality but it works for us."

Indeed, fetal abnormalities cases drew the greatest sympathy as doctors condemned the Irish healthcare system simply "dropping" them, expecting women to carry pregnancies to term, or in any case to disappear. These women complete their care in UK hospitals. Women who rely on public health insurance, HSE, are often delayed in traveling to the UK because they lack the funds to get to the front of the queue for the scans they need to pursue further care. Dr. Sean Flood labeled this pattern as "denial." Dr. Flood, who grew up in a Catholic household, has been in practice for over 30 years, and services two clinics in mostly rural areas in the north, argued:

> The reason you have Irish women traveling to the UK for terminations is one word: denial. Denial is the strongest force in the world. You know some people think it's gravity, some people it's love and hate or sex or gambling or compound interest. Believe you me, the strongest force in the world is denial. We, you know as a political system here, the political system is in denial. They don't want to know because, and do you know why they don't want to know? Because they don't have to, because they can export. If it was bubbling here and nobody could go to England and the airports were closed, I mean abortion is here, it's here! It's just not done here, but it's here. It's just not done here. […] The law won't change in the immediate future, you see, there's no pressure, it won't change in the short term because the pressure cooker, there's no pressure cooker effect, the lid is off. People have very easy access to cheap flights to London now, cheap flights to Amsterdam, there is no pressure. England and the UK take care of our dirt.

Medical reproductive laws were originally religious, Dr. Flood argued, because "it was a cultural authority that the Church had," and while this authority is now dwindling, the law is holding. When he decided to offer contraceptives before they were legal to do so, he found it surprising that few repercussions resulted: "There was always opposition from the [local] Church, but when I look back on it, I probably wasn't as challenged as I probably would have been expecting to be because I was fairly open about pill prescribing and IUDs and morning-after pills, emergency contraception." He knew patients supported him, but the priests were critical: "I knew there was rumblings, but I was never actually openly challenged [by the Church]." Dr. Flood was never denied communion, nor was he excommunicated. The low social or economic cost to opposing the Church's authority is significant given the general silence among providers on the current abortion law, which they instead oppose in quiet and individualized ways.

Conclusions

Ireland's abortion law, one of the most severe in Europe, fuels the export of abortion services abroad, but this option is mainly for those who can afford to travel. The ordeal involves anxiety, fear, indignity, secretiveness, and unknown places. A recent Human Rights Watch report (2010) assessing abortion access in Ireland highlights the sense of isolation that Irish women experience when facing a crisis pregnancy. Focusing on the role of physicians in the contested terrain of reproductive health policies, this study reveals the incipient forms of resistance to the current law by some members of the medical community, suggesting a flux in reproductive governance at the individual level. Aside from the few visible confrontations in the past, including the contraceptive train and Dr. Rynne's row over condom prescriptions, the political struggles between the incommensurable medical and religious views are played out in a relative quiet. Women enact individualized contestation in practice through the abortion travel, aided in their clandestine journeys by feminist groups working behind the scenes and providers who support their decisions in their everyday clinical work, but who otherwise employ "semantic subterfuge" in their reluctance to initiate political discourse about the laws. Many would also prefer that Ireland openly confronts the fact that Irish Catholic women get abortions. The view that abortion is outsourced to the UK and elsewhere is understood as a kind of "Irish solution to an Irish problem" which keeps the issue out of sight of the Irish public space. Despite the disapproval of the status quo among many in the medical community, Dr. Flanagan concludes, "It's a very strange mentality but it works for us."

Considering the historical influence and the social and political importance of the Catholic Church, it is perhaps not surprising that semantic subterfuge works in the Irish setting. While the role of the Church in everyday life may be changing and its influence waning, it is clear that Catholic religiosity as a source of spirituality and comfort continues to hold an important place in Irish society, even if religious perspectives and practices are heterogeneous (Wilson and Donnan). Dr. Gallagher theorized the overall reluctance to speak openly in the medical community as an effect of a specific historical habitus: "When you look back and think about it, that we are actually coming from a background which assumes really that abortion is wrong, you know. It can be very difficult to fully escape from that, it's one of those conditioning things.[…] It is probably not something that we're all comfortable discussing, even among

our peers, unless you're very sure that they're going to agree with you." This reluctance also reflects a sense of fatigue of debating the issue, which many providers identified goes back to the fierce but short-lived abortion debates which accompanied the 1992 and 2002 referendums. On the whole, however, it is significant to note that restrictions on abortion in Ireland are not simply reflective of the Catholicism of the country—an assumption that forecloses the nuance and complexity that are involved in recognizing that most Catholics do not necessarily follow all of the Church teachings, and that many hold views that may be simultaneously conflicting. The role of religion in Irish life can perhaps be better understood not as a set of beliefs, but as a set of relationships—an experiential view of religious influence that plays out in everyday interactions which include both open debates and silences (Taylor 4).

Everyday interactions with patients certainly shape some doctors' motivations to discuss abortion policy more openly. However, Irish doctors typically are not confronted by serious maternal health consequences of back-alley procedures because most women find a way to travel abroad (even if clandestine abortions likely exist in Ireland). This seemingly problem-free setting makes it easier for doctors, policymakers, and the public to stay silent. In addition, there also appears to be a lack of legitimate language in favor of abortion rights that makes it difficult to frame the issue symbolically and effectually to garner sympathy. Careful distinctions between "legitimate" abortions and those "on demand" perhaps illustrate the dilemmas of the Catholic habitus and rhetorical hegemony wherein oppositional speech is possible, but only so far.

The low level of public debate around reproductive legislation is further complicated by policymakers who, like doctors, generally stay away from the topic and continue to portray Ireland as a fundamentally Catholic nation. Given the Church's historical importance and authority, the recent criticism waged by Prime Minister Enda Kenny against the Vatican in July 2011 for concealment of sex abuse by 19 priests in Cork was unprecedented (McDonald). The Vatican responded by recalling the papal nuncio from Dublin. However, the growing presence of the EU in extra-economic realms of health, human rights, and social policy will likely fuel continued confrontations with religious paradigms in medicine in Ireland and other EU states. The directions that emerge from these confrontations in light of EU's expanding reach will be important for anthropological and feminist scholars to observe, especially as they play out in the emerging debates regarding the meanings of EU citizenship in the domains of women's and health rights in Ireland and in other member states.

PART III

The Social and Discursive Spaces of Abortion

CHAPTER 13

The Landscape of Unwanted Pregnancy and Abortion in Highland Bolivia, 1982–2010

Natalie L. Kimball

At the time, my youngest daughter was a year and seven months old and she was sick with diarrhea. I went to the doctor and he told me, "You are pregnant." I thought, "What am I going to do, my other child is so small still!" My husband said, "Women can't go around like that [with two small children]—they can just get rid of it. Carry this cement." So, I carried the bag of cement all the way from the marketplace to the house. And I felt a big pulling and a kind of bursting, and I fainted…My daughters got me into bed. I bled for three days until a doctor, a naturopath, came to see me and gave me an injection. "You aborted," he said.

—"Doña Celestina," an Aymara indigenous woman living in El Alto, speaking of an experience from 1989[1]

[1] The names of interviewees cited here are pseudonyms. All interviews were conducted by the author in the cities of La Paz and El Alto between 2009 and 2010 and recorded digitally. The research for this project was reviewed and approved by the Institutional Review Board of the University of Pittsburgh. All translations of Spanish-language material were completed by the author.

N.L. Kimball (✉)
Department of History, College of Staten Island, City University of New York, New York, NY, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_13

This chapter traces a broad history of policies on and services in reproductive health care alongside women's personal experiences with unwanted pregnancy and abortion in La Paz and El Alto, Bolivia, between 1982 and 2010. I argue that women persisted in procuring abortion despite the obstacles presented by its illegal status. In so doing, they spurred changes in reproductive health policy and provisioning that altered the landscape of abortion care in Bolivia, making the procedure safer and more available even while restrictive government policies maintained abortion's illegal status. The chapter further highlights the wide range of women's reasons for terminating pregnancies and their feelings toward these events. These testimonies suggest that fear, shame, and guilt surrounded many women's experiences with pregnancy termination, due in part to a deep-seated social stigma against abortion, but also to personal factors, such as women's relationships with family members, friends, and partners. For many, abortion's illegal status intensified the emotional difficulty of the abortion experience, since the fear of legal repercussions colored the ways in which abortion providers approached their patients and the medical appointment of pregnancy termination itself.

Most historical scholarship on abortion in Bolivia consists of demographic and policy reports that offer little historical perspective on abortion and fail to highlight women's personal experiences with the phenomenon. Recentering the discussion of abortion on women and their experiences raises new questions about the significance of pregnancy termination for women and for society more broadly. As of the late 1990s, it was estimated that 3 out of 5 women would have at least one abortion in their lifetime (Zulawski 2007). Since these procedures are illegal—and thus often performed in unregulated and often unsafe conditions—these abortions are often dangerous. Estimates over the last few decades of the twentieth century found that 27–43% of maternal deaths in the country resulted from complications following abortion (Alanes 1995; Ministerio de Salud y Deportes 2006). Yet abortion in Bolivia is, as more than one of my interviewees noted, "*un secreto a voces*," an open secret—ubiquitous, but rarely acknowledged publicly. What effect does it have on a society when more than half of the women in the country will undergo a procedure that they feel they must keep secret, and for which they are often morally condemned? How is society affected when women often suffer complications from one of the most commonly performed and consistently demanded surgical procedures, simply because it is illegal, and thus, unregulated? In listening to Bolivian women's stories about abortion—such as that of

Celestina, quoted above—we can learn from the ground up the impacts of abortion's illegal and stigmatized status on women, doctors, and society at large. These lessons can, in turn, bolster the struggle to ensure women's reproductive autonomy in the Andes and around the world.

This chapter draws on interviews and on local and international studies and policy reports to illuminate changes in abortion care and in reproductive health policy during the period. Excerpts from the testimonies of 12 women who terminated pregnancies from the early 1980s to 2007 offer a unique personal account of abortion in Andean Bolivia. In my discussion of abortion experiences, I make a particular effort to emphasize women's voices, often quoting interviewee testimonies at length. My concern with including women's personal testimonies of abortion engages with debates in the fields of subaltern studies, oral history, and Latin American *testimonio* that recognize individuals who have experienced a given phenomenon as the most suitable individuals from whom we can learn about it. The process of giving testimony and the testimonios that result have the potential to be deeply transformative, not only for the women who share them, but for society more broadly. These stories speak truth to power and possess the capacity to effect personal, social, and legislative change around reproduction and abortion in highland Bolivia (Beverley 2004; Abu-Lughod 1993; Guha 1996; Gluck and Patai 1991; James 2000; Portelli 1991; Sanford 2003).

Bringing a historical perspective on abortion in Bolivia allows us to see connections between women's experiences with the procedure and the evolution of government policies and programs in the country. While on the one hand, these experiences helped draw public attention to abortion's role in maternal mortality, they also contributed to shaping public policy on the treatment of incomplete abortions. In the wake of free-market austerity measures instituted after 1985, and the closure of the country's largest state-owned mines the same year, rising poverty rates led many women to need to limit the size of their families. Since access to contraception continued to be restricted, women turned to induced abortion. Women's persistence in seeking out abortion despite its illegal status—alongside the concomitant rise in medical complications and maternal death due to the procedure—contributed to a growing public awareness of illegal abortions. This awareness culminated in the formation of public forums on abortion and the establishment of key policies for the treatment of pregnancy loss beginning in the mid- to late 1990s (Kimball 2013). Thus, women's experiences with abortion in Bolivia, far from constituting

private matters, had significant impacts on the development of national reproductive health policy in the country. Understanding the dynamic relationship between women's personal experiences with reproduction and state policy on these phenomena can broaden our understanding of the factors shaping the evolution of national political and social processes.

The Changing Landscape of Abortion Provisioning in Andean Bolivia

While exact rates of abortion in Bolivia in the twentieth century are notoriously difficult to determine, it is clear that the procedure has been available in the country since the mid-1950s, if not a great deal earlier (Benitez Reyes 2000; Bury et al. 2012; Kushner López et al. 1986; Paxman et al. 1993; Remez 1995). "Doña Magda," a Quechua-speaking woman I interviewed in 2010, reported that a high school classmate succeeded in procuring an abortion in the city of Potosí in the mid-1950s. Providers of illegal abortions in La Paz prior to the 1980s (and in El Alto likely beginning in the mid-1980s) were diverse in scope, and included medical doctors working in public and private spheres, Western-trained health care workers like nurses and medical students, and midwives and herbalists. Some women, rather than visiting providers, resorted to a diverse range of strategies to terminate their pregnancies on their own, including throwing themselves down stairs or lifting heavy items. Women also purchased and ingested herbal abortifacients without seeking the expertise of providers like midwives and herbalists. Often, women attempted to induce abortion by themselves unsuccessfully before seeking out a provider to perform the procedure.

Prior to the mid- to late 1990s, abortion providers in Andean Bolivia terminated pregnancies by employing one or more of the following methods: introducing an object into the cervix or a liquid through the cervix into the uterus (which the body would then—it was hoped—expel, along with the pregnancy); dilating the cervix and removing the contents of the uterus (a procedure known as dilation and curettage, or "D and C"); and administering a herbal abortifacient, or, after it became available in the late 1980s or early 1990s, giving an injection of methotrexate (Paxman et al. 1993). Providers with Western medical training were probably more likely than those without to perform dilation and curettage procedures; however, dilation and curettage and placing an object or liquid into the cervix

were likely the two most commonly used abortion methods by all types of providers until the mid-1980s, if not longer (Kushner López et al. 1986).[2]

Women who attempted to abort on their own prior to the mid-1990s (and to a certain extent, still today) ingested herbal abortifacients, carried heavy items, inserted objects into their vaginas, or attempted to cause physical trauma to their own abdomens either by themselves or with the assistance of their partners (Gisbert and Quitón Prado 1992). Sometimes these methods were successful in provoking abortion. Other times, they were not, and women tried still other methods or sought out providers to perform the procedure surgically or by administrating medications. After discussing her unwanted pregnancy with her husband, Celestina, quoted above, carried a heavy load of cement several blocks to induce an abortion in 1989. Although it took three days of painful bleeding and cramping in order to miscarry, ultimately, Celestina passed the pregnancy. "Doña Lupe," who faced an unwanted pregnancy in the early 1980s, first ingested herbs in an attempt to provoke an abortion, and when that did not work, eventually located a provider to perform a dilation and curettage procedure. "Señorita Vania" succeeded in terminating her unplanned pregnancy by ingesting a tea made from a variety of herbs that she and her partner purchased from a vendor in a public marketplace.

The abortion methods described above vary in efficacy according to the gestational age of the pregnancy and other factors; they also carry varying degrees of risk. While some methods, when used correctly, can be relatively safe, others can be quite dangerous, causing uterine perforation, infection, poisoning, and, in some instances, death—particularly when performed in sub-standard conditions or by an individual lacking the necessary midwifery- or Western-derived training. In particular, surgical procedures, which involve the insertion of objects into the cervix and uterus, and remain the most commonly performed abortion procedures in Bolivia, carry significant risk of infection and uterine perforation (Bury et al. 2012). The risk of sepsis, a life-threatening infection, is greater with insertion-based abortions than those induced by medications because these procedures dilate the cervix, opening a pathway to the body through which bacteria may more easily travel (Bailey et al. 1988; Kushner López et al. 1986). Furthermore, most abortions that were performed by providers prior to the last decade and a half, regardless of method, probably took place in facilities ill equipped to handle surgical procedures. Instead,

[2] Interviews and medical record data also support these assertions.

abortions took place in medical offices, called *consultorios* (rather than in clinics), or in private homes—that of the patient, the woman's partner or friend, or the person performing the abortion. "Doña Adela's" 1998 surgical abortion, for instance, took place on a hotel room bed, putting her at serious risk of infection. In fewer instances, abortions were performed in hospitals and clinics equipped to handle surgical procedures.[3]

The outline of abortion provisioning in La Paz and El Alto described above remained relatively stable between the early 1950s and the mid-1990s, and to a certain extent, continues to exist today. Beginning in the last few years of the twentieth century, however, a number of factors began to alter the face of abortion provisioning in La Paz and El Alto, making the procedure a great deal safer, more affordable, and more accessible. One of the first such factors was the introduction of the innovative manual vacuum aspiration method of pregnancy termination to Bolivia (known as *aspiración manual endouterina*, or AMEU, in Spanish). The method, which is performed with an inexpensive and reusable plastic device (which is also referred to as the AMEU), reduces the risk of uterine perforation associated with other surgical abortions, since it terminates pregnancy through aspiration, rather than the more invasive curettage method. It may also be used to treat incomplete miscarriage, in addition to inducing abortion. The AMEU method was originally introduced to Bolivia when a group of medical doctors traveled abroad to learn the technique and later brought the device back. (The device was developed by Ipas, a reproductive health and rights organization based in the USA.) These providers, some of whom were already providing abortions in Bolivia, were compelled to seek training in the AMEU method due to the frequent cases of abortion-related medical complications and deaths they encountered in Bolivian hospitals. One doctor explained that "one time a patient arrived from the Yungas, a young girl about 16 years old [and] despite the hysterectomy that we performed [after her complicated abortion], despite all of our interventions, she still died." It was this experience that led the physician to seek out training abroad in the AMEU method. Thus, women's demand for abortion, which often resulted in complications, spurred sympathetic medical personnel to seek safer technologies with which to perform the procedure.

[3] In their 2000 study of 20 middle-class Bolivian women who had abortions in unknown years, 12 had their abortions in medical offices and 8 in clinics equipped for surgical procedures. Aliaga Bruch et al., *Veinte historias, un mismo tema*, 54. See also interview data.

According to medical personnel, the introduction of the AMEU has greatly improved the ease, efficacy, and safety of both abortion care and the treatment of incomplete miscarriages in Bolivia. One physician who works at a public hospital in El Alto explained that the "resolution [of cases of incomplete abortion] is simpler [and] less costly…and not only specialists can perform the procedure, but also family practice doctors. Even nurses could be trained to do it." Just a few years after the introduction of the AMEU to Bolivia, the country's Ministry of Health, in partnership with the US-based manufacturer of the AMEU device Ipas, introduced two policies that further improved the landscape of abortion care. With its "Program for the Treatment of Hemorrhages in the First Half of Pregnancy" launched in 1999, the Ministry of Health began to train medical personnel at public health facilities in the country to use the AMEU to resolve cases of incomplete miscarriage and abortion. The program also included sensitivity training designed to end the mistreatment of women coming to hospitals with complications that might have resulted from an induced abortion (Del Pozo and Alanes Bravo 2007; Ministerio de Salud y Deportes 2004). "Alessandra Muñecas," a doctor who sought training in the AMEU method, recalled, "We did the first workshop to introduce the AMEU in La Paz in 1999 [and] post-abortion care has improved remarkably since that time." The aim of the program was to reduce maternal mortality due to abortion and other types of pregnancy loss by two means: first, by promoting the AMEU method, and second, by increasing women's willingness to seek out medical care (by eliminating discrimination against women with induced abortion). "Daisy Serrato," a medical doctor who performed abortions in La Paz in 2009, remarked, "There was a lot of mistreatment of women with incomplete abortion, many clients would go to hospitals and say to themselves, 'Darn! They treated me so poorly, I don't want to go back ever again.'"

In addition to the hemorrhage treatment program, a second government policy instituted the same year may have further empowered women to seek care after their abortions. In late 1999, the Bolivian government expanded the universal health insurance, the *Seguro Básico de Salud* (Basic Health Insurance), to include the treatment of complications related to pregnancy loss, making the AMEU procedure free of charge to all women. Two years later, with the *Seguro Universal Materno Infantil* (Universal Maternal-Child Health Insurance), insurance was expanded even further to include not only the AMEU procedure but medical attention for "all conditions related to pregnancy and childbirth and care for the child up

to age five" (Ministerio de Salud y Deportes 2004: 11–12). "Before the insurance programs," recalled one doctor, "if a patient arrived with vaginal bleeding, she had to pay between 400 and 500 *Bolivianos*,"—about US$60 to US$70 in 2009—"in addition to paying for any medications." Another doctor who completed his residency at a public women's hospital in La Paz concurred, saying, "Treatment for women in these situations was far from free—not the least because, to do a dilation and curettage procedure, a patient had to be hospitalized for more than one day." Medical records from public hospitals in the region demonstrate that, after the introduction of the AMEU method, the length of a woman's hospital stay was shortened from two or more days, to just hours.[4] While in theory, the hemorrhage treatment and insurance programs were designed to improve care for women suffering spontaneous miscarriage, in practice, the policies guaranteed care for any woman experiencing symptoms of a pregnancy loss—including those who might have induced their own abortions.

Concurrent with the introduction of the AMEU method and related policy developments, the 1990s also saw the growing utilization of a new medication to provoke abortion, called misoprostol (or Cytotec, for the name of its manufacturer). Although its earliest use in pregnancy termination in Bolivia probably dates from the mid-1990s, misoprostol—which can be used to treat ulcers, in addition to other ailments—may have been available in the country a great deal earlier. One doctor who works at a public hospital in El Alto remarked, "Before the 1990s misoprostol was already being used in Brazil to terminate pregnancies, but people didn't start using it here until later—and it's totally changed the epidemiology of abortion."[5] Although the first studies worldwide on the use of misoprostol to induce abortion date from the early 1980s, medical abortion was not approved until 1988 in France and 2000 in the USA. In these countries, misoprostol—a prostaglandin that functions by inducing contractions of the uterine muscles—is used in combination with mifepristone, a more expensive medication that stops the growth of a pregnancy and detaches it from the uterine wall. Although in countries where abortion is legal the regimen is only approved for use early in a pregnancy (up to about nine

[4] This assertion is supported by medical record data for the 1990s–2008 at the Hospital de la Mujer in La Paz and for 2005–2007 at the Hospital Municipal Boliviano-Holandés in El Alto.

[5] The first reports of misoprostol's use in pregnancy termination in Latin America originated in Brazil in 1986. Ipas, *Misoprostol and Medical Abortion in Latin America and the Caribbean*, 3.

weeks), in Bolivia and elsewhere in Latin America, women often ingest misoprostol alone, without mifepristone, and many take it throughout pregnancy, even at more advanced gestational age (Bury et al. 2012; Ipas 2010).

Recent estimates suggest that the developments in abortion care in La Paz and El Alto since the early 1990s—including the introduction of the AMEU and related government programs and the use of misoprostol—have had significant impacts for women. Most notably, the past 15 years have seen a significant reduction in medical complications and death due to abortion and other types of pregnancy loss. While in 1994, Bolivia's maternal mortality rate was 390 maternal deaths per 100,000 live births, 37% of which were due to pregnancy loss, in 2008, this number had decreased to 310 per 100,000 live births. One official of Bolivia's Ministry of Health estimated that, after the introduction of the AMEU method, maternal deaths due to pregnancy loss decreased by 10% (Del Pozo and Alanes Bravo 2007; ENDSA 2008). A medical doctor who operates a private practice in La Paz concurred, saying that she "very rarely" sees women with severe complications following induced abortion: "After ten years [of not seeing a death due to botched abortion], I saw a woman who died last year after she had one in a rural area, but now it is rare that women die." Another doctor of a public hospital in El Alto observed, "Since the mid-1990s, the pathology of abortion has changed, because before, patients arrived in very grave condition to the hospital—with terrible bleeding, anemia, shock, infections of all kinds. But now, abortion methods have changed…and we don't see the same kinds of complications."

The changes that have taken place in abortion care in Bolivia since the early 1980s were spurred by a number of interconnected phenomena at the local, national, and international levels. On the one hand, concern with the public health impact of unsafe abortion increased both domestically and internationally beginning in the 1970s and 1980s. A decade later, two key UN conferences—the International Conference on Population and Development (Cairo 1994) and the Fourth World Conference on Women (Beijing 1995)—highlighted the growth of international attention to unsafe abortions. This international attention further coalesced around increasing political mobilization following Bolivia's 1982 democratic opening, unleashing waves of activism on the part of women's groups and creating the willingness on the part of activist doctors and lawmakers to improve abortion care in specific (and sometimes illegal) ways. On the other hand, the drive to improve abortion care also arose from intensely

personal experiences, particularly women's demand for illegal abortion. Evidence suggests that, while women's need to limit their pregnancies has always been present, their demand for abortion likely increased in the mid-1980s in the wake of neoliberal austerity measures that added urgency to women's need to limit family size (Kimball 2013). This increased demand ultimately pushed policymakers and sympathetic medical professionals to adopt new strategies for providing, and dealing with the consequences of, illegal abortions.

Unwanted Pregnancy, Abortion, and Reproductive Decision-Making in the Andes

Personal testimonies offer rich insight into women's experiences with abortion and unexplained miscarriage. While conducting research for this project in 2009 and 2010, I interviewed 55 women about their experiences with pregnancy, 12 of whom shared with me their abortion experiences. Many of these women had not spoken about these experiences in several years, and most had only shared their abortion stories with a partner or a close friend. For many women, these were difficult conversations. Most of the women who shared with me their testimonies terminated their pregnancies between the early 1980s and the late 1990s, so much of the discussion that follows focuses on these years.

The women whose testimonies appear here navigated complex, often conflicting, emotions as they decided how to confront their unwanted pregnancies. In the pages that follow, I explore the complicated territory of emotions and reproductive decision-making that underlies the experience of abortion. In it, I argue that, while many women articulated reasons for terminating their pregnancies, few felt that they unequivocally "chose" to do so. Instead, facing difficult circumstances, women's choices to seek abortion were significantly constrained—even at times nonexistent. In addition, while abortion's illegal status did not deter women from seeking the procedure, it did likely add to the stress of the experience. Finally, widespread societal condemnation of abortion, coupled with women's spiritual beliefs, sometimes led women to feel guilt, shame, or ambivalence following their procedures.

The most common reasons that women cited for terminating their pregnancies during these years included household economic problems and difficulties in their relationships with male partners, often in combination with a desire to limit or to space their pregnancies. Three of the 12 women

I interviewed had not yet had children when they had their abortions, and half of the women already had two or more children. Women also terminated pregnancies in response to, or in fear of, negative reactions to their pregnancies on the part of partners or family members. Women often cited multiple reasons for seeking abortion.

"Doña Pilar" and "Doña Marcela" both terminated two pregnancies over the course of their reproductive lives due to economic concerns and due to problems in their marital relationships. Although they did not specifically intend to do so, Pilar and Marcela ultimately utilized abortion to space their pregnancies; both women had additional children after at least one of their abortions. Pilar, who described her ethnicity as *Castellana* (Castilian or Spanish), was married and only about 19 years old in 1995 when she became pregnant with what would have been her third child. At that time, she and her partner decided together to terminate the pregnancy, since their income from working as small-scale merchants was already stretched thin. In the intervening years, Pilar and her partner had two more children. When she became pregnant a fifth time at the age of 28, Pilar again terminated the pregnancy, but this time she sought the abortion because her partner had become involved with another woman and she feared she could not support another child on her own. Pilar also complained that her partner blamed her for becoming pregnant and believed that she had done so intentionally in order to "trap" him in the relationship.

Marcela, a married *mestiza* woman (of "mixed" indigenous and European heritage) who in 2009 worked as a medical assistant, sought abortions after her second and third children at approximately 26 and 30 years of age. While at first Marcela said that financial concerns and her partner's rejection of her pregnancies led her to seek abortion, later, she added that her partner's excessive sexual appetite—and implicitly, abuse—occasioned the unwanted pregnancies and obligated her to terminate them:

> I became pregnant and I had to recur to abortion because economically, we were not doing well…My husband has always rejected my pregnancies. I mean, I've suffered a lot—actually, economically, we were doing okay, but my husband was very into sex…I've never told this to anyone…but my husband thought only of his own satisfaction, he didn't think about me. So, I got pregnant two times, and both times I had to abort it because I couldn't have it. I argued with my husband, he said to me, "Then, why'd you get pregnant?" I responded, "I didn't ask you [for sex], you looked for me, I

> mean, you use me"…I think many women experience this in Bolivia because men use you sexually…There's a lot of *machismo*, for that reason, yes, I've aborted two times…At the moment that I found out I was pregnant, I did think about it—Should I have it? Should I not have it? But my husband also said to me, "What are we going to do? Another mouth to feed!" So, it was him that—well, all in all, we both decided.

While she draws parallels between her own difficult sexual experiences and those of other women in Bolivia's *machista* or sexist society, Marcela also struggles with how to best explain her decision to terminate her pregnancies. Although she alternately asserts that she "had to" have the abortions due to economic constraints and also suggests that it was her husband's idea to seek abortion, she ultimately states that she and her husband decided together to terminate the pregnancies.

As Marcela's comments perhaps suggest, intra-relationship coercion and violence in Bolivia are distressingly common. According to a 2003 national demographic survey, 68% of women in the country have suffered some form of physical, emotional, or sexual violence within a romantic relationship (ENDSA 2003). Sexual violence often results in pregnancy—6 of 55 women in my interview sample became pregnant at least once as a result of acts of intercourse that they described as forced, coerced, or otherwise nonconsensual. Many women who suffer sexual assault in Bolivia, as elsewhere, do not report the violence to authorities—and for understandable reasons. Women may fear that police will interrogate their sexual histories or deny their accusations of rape, or, if their attacker is a relative, may be hesitant to upset the dynamics of their families. Although the law ostensibly provides women access to legal abortion when they have become pregnant as a result of sexual assault, the inefficacy of the legal system and survivors' hesitancy to report the crime mean that most women who terminate pregnancies following rape seek the procedure from unregulated providers (Kimball 2013). Thus, "Andrea Cima," an ombudsperson who worked with adolescent survivors of rape and other abuse in El Alto in 2010, believed that many of her clients who became pregnant as a result of rape sought abortion on their own, rather than through the state.

Although many interviewees could provide reasons or motivating factors that led them to terminate their pregnancies, few women stated unequivocally that they "decided" or "chose" to do so. Women interviewees utilized a number of expressions to describe their abortion experiences, reflecting a range of attitudes toward how they came to seek

abortion. While some women stated that they "decided" to have abortions—either on their own or together with their partners—other women said that they "had to" have abortions, or were "obligated," "compelled," or "forced" to do so. Several women used both sets of expressions to describe their experiences, remarking at one point during the interview that they had decided to terminate their pregnancies and at another point that they had been compelled or obligated to do so. Finally, some women were pressured by their partners to terminate their pregnancies, while two of my interviewees were unambiguously forced to have abortions—one by her mother and another by her husband.

"Doña Noel," who had three abortions between about 1987 and 2000, alternately explained that she terminated her pregnancies because her partner "convinced" and "obligated" her to do so, but also because she had planned to have only two children and was concerned with her family's poor economic situation. Noel, now 51 years old and of mixed Quechua and Aymara descent, remarks:

N: I was not in a good situation to have my child…My partner did not earn enough to have another baby…and I only planned to have two children, no more, so because of this I interrupted the three pregnancies…

NK: And at that time, did you speak with your partner about the abortions?

N: I did want to have the children, it was him that didn't want to. Buuut he also convinced me. And the truth is I saw my situation—that we barely had enough to eat. He said to me, "Look, the situation is critical—where are we going to get money?…What are we going to do?"…I was surprised and I said, "How are you going to do this [have an abortion] if God is sending us another child?" But he obligated me and he said, "No, no, we can't have it because where are we going to get money to pay for food?" I mean, he convinced me, you know. And I also thought about it and said yes…But I have a lot of guilt and I always ask God for forgiveness for all of things I have done wrong, because I'm a Catholic and God says, "Do not kill—it isn't your decision." I already said that it wasn't ever my decision. But it was the situation that led us to do these bad things.

Torn by the desire to provide her existing children with a better life and her objections to abortion on religious grounds, the path that led Noel

to terminate her pregnancies was clearly fraught. While in part Noel says her partner obligated her to seek abortion and that the decision to abort was not her own, she also expresses a sense of responsibility for terminating her pregnancies. In part, Noel's conflicted attitude about her abortions relates to the condition of her youngest child. Born in 2001, when Noel was 43 years old (after her third abortion), Noel's son "Marco" has trisomy 21, commonly known as Down syndrome. Despite the fact that the risk of Down syndrome may increase in children born to older mothers like Noel, she often wonders if "God brought [her] a child with [the] syndrome" because she had abortions earlier in life.

Tragically, two women I interviewed were unambiguously forced to terminate their pregnancies, one of whose stories appears below. "Doña Leticia" was approximately 22 years old when her partner took her to get an abortion at a clinic in the Garita neighborhood of La Paz. At the time of the abortion in about 1996, Leticia, an urban Aymara woman from El Alto, had a two-year-old child and did not realize that she had become pregnant a second time—although her partner evidently did. Throughout her testimony, Leticia refers to her abortion as a "cleaning" (or *limpieza*), a term commonly used in the Andes to indicate abortion.

> I was pregnant and I didn't know it, and one day my husband said to me, "Let's go buy vegetables…." So I left my son who…then must have been two years old and I went innocently to buy vegetables. This is why sometimes it's not good to be a person that doesn't know things…I say this because, since I didn't know things, my husband took me, he told me, "I called a doctor and I told him to do a cleaning for you." I didn't know what "cleaning" he referred to…We entered a house and the doctor says, "How many children do you have?" "Just one," I said. "Ah, and your baby is very young?" "Yes," I said… "Ok, get up on the table…Don't worry, we're going to give you an injection…" And I don't remember anything else… Like I told you, I didn't use to go out anywhere, I was an innocent person. Many girls fall into this position. Before, I was scared to talk, but now I communicate more easily with people, even with doctors, asking, "What's this? What's that?" One time I read about abortion and then I realized that they did an abortion on me, a *cleaning*… Now, I am 34. Since I have my [beauty] salon, there are girls that come to talk to me and I, having had this experience, advise them, "Look: Always ask. You have to be informed. You should ask doctors, 'What's this for? What are you going to do to me?'… You have to say this to them, never be silent," I tell them, because I have had this experience, I have lived it.

Leticia's experience undergoing an abortion to which she did not consent convinced her of the importance of asking questions when visiting medical providers. While she was deeply troubled by her experience of being forced unknowingly to get an abortion, Leticia's comments also reveal the ways in which women share information with and encourage one another to defend their own interests in day-to-day life.

Conclusion

Reflecting back on their abortions anywhere from 3 to 30 years earlier, the women I interviewed had a variety of feelings about these experiences. Some felt relief, while others were troubled by guilt and religious concerns. Most women fell somewhere in between, feeling both sadness, as they wondered how their child might have turned out, and also the desire to "*salir adelante*," or move on. About three-quarters of interviewees who had abortions disagreed with abortion in principle, and yet most also felt that in specific situations—such as prior to the last 10–15 years, when birth control was largely unavailable, or in dire economic circumstances—abortion represented the most feasible alternative.

Interestingly, not one interviewee who terminated a pregnancy during these years took into account the procedure's illegal status when making her decision to seek abortion, nor did those women who felt guilt following their abortions attribute these feelings to having broken the law. Instead, social factors—particularly the stigmatization of abortion and of particular "types" of pregnancy and motherhood—shaped women's experiences with pregnancy termination. On the one hand, the social and religious stigmas attached to abortion—stigmas shaped both by abortion's illegality and by the strength of the Catholic Church and other religious denominations in the country—contributed to the stress and pain of women's experiences with the procedure. Women who terminated pregnancies worried that they had committed an unethical act, or that others would judge them for seeking abortion. At the same time, societal stigmas attached to particular "types" of pregnancies—such as those that occur when a woman is single or "too" young—often led women to seek abortion in the first place. Thus, negative social attitudes in Bolivia surrounding abortion and pregnancies that occur in particular circumstances sometimes meant that both abortion and its alternative represented difficult options that were laden with conflict.

While some women facing unwanted pregnancy in Bolivia articulated their desires to continue or to terminate their pregnancies in terms of "choice," most did not. Many women I interviewed in Bolivia who continued unwanted pregnancies felt that they had no other option but to do so—as did many women who sought abortion. In addition, whether a woman continued or terminated a pregnancy often had little to do with her personal stand on abortion. Conditioned by a range of personal circumstances and by broader, societal conceptions of motherhood, women's experiences with unwanted pregnancy suggest the need for a new analytical framework that pushes beyond either medical considerations or a politicized language of choice. Women's feelings about abortion in Bolivia may lend credence to scholarship on abortion elsewhere in the world that contends that the pro-choice and pro-life dichotomy may be of limited relevance to the reproductive experiences of women of color, in particular (Smith 2005). It is my hope that understanding the constraints shaping women's reproductive experiences may infuse both scholarship and policy debates on these themes with greater depth—and perhaps, with greater urgency.

CHAPTER 14

Settler Colonialism, Native American Motherhood, and the Politics of Terminating Pregnancies

Brianna Theobald

In 2006, reproductive, colonial, and tribal politics collided on the Pine Ridge Reservation in South Dakota, United States. When Governor Mike Rounds signed a law banning abortions in all cases except those that directly threatened the mother's life, Oglala Sioux President Cecelia Fire Thunder announced her plan to open an abortion clinic on tribal land. Fire Thunder's proposal provoked immediate criticism, and the controversy culminated in Tribal Council members voting nine to five in favor of her impeachment. The standoff between Fire Thunder and her opponents provoked a heated debate regarding colonialism and sovereignty. When Fire Thunder advocated her plan to Lakota audiences, she invoked the politics of power and race by rhetorically imploring the absent members of the state legislature to "[k]eep your white hands off my brown body!" In turn, Fire Thunder's opponents accused her of acting as "a scout for the cavalry" and displayed bumper stickers that read "National Security Must

B. Theobald (✉)
American Indian Studies, University of Illinois at Urbana—Champaign, Urbana, IL, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_14

Begin in the Womb."[1] Fire Thunder claimed she had the legal right to circumvent the recently passed state law because the state "has absolutely no jurisdiction" within reservation boundaries (Giago 2006). Her opponents countered that Fire Thunder "invited federal and state law onto our sovereign reservation by challenging the new abortion law…under the auspices of the Oglala Sioux Tribe" (Wagoner 2007: 3). Such debates were not restricted by reservation borders, as the events at Pine Ridge sparked commentary from men and women throughout Indian Country.

Scholars have persuasively argued that the "pro-life versus pro-choice paradigm" is an inadequate model for understanding reproductive politics among communities of color and in impoverished communities, as it simplifies and distorts the experiences of women in these groups and the contexts in which they live (Smith 2005a; Solinger 2001; Nelson 2003; Silliman et al. 2004). These scholars, as well as many reproductive activists, contend that reproductive politics cannot be disentangled from the structures of white supremacy and capitalism. For Indigenous women, the politics of abortion have further been shaped by an (ongoing) history of settler colonialism in the United States that resulted in Indigenous communities' unique relationship to the State. First Nations Studies scholar Glen Coulthard defines a settler-colonial relationship as "one characterized by a particular form of *domination*…where power…has been structured into a relatively secure or sedimented set of hierarchal social relations that continue to facilitate the *dispossession* of Indigenous peoples of their lands and self-determining authority" (2014: 6–7; see also Wolfe 2006). This chapter explores the relationship between settler colonialism and reproductive politics by providing a brief overview of government discourse, policies, and practices regarding abortion at two different historical "moments": the turn of the twentieth century, when policymakers and social reformers promoted the rapid assimilation of Native peoples, and the decades following World War II, when Native activists organized what became a national movement for self-determination. I argue that abortion and reproductive politics more generally can best be understood in the context of what sociologist Barbara Gurr calls the settler State's "double discourse of control and neglect" with regard to Indigenous women's bodies and Indigenous health (Gurr 2015).

[1] Quotes are taken from a documentary that aired on PBS's Independent Lens. Marion Lipschutz and Rose Rosenblatt, *Young Lakota* (Lincoln, NE: Independent Lens, 2013).

Abortion at the Turn of the Twentieth Century

In the last decades of the nineteenth century, the federal government's solution to the "Indian problem" shifted from violent conquest to cultural assimilation, a transition that scholars have emphasized was gradual and at any rate did not represent a radical break with regard to desired outcome (Jacobs 2009). As Indigenous Nations were confined to ever-shrinking reservations, a generation of settler policymakers and social reformers optimistically predicted that with the government's help, Native Americans could be transformed into American citizens. The goal of the Office of Indian Affairs (OIA), by this point located within the Department of the Interior rather than the Department of War, was to lead Native Americans along the path from barbarism to civilization through the work of government and church employees at the reservation level. The government hired white men to teach Indigenous men Western-style agriculture; white women, known as field matrons, visited Native American homes to inculcate Indigenous women in the "arts of white settler domesticity"; and underfunded government physicians simultaneously worked to address diseases of poverty while undermining Indigenous beliefs about health, healing, and spirituality (see Hoxie 1984; Emmerich 1987; Trennert 1998). At boarding schools on and off reservations, teachers and superintendents imparted a curriculum of Western lifeways, basic academic instruction, and vocational training, and pressured Indigenous children to reject their cultural upbringing (see Adams 1995; Lomawaima 1994). On reservations and in schools, authorities surveilled Native women's bodies and disciplined their sexuality.

The transition to reservation life, which for some Indigenous Nations involved military occupation, had devastating consequences (see Madley 2015: 119). The disappearance of the buffalo, for example, forced Indigenous societies on the Plains increasingly to rely on inadequate and unreliable government rations. Malnutrition, combined with a forced sedentary lifestyle, created the conditions for the rapid spread of disease, and tuberculosis ravaged reservations by the turn of the century. An alarming demographic decline characterized the early reservation years for many tribes, some of which had already weathered cycles of epidemics and loss prior to forced settlement on reservations. For instance, the Crow Nation in southern Montana lost nearly one-third of its population in the 1890s, and youth proved to be the most susceptible (Hoxie 1995).

Late-nineteenth-century disruptions, dislocations, and hardship shaped reproductive patterns and influenced women's reproductive decisions. Women in many Indigenous societies had knowledge of pre- and post-coital contraceptive methods that allowed them to limit fertility in circumstances in which a pregnancy or child would have posed a burden to the woman and/or her family (see Moerman 1998; Koblitz 2014). Such methods often entailed ingestion of a plant-based abortifacient. Women who ingested abortifacients may not have viewed themselves as terminating a pregnancy per se; rather, they were taking care of their health by making their menses come (Asetoyer 2005). In some cases, the dislocation, food insecurity, and morbidity and mortality of early reservation life made women wary of bringing a child into such conditions. Reflecting on the violence that accompanied the encroachment of white settlers and soldiers in the nineteenth century, as well as her people's well-being more generally, Paiute activist Sarah Winnemucca observed in 1883, "My people have been so unhappy for a long time they wish now to disincrease, instead of multiply" (quoted in Deer 2015).

Government employees who commented on the practice of abortion on turn-of-the-century reservations rarely acknowledged any link between women's reproductive practices and reservation conditions. Rather, these Euro-American observers used abortion—as documented practice or as rumor or innuendo—to stigmatize Indigenous women and to divert blame from violent federal policies and practices. By the late nineteenth century, reproductive practices had been incorporated into the evolutionary discourse of "civilization" versus "barbarism." In support of their ultimately successful campaign to criminalize abortion in these decades, American physicians conflated abortion and infanticide and pointed to the high rates of these practices among "several savage people of North America" (quoted in Beisel and Kay 2004: 507; see also Reagan 1997). Anti-abortionists' message was simple: savage women aborted their children, and civilized women did not. The reality was more complicated, as many anti-abortionists feared that nonwhite women were in fact having too many children and middle-class white (Anglo-Saxon) women were having too few. By associating abortion with savagery, Euro-American physicians—predominantly men—pressured Euro-American women against terminating pregnancies.

Abortion as a marker of a woman's—and a society's—distance from civilization dovetailed with the federal government's assimilation agenda. Policymakers and social reformers justified colonial intervention in large

part by emphasizing Indigenous groups' urgent need of "moral uplift." From colonial America through the Lewis and Clark expedition and beyond, a combination of sensationalism, self-serving rationalization, and insufficient or outright inaccurate understandings of Indigenous social, economic, and cultural practices encouraged Euro-American observers to associate Indigenous women with sexual excess and promiscuity (see, e.g., Fischer 2002; Brown 1996; Lowry 2004). Government employees on late-nineteenth-century reservations repeated such generalizations, pointing to the practice of abortion as evidence.

Reservation employees also presented the practice of abortion as proof of Indigenous women's maternal apathy. Women terminated pregnancies, one physician contended, because a pregnancy and/or a child would interfere with sexual pleasure—and profit.[2] Non-Native observers' implicit and explicit references to prostitution—or sexual "commerce"—can sometimes be read as a partial acknowledgment of the destructive consequences of colonization. In the early twentieth century, for example, one government bureaucrat lamented the desperate economic circumstances that drove some women into sexual relations with white men and the ways in which white men preyed on Indigenous women without penalty.[3] More frequently, however, government employees blamed Native women and perpetuated stereotypes that characterized all Indigenous women as prostitutes.

Abortion also functioned as one among many ways government officials and bureaucrats attributed the demographic and health crises plaguing many reservations to Native women's bodies and behaviors. In the 1860s, for example, an army physician stationed near Bosque Redondo, where Navajo men and women were being held in captivity, reported that the Navajo population was decreasing and that "what does and will decrease the number of the tribe and finally wipe them out is the extensive system of abortion carried on by the young women" (quoted in Shoemaker 1999: 49). Decades later, A. B. Holder, a physician employed by the Office of Indian Affairs, similarly argued that the Native population's rate of growth was slower than other races, a phenomenon he explained by pointing not

[2] See W. Q. T. Tucker to William Jones, Dec 31, 1903, Press Copies of Letters Sent to Commissioner of Indian Affairs 1901–1905, Crow, RG75, Box 6, Volume 1903, National Archives and Records Administration [Hereafter NARA], Broomfield, Colorado.

[3] Inspection Report, Flathead, Dec 30, 1919, Records of the Bureau of Indian Affairs: Central Classified Files 1907–1938, FILM 9730, Reel 4, Labriola American Indian Center, Arizona State University.

to harsh conditions and high mortality but to "the enormous prevalence of abortion, both procured and from venereal taint" on reservations (Holder 1892: 44). Such explanations and accusations continued into the twentieth century.

Although practices varied from group to group, the ability of Native women in many communities to control fertility and their community's acceptance of such practices reflected Indigenous women's relative sexual and reproductive autonomy, which stood in stark contrast to Euro-American gendered ideals. In their zeal to assimilate Native Americans, government employees as well as social reformers increasingly emphasized the role biological reproduction could play in the imposition of patriarchal familial relationships and structures of governance. This was not a new concept. In the first decades of the century, colonial pressures had led the all-male Cherokee Council to criminalize abortion, passing a law that enumerated a penalty of 50 lashes for "any woman or women whatsoever, who shall be found guilty, before any of the courts of justice of committing infanticide during her or their state of pregnancy" (quoted in Perdue 1997: 148). The use of "during" instead of "after" suggests that the council may in fact have been referring to abortion rather than infanticide. As historian Theda Perdue has emphasized, the Cherokee Council's 1826 action represents Cherokee men's intrusion into what had to that point been "woman's prerogative" (Perdue 1997; see also Shoemaker 1999).

Six decades later, Congress passed the General Allotment Act, an ambitious policy intended to transform the way Native Americans related to land and to one another (see Stremlau 2011). Allotment involved the division of reservation land into individual plots to be farmed in nuclear family units; "surplus" land would be sold to encroaching white settlers. By the early twentieth century, many agents determined that the allotment process was proceeding too slowly for their liking and pushed for its rapid completion (Hoxie 1984). At the reservation level, allotment provided agents and other government employees with a new tactic by which to make an appeal against abortion and an ostensible reason to involve men in reproductive matters.

In 1905, one agent reported to the commissioner of Indian affairs that the reservation physician had been busy visiting pregnant women and their husbands "to impress upon them, the importance of raising babies," part of a broader effort to ensure men's proprietary interests in their wives' sexual and reproductive practices. For his part, the agent directed

his attention toward male leaders, through the tribal council and in private conversations, urging them to "use their influence to discourage this practice" and arguing that if women terminated pregnancies, there would be fewer tribal members to receive allotments, resulting in less land for the tribe.[4] Far easier, from the agent's perspective, to blame women for Native Americans' dwindling land base, rather than the predatory land policies in which he himself was implicated.

Although the centrality of land reflects the specificity of the settler colonial relationship, the link between control of reproduction and the imposition of patriarchal social relationships and structures of governance had parallels in other colonial contexts (see, e.g., Thomas 2003). Lynn Thomas has further demonstrated that government anti-abortion campaigns in early-twentieth-century Kenya, as in the United States, furthered both the material and moral objectives of colonial rule. These colonial objectives appeared even more urgent with the emergence of a global movement for the improvement of maternal and infant health. Consistent with the Progressive quest for order and faith in scientific objectivity, government agencies and social reform organizations began documenting and interpreting data on maternal and infant mortality, facilitating global comparisons as well as domestic comparisons by region and race. Americans were troubled to learn that they lagged behind other industrialized nations (see Meckel 1990), but national infant mortality rates did not compare to the startling rates plaguing many reservations. In the mid-1910s, Commissioner of Indian Affairs Cato Sells alleged that "approximately three-fifths of the Indian infants die before the age of 5 years."[5] In the United States, an increasingly unavoidable awareness of Indigenous infant mortality prompted something of an existential crisis for the OIA. As Sells declared, "We can not solve the Indian problem without Indians [sic]."[6]

Commissioner Sells intensified a pronatal campaign initiated by his predecessor that the OIA called "Save the Babies." Save the Babies was a distinctly Progressive-Era campaign with parallels off the reservation. On

[4] Samuel Reynolds to Francis Leupp, July 11, 1905, Press Copies of Letters Sent to Commissioner of Indian Affairs 1901–1905, RG75, Box 7, Volume Jan. 9 1905–Oct. 2 1905, NARA, Broomfield, CO.

[5] Commissioner of Indian Affairs [Hereafter CIA], *Annual Report*, 1916, 5.

[6] Ibid.

reservations, as historian Lisa Emmerich has argued, the OIA's pronatal initiatives were highly assimilationist. Sells directed OIA employees, and field matrons in particular, to save Indian babies by transforming their mothers; field matrons visited women's homes to impart the tenets of scientific motherhood (including nutrition, sanitation, and childcare techniques) as well as the tenets of Euro-American femininity and domesticity. The nuclear family remained the ideal, and field matrons targeted biological mothers while excluding the many "social" mothers, especially grandmothers, who assumed much of the responsibility for daily childrearing. Implementation of the OIA's pronatal campaign was uneven, limited by inadequate funding and resources, and Emmerich concluded that Native women's responses also varied. Some mothers appreciated aspects of the campaign, and disregarded others, while some mothers were turned off by government employees' cultural assumptions or found field matrons' teachings irrelevant to their lives (Emmerich 1997). The Save the Babies campaign heightened scrutiny of Native mothers, buttressing and expanding a number of negative tropes, including that of the negligent or apathetic mother, which had previously been circulated in abortion-related discourse.

Biological mothers were not the only group who came under critical scrutiny. In the first decades of the twentieth century, American physicians and obstetric specialists, concerned with overcrowding in the field and in service of an ongoing shift toward professionalization, waged a campaign against midwives. They accused midwives of a host of dangerous and immoral acts, including abortion. At the national level, physicians showed little concern regarding Indigenous midwives and instead directed their scorn and criticism toward immigrant midwives, who they alleged were "dirty," "backward," and "barbarian" (Litoff 1978; Reagan 1997). Although OIA bureaucrats and reservation employees had shown minimal interest in Native midwives through the nineteenth century, following the turn of the century and especially during the Save the Babies campaign, employees began urging women to give birth in newly constructed government hospitals. In various ways, through disparagement and the threat of police power, employees attempted to stop the midwife's practice as well as the transmission of her extensive knowledge regarding reproduction.

In part, OIA anti-midwife campaigns reflected the prevailing anti-midwife sentiment in the Progressive Era, but on reservations, these campaigns were about much more than changing the location and dynamics of

childbirth. They were part of a broader effort to alter gendered and generational relationships and to disrupt the transmission of cultural beliefs and practices. On some reservations, the political nature of this struggle was overt. The superintendent on the Cheyenne and Arapahoe Reservation in Oklahoma, for example, reported in 1918 that although the reservation hospital had been open for two years and the prejudice of the "medicine men" was wearing off, "we have never been able to get a maternity case into the hospital—the old women considering that service their peculiar prerogative." The struggle continued the following year. The superintendent repeated his report almost verbatim, this time substituting "peculiar" for the stronger "inalienable."[7] On other reservations, this struggle was less pronounced, as women quietly continued to give birth according to their wishes. When and if women did choose a hospital birth, this did not necessarily mean that midwives, grandmothers, and mothers stopped passing down other reproductive knowledge.

In many cases, this knowledge included various forms of pre- and/or postcoital birth control methods, but by the 1920s and 1930s, there is evidence of some change in attitude toward such methods. In addition to ongoing fears about tribal survival and the future of the Indigenous land base, the spread of Christianity on reservations altered the way some Native women—and men—viewed the termination of pregnancies (see Koblitz 2014). For example, one Native woman recalled in a memoir written decades later that when she became pregnant as a result of rape while still a teenager, her friends and family gave her all sorts of different advice. One relative offered to take her to a nearby town to obtain an abortion, a reminder that despite the illegality of the procedure, some women had knowledge of resources available off the reservation. For her part, however, the memoirist recalled, "I was a Christian, and I didn't want to end my pregnancy" (Snell 2000: 136). In my conversations with Native women, the threat of legal action emerges as another factor that shaped the way they or their ancestors viewed the termination of pregnancy in this period, a threat that, as the next section demonstrates, continued in subsequent decades.

[7] Cheyenne and Arapaho, *Annual Report*, 1918 and 1919, Superintendents' Annual Narrative and Statistical Reports from Field Jurisdictions of the Bureau of Indian Affairs, 1907–1938, RG75, FILM 3748, Labriola, ASU.

Abortion in the Post-World War II Decades

Assimilation returned as the paramount policy objective in the years immediately following World War II, after a partial diversion during John Collier's tenure as commissioner of Indian affairs in the 1930s and early 1940s. By the postwar period, however, policymakers' motivations for pursuing assimilation and their strategies for accomplishing it looked much different than the assimilation campaigns waged by their early-twentieth-century predecessors. Driven primarily by a desire to reduce the federal government's fiscal responsibility for Indigenous welfare, policymakers attempted to force Indians to integrate into mainstream society once and for all. They did so through two complementary policies: the relocation program, which encouraged individual Native Americans and their families to move from their reservations to urban locations, and termination, which ended the trust relationship between the federal government and the tribes that policymakers deemed capable of existing without federal aid, services, and protection. The negative and sometimes tragic consequences of relocation and termination prompted a surge of Indigenous activism and led to a reversal of these policies in the 1970s. The government began to restore the legal status of terminated tribes in 1973, and the Indian Self-Determination and Education Assistance Act of 1975 signified the federal government's shift toward increased tribal autonomy and self-governance (see Fixico 1986).

The postwar period also brought structural changes within the OIA, known as the Bureau of Indian Affairs (BIA) after 1947, that affected the way Indigenous women received health care. During the termination era, Congress renewed a decades-old debate about consolidating the BIA's Indian Medical Service with the Public Health Service (PHS), located within the Department of Health, Education, and Welfare (HEW). This time, proponents of a transfer to PHS carried the day. Congress approved the Indian Health Transfer Act in 1954, and on July 1, 1955, 56 hospitals and 3500 health employees were placed under the authority of the US Surgeon General (Dejong 2008: 136). The Indian Health Service (IHS) was established within PHS in 1956 to deliver this care. By this time, most Native American women were giving birth and receiving their reproductive health care from hospitals, but women who relocated to cities and women from terminated tribes faced obstacles in accessing care, as the bureaucracies in question debated jurisdiction and eligibility.

Abortion remained illegal. In fact, Leslie Reagan argues that in the 1940s and 1950s, the state exhibited renewed aggressiveness in suppressing abortion. This heightened repression was a response to an increase in therapeutic abortions during the Depression; to what many saw as an unsettling transformation of gender roles signaled by women's accelerated entry into the labor force during World War II; and to Cold War imperatives to showcase the happy American housewife (Reagan 1997). Law enforcement officials and prosecutors advocated police tactics in this effort, which was not a new threat for Native women who had become accustomed to governmental scrutiny of their bodies and of the most intimate aspects of their lives. The postwar repression of abortion did not affect all women equally. Ironically, white, middle-class women—the women most likely to be represented in Cold War depictions of the happy American housewife—were also most likely to have the resources, insurance, and social networks that enabled them to obtain safe and legal abortions in hospitals. Poor women and women of color, in contrast, were less likely to obtain hospital abortions and more likely to suffer the worst effects of criminal abortion. Some Native women continued to have access to plant-based abortifacients, but decades of government effort to suppress this knowledge and its transmission had taken its toll (see Lawrence 2000).

This two-tiered system did not end following *Roe v. Wade*. The Supreme Court decision sparked a backlash and a movement dedicated to its repeal, with Congress debating a proposed right-to-life amendment the very next year. The emerging anti-abortion movement's first success was the passage of the Hyde Amendment in 1976, which eliminated public funding for abortion. The amendment hindered the ability of all women receiving government assistance for health care to obtain an abortion and disproportionately affected women of color. Native women recognize, however, that the amendment discriminates against them specifically because of their entitlement to health care through a federal agency. As Comanche activist Charon Asetoyer explains, "we're the only race of people in this country that are restricted purely—from abortion access and under the constrictions and restrictions of the Hyde Amendment—based on race" (Asetoyer 2005: 49). The Hyde Amendment thus intensified an earlier pattern in which abortion was most accessible to the demographic group whose access late-nineteenth-century physicians had most wanted to restrict. Although policymakers and medical authorities continued to want white middle-class women to procreate, emerging notions of motherhood as a "fundamentally private experience," facilitated expanded

reproductive autonomy for these women (Plant 2010: 3). This expanded autonomy did not extend to women whose reliance on various forms of public assistance seemed to preclude a "private" or individual choice framework (Solinger 2001).

Despite this continuity of discrimination, however, many Indigenous communities did not view abortion as the most salient reproductive issue in the 1950s, 1960s, and 1970s. By this time, non-Native citizens' enthusiasm for "uplifting" the government's "wards" had waned. As US policymakers and commentators embraced and popularized anthropologist Oscar Lewis's "culture of poverty" thesis, social workers, journalists, and non-Native citizens came to understand the poverty plaguing many reservations—as well as the poverty plaguing inner cities—as a matter of cultural pathology, rather than a structural issue. Since the late 1930s, states and counties had clashed with tribal nations and the federal government over the distribution of Aid to Dependent Children and other forms of public assistance. Almost from the start, county officials and employees, as well as non-Native citizens, had charged that Indigenous families posed unwarranted burdens for taxpayers.[8] Local newspapers presented Native women's reproduction as excessive, immoral (out-of-wedlock), and costly, once again placing blame on women's bodies and behaviors.[9] The rapid growth of the Indigenous population at mid-century, fueled in part by high birthrates, eradicated white Americans' guilt-ridden fears about "vanishing Indians" (Shoemaker 1999). Instead, in the midst of non-Natives' anxieties about growing minority populations and an expanded welfare state, Indigenous women, like other nonwhite and economically vulnerable groups, not only faced restrictions in abortion access; they faced policies and practices that limited or restricted their reproductive capacity permanently.

Rather than facing pressure to reproduce, Indigenous women found their maternal rights under increased attack as racialized tropes facilitated racist reproductive policies. Historian Rebecca Kluchin has demonstrated how the stereotype of the racialized welfare queen facilitated the forced sterilization of women of color and specifically black women in this period

[8] I address this earlier history in an article-in-progress entitled "Managing Mothers: Government Social Workers on the Reservation, 1931–1945."

[9] See Dick Palmer, "Cold Weather Poses Severe Problem for North Dakota Indian Tribes," Jan 18, 1962, Newspaper Clipping, General Records of the Department of Health, Education, and Welfare, Records of the Office of General Council, Publications Division, RG235, Box 2, Folder PHS—INDIAN #5 1961, NARA, Baltimore, Maryland.

(Kluchin 2009). The "rez welfare queen" was the counterpart of the better-known "poor black welfare queen." Mary Brave Bird, a Lakota activist, illuminates the racial prejudice, moral judgments, and economic fears embedded within this stereotype: "The prevailing attitude among the white people running our lives was: Those damn Indians, breeding like rabbits, living in substandard conditions, existing on welfare, are being a burden on the American taxpayer. And most of them are not even legally married! Let's prevent those squaws from having more papooses!" (Brave Bird and Erdoes 1993: 192). In 1970, the federal government began subsidizing sterilization operations as part of a broader effort to increase programs that covered the costs for the sterilization of Medicaid patients (see Smith 2005b). Federal financial incentives and IHS and contract physicians' susceptibility to pervasive cultural stereotypes about Indigenous women, mothers, and families resulted in abuse.

Native activists were aware of the issue by the 1970s, but sterilization abuse was frustratingly difficult to document. Under pressure from activists and Native American organizations, the Government Accountability Office (GAO) investigated and released a report in 1976. The GAO report focused on those instances in which the IHS clearly violated federal guidelines regarding informed consent. First, the report indicated that IHS facilities had violated the moratorium on sterilizations of women under the age of 21. Second, the report highlighted violations occurring because of confusion surrounding consent regulations. The IHS used a consent form that did not meet HEW standards, and at any rate, physicians seemed unclear about what they needed to tell patients to obtain informed consent (Carpio 2004: 42–45). The GAO report covered 4 of the 12 geographic areas serviced by IHS and concluded that 3406 Indigenous women of childbearing age had been sterilized between 1973 and 1976.[10]

Many Indigenous activists contended that the government report was far too conservative (Ralstin-Lewis 2005). The Native women who established the Women of All Red Nations (WARN) in South Dakota in 1978, for example, contended that physicians had sterilized more than 40 percent of Indigenous women of childbearing age.[11] Marie Sanchez, tribal

[10] Elmer B. Staats, Comptroller General, *Report to Senator James Abourezk: Investigation of Allegations Concerning Indian Health Service* (Washington, D.C.: Government Printing Office, 1976).

[11] "W.A.R.N. Report II," 1979, Liberty Hill Foundation Records, 20th Century Organizational Files, Box 10, Folder Women of All Red Nations '79/'80, Southern California Library for Social Studies and Research, Los Angeles, California.

judge on the Northern Cheyenne Reservation in Montana, interviewed 50 women on her reservation and found that more than half had been sterilized within a four-year period (Torpy 2000; Lawrence 2000). Activists further challenged the report's conclusions by noting the researchers' failure to consider how language and cultural barriers hindered informed consent and protesting their reliance on a very narrow definition of coercion. Indigenous women cited examples of social workers and hospital personnel threatening to remove their children or strip them of their welfare benefits if they did not "consent" to a sterilization procedure (Brave Bird and Erdoes 1993; Lawrence 2000).

As women like Mary Brave Bird were well aware, child removal was not an empty threat. State agents' regulation of Native women's biological reproductive practices coexisted alongside and benefited from State agents' ability to exert control in Indigenous parenting. Although federal policy no longer centered on a boarding school education, the removal of Indigenous children from their homes continued, as social workers and other federal employees facilitated the placement of Native children in white foster homes. In the early 1970s, Norma Jean Serena, a Creek-Shawnee woman in her thirties, endured a coercive sterilization *and* the removal of her three children, securing their return only after years of legal battles (Jacobs 2014). The stated rationale for Serena's sterilization was "socioeconomic," and Native women charged that economic, as well as social and cultural, factors also shaped child removal practices. Brave Bird asserted that Lakota children were placed in foster homes "even in some cases where parents or grandparents are willing and able to take care of them, but where the social workers say their homes are substandard, or where there are outhouses instead of flush toilets, or where the family is simply 'too poor'" (Brave Bird and Erdoes 1990: 16). Historian Margaret Jacobs argues that the placement of Indigenous children in foster care reached a point of crisis by the late 1960s and 1970s (Jacobs 2014). Despite passage of the Indian Child Welfare Act in 1978, these battles are far from over.[12]

In the decades following World War II, the complex, multisited bureaucratic apparatus that managed Indian affairs—summed up by Mary Brave Bird as "the white people running our lives"—in various ways delineated

[12] See Lakota People's Law Project, "Reviewing the Facts: An Assessment of the Accuracy of NPR's *Native Foster Care: Lost Children, Shattered Families*," Report to Congress (Jan 22, 2013).

the parameters of choice in Indigenous women's reproductive lives. As detailed above, the removal of children remained a looming threat for many Native mothers. Moreover, the relative inaccessibility of abortion—or even, in some cases, safe, reliable birth control—in the 1960s and 1970s, before and after *Roe*, contributed to the pressure on Native women to "choose" more permanent birth control measures such as sterilization (Gurr 2015; Smith 2005b). Inadequate or inconsistent preventative reproductive health care also increased the likelihood that Native women would develop medical conditions that made them candidates for medical (as opposed to "therapeutic") sterilizations, typically hysterectomies.

By the late 1970s, the publicity surrounding the disproportionate sterilization rates in IHS hospitals forced the agency to tighten its sterilization policies, a positive and necessary development that unfortunately may have contributed to the difficulties a Native woman faces in attempting to obtain an abortion. IHS physicians explain that the controversy surrounding the institution's past resulted in a cautious approach to restrictive reproductive procedures (Donovan 1997). A study conducted by the Native American Women's Health Education Research Center at the turn of the twenty-first century found that only 5 percent of surveyed IHS service units performed abortions even in the limited circumstances allowed by the Hyde Amendment (Smith 2005b: 96–97). At the same time, activists continued to fear that physicians and nurses used coercive tactics to encourage Native women to accept long-term and inadequately tested birth control measures such as Depo-Provera and Norplant (Asetoyer 2005).

Conclusion

Scholars have shown that policies and discourses pertaining to the termination of pregnancy have been used to stigmatize women and to reinforce gender norms (see Reagan 1997; Schoen 2015). The intersection of colonial and reproductive politics has had particular implications for Native women's reproductive options and decisions that demand but also push beyond a racial analysis. As Patrick Wolfe has argued, settler colonialism hinges on what he terms "the logic of elimination," which has historically manifested in various attempted solutions to the so-called Indian problem (Wolfe 2006: 387). Although Wolfe does not explore the issue, the various iterations of the logic of elimination have been profoundly gendered, placing particular burdens on Native women as social and biological reproducers. Federal policies and practices have attempted—

often unsuccessfully—to *control* Native women's bodies by shaping the parameters in which they made decisions (or eliminating decision-making entirely, in cases of coercive procedures), while the chronic underfunding of government health services reflects a broader colonial *neglect* that has similarly constrained Native women's reproductive autonomy (see Gurr 2015).

This chapter has provided only a brief historical overview and cannot adequately explain Indigenous attitudes toward abortion, historically or in the twenty-first century, which have been influenced by a host of factors, including personal experience, religious beliefs, and understandings of cultural practices and beliefs. As the controversy surrounding Fire Thunder demonstrated, abortion is a subject of disagreement in Native communities, as it is among many twenty-first-century Americans. On and off Pine Ridge, many Native women (and men) expressed their support for Fire Thunder's clinic, but the Tribal Council opposed her efforts and unanimously voted to ban abortions on the reservation, an act taken by a handful of tribal councils throughout Indian Country (see Gurr 2015; Thomsen 2008). Nonetheless, in an online expression of support for Fire Thunder's leadership, Indigenous Studies scholar Kim TallBear explicitly argued, as have other Native women, that "our moral and political response to terminating a pregnancy is not captured" by the categories of "pro-choice" and "pro-life." Rather, TallBear emphasized the need to strike a "sensitive balance" that aligned with cultural values, acknowledged colonial consequences, and supported Native women, families, and communities (quoted in Thomsen 2008: 137).

In recent decades, this quest for a culturally and historically appropriate balance has encouraged some Native women to embrace reproductive justice, a model of activism developed by women of color that links women's reproductive rights to broader social justice agendas. These women, many of whom have long personal histories of activism, emphasize the need to reclaim the reproductive knowledge and authority that has been compromised by colonization (see Asetoyer 2005; Cook 2005). Yet they reject the tendency of many in the mainstream feminist and women's health movements to privilege abortion above other important issues in women's lives. Rather, they present access to safe, affordable, legal abortions as one part of a broader reproductive agenda, which they in turn understand to be intertwined with ongoing struggles for political and cultural sovereignty and self-determination. Native reproductive justice activists organize, for example, around Indigenous poverty, lack of substance abuse treatment

for Native women, the disproportionate rates of violence Native women face, and the environmental degradation of reservation land, all of which, these women have shown, are in fact reproductive issues (see Gurr 2015; Deer 2015; Asetoyer 2005; Cook 2005). As Charon Asetoyer explains, "there's more than abortion, a whole lot more, and if we don't acknowledge that…then it becomes oppressive" (Asetoyer 2005: 43).

CHAPTER 15

Revelation and Secrecy: Women's Social Networks and the Contraception-Abortion Process in Cameroon

Pamela Feldman-Savelsberg and Sylvie Schuster

Former versions of this contribution were presented at the Reproductive Health Challenges conference in Granavolden, Norway, August 2008, and the IUSSP International Seminar on Interrelationships between Contraception, Unintended Pregnancy and Induced Abortion in Addis Ababa, December 2008. We are grateful for the helpful comments of discussants Friday Okonofua and Clémentine Rossier, as well as to the editors of this edited volume. We especially acknowledge Dr. Flavien T. Ndonko's collaboration on the hometown association "Social Networks and Reproductive Health" project. The research was supported by a dissertation grant awarded to Sylvie Schuster by the German Academic Exchange and by awards to Pamela Feldman-Savelsberg by Fulbright/IEE, the Wenner-Gren Foundation, the Sigma Xi Foundation, the National Science Foundation Professional Opportunities for Women in Research and Education award (Grant No. SES-0074789), the Andrew W. Mellon Fellowship in Anthropological Demography, and Carleton College. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the authors and do not necessarily reflect the views of the granting agencies.

P. Feldman-Savelsberg (✉)
Sociology and Anthropology, Carleton College, Northfield, MN, USA

S. Schuster
Gynecologist/Obstetrician and Medical Anthropologist, University Hospital of Basel, Basel, Switzerland

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_15

Induced abortion is a common but never routine experience in Cameroonian women's lives. As in much of sub-Saharan Africa, induced abortion is illegal in Cameroon. Nonetheless, Cameroonian women frequently turn to abortion to manage ill-timed and ill-conceived pregnancies. They do so in highly varied circumstances, facing both medical and social risks. Women's social networks mediate these risks, but information and social support regarding abortion do not flow freely through these network ties. Our contribution examines how Cameroonian women manage issues of revelation and secrecy within their social networks as they make decisions regarding contraception, pregnancy, and abortion. We call this chain of events and decision-making the "contraception-abortion process."

Women in Cameroon make decisions about contraception and abortion not as isolated individuals with complete freedom of choice, but rather as people embedded in networks of social relationships. Understanding the ways social networks and cultural contexts shape women's decisions is particularly urgent in countries like Cameroon. Despite a policy that officially promotes family planning and drastically restricts abortion, in Cameroon contraceptive use is low, and the incidence of unsafe abortion is high (WHO 2011). Solving this conundrum means understanding the entire path of decisions that women—as social beings—make regarding sexual activity, contraceptive use, method choice, defining an unintended pregnancy as unwanted, and resort to abortion. Thus, we examine how Cameroonian women make decisions along the entire contraception-abortion process in interaction with key social actors—sexual partners, kin, friends, fellow voluntary association members, and health-care providers.

Widening the lens to include these social actors changes the way we look at reproductive decision-making. First, contraceptive and abortion decision-making are social acts. When a pregnant woman decides to contracept or abort, she does so influenced by negotiations with others, anticipated reactions from her social environment, and occasionally coercion of sexual partners, parents, or other family members. Women either keep reproductive matters secret or seek information from, confide in, and are influenced by their social network members.

Second, there is more than one story about women's abortion decisions. Cameroonian women who resort to abortion are heterogeneous along dimensions of relationship status, age, number of children, education, wealth, and urban versus peri-urban residence. They have abortions at different points in their reproductive careers and for various reasons.

This heterogeneity is further reflected in the varying composition of women's social networks, promoting different kinds of information, advice, and support in the contraception-abortion process and creating different vulnerabilities. Heterogeneity in women's social networks results in the uneven distribution of knowledge about and access to reproductive and sexual health services, as well as exposure to medical and social risks associated with unwanted pregnancy and abortion. These differences mean further that women either reveal or keep secret their pregnancy dilemmas vis-à-vis different kinds of people. Structural factors, social network composition, and cultural ideas about discretion interact to expose women to the risk of unwanted pregnancies, leading them to seek pregnancy termination in unsafe circumstances. We use women's abortion narratives to better understand these interactions.

Research Setting

Cameroon and the Grassfields

Cameroon is a geographically, religiously, linguistically, and ethnically diverse country on the boundary between west and central Africa. With over 250 distinct linguistic and ethnic groups, Cameroonians practise a variety of local, Christian, and Muslim religions. After WWI, the German colony of Cameroon was divided between Britain and France under a League of Nations' mandate. Since achieving independence in 1960, Cameroon's official languages have been English and French, representing 20% and 80% of the population, respectively.

In states with ethnically based political parties and well-developed patron–client relations such as Cameroon, state resources are unequally distributed, reinforcing ethnic differences in regard to women's experiences of reproductive risk (Weinreb 2001). Studies of abortion in Cameroon have focused on young adults among the Beti, the politically and geographically dominant ethnic group (Calvès 2002; Johnson-Hanks 2002).

This study recognizes the unique context of Grassfields populations, who comprise at least one-third of the Cameroonian population.[1] First, despite their modernity-seeking outlook, Grassfielders continue to have high fertility, creating a demographic paradox (Wakam 1994). Grassfielders are

[1] Grassfielders include the ethnically diverse anglophone Northwest Region, and the francophone West Region inhabited mainly by Bamiléké and Bamoun peoples.

both socially and geographically mobile within Cameroon, and have a long history of participation in opposition politics (Dongmo 1981; Konings and Nyamnjoh 1997). Thus, reproductive insecurity shapes Grassfields' women's contraception and abortion experiences (Feldman-Savelsberg 1999, 2016). We focus on Grassfields women living in their region of origin (the Northwest and West regions of Cameroon) and as émigrés to the capital city, Yaoundé, allowing us to capture the impact of international and national health policy within a specific social and cultural group.

Cameroonian Contraception and Abortion Policy

National family planning and abortion policy and its implementation create the conditions under which social networks influence the contraception-abortion process. As in many sub-Saharan African countries, most abortions are illegal in Cameroon. Abortion is only permitted when the woman's life is endangered in order to preserve her physical and mental health or following rape or incest, but *not* on socioeconomic grounds (United Nations 2011).

Illegal abortions are punishable by imprisonment for the abortionist, the woman, and anyone supplying drugs or instruments to induce abortion (United Nations 2007). Cameroon's ratification of the Maputo Protocol, which calls for a liberalization of abortion laws in Africa, sparked vehement controversy in Cameroon and strong opposition from the Catholic Church (Ricker 2009). Although rarely enforced, the criminalization of abortion in Cameroon negatively influences the availability of safe and affordable abortion services. Women can rarely take advantage of their legitimate claims to a legal abortion (e.g. following rape) (Schuster 2010). Even more than the illegality of abortion, a woman's decision for or against abortion is rather determined by fear of public shaming and social control from classmates, husbands, families, and neighbours (Schuster 2005).

Despite international and national efforts in the area of family planning, the incidence of unwanted pregnancies and unsafe abortions remains high and has steadily increased in Cameroon over the past two decades. By 2011, the World Health Organization estimated that 30 or more unsafe abortions occurred per 1000 women aged 15–44 (WHO 2011: 20). Simultaneously, while abortion-related mortality and morbidity declined globally, it remained exceptionally high throughout sub-Saharan Africa (WHO 2011: 27).

Two decades of the criminalization of contraceptive use (1960–1980), followed by one decade of its legalization tempered by official discouragement, did little to prevent unwanted pregnancies in Cameroon (Feldman-Savelsberg and Ndonko 2002: 222). In response to the 1990s economic crisis, Cameroon's national population policy changed, stating that "everyone of reproductive age has a right to contraception" (Ministry of Public Health 1995: 5; National Population Commission 1993: 3). Nonetheless, day-to-day practices lag behind official pronouncements, and health-care providers often resist making contraception available to *all* men and women of reproductive age. Data from the Demographic and Health Survey (DHS) indicate that while the proportion of married users of all methods was 23.4% in 2011, married women's use of contraceptive technologies (e.g. oral contraceptives, IUDs) remain low at 14.4% (2013: 226). Knowledge regarding emergency contraception among women in union is 32.5% (DHS 2013: 226), accompanied by a high degree of misinformation (Kongnyuy et al. 2007); data on usage is lacking (DHS 2011: 226).

Methodology

The research was carried out among two distinct subject populations and settings. After having obtained informed consent, interviews were conducted among, first, women with abortion-related medical complications in a hospital with a peri-urban catchment area in the Grassfields (Schuster 2004), and second, members of six hometown associations in Yaoundé (Feldman-Savelsberg et al. 2006).

To make contact within the hospital-based study, women who were admitted on the gynaecological ward due to medical complications arising from induced abortions, had an induced abortion in their medical history, or were identified for interviews through a snowball sample were interviewed over a 16-month period (1996–1997). Data were examined on 194 women with abortion-related complications and on 940 women registered at the hospital-based family planning services; 65 in-depth interviews were conducted with women who had had an induced abortion as well as 23 key informants, including medical personnel.

The second study placed contraception and abortion experiences broadly within the social management of reproductive events, using six women's hometown associations in Yaoundé as an entry point. Over the course of two years (2001–2002), we took extensive reproductive histo-

ries and conducted a two-round support network survey with 152 urban women. Fifty women, including those who had undergone induced abortions, were selected for follow-up in-depth interviews.

In all, 115 of the women we interviewed had had at least one induced abortion at some time in their life. Both projects included participant observation in women's homes, neighbourhoods, and in hospital wards.

We emphasize women's socioeconomic heterogeneity in our combined data sets. The interviewees from the hospital study include married and unmarried women of frequently limited financial means and education—housewives, farmers, market or street vendors, and students or apprentices in trades such as hairdressing. The Yaoundé study distinguishes between elite and non-elite women using education and a nine-point economic scale based on household items ranging from running water to a car, where the *femmes élites* consistently score nine and had advanced university-level educations. Non-elite women in the hometown association study and their hospital-study counterparts have similar occupational and economic profiles and face similar constraints and choices regarding reproductive health. In contrast, elite women make their reproductive decisions under more privileged circumstances.

We drew information from the in-depth interviews regarding contraception and abortion decisions focusing on: who decides, who knows (about contraceptive use, unintended pregnancy, or abortion), who helps (in defining the situation, in providing material and informational resources, in providing social resources such as links or escorts to providers or alibis for absences and illnesses, in providing emotional support), who condemns or supports either contraceptive use or recourse to abortion, and which key social actors become involved in contraception and abortion decisions.

Defining the Contraception-Abortion Process

Induced abortion is but one step in a chain of events that begins with the onset of sexual activity and ends—at its best—with post-abortion contraceptive counselling. Each of these events involves social interaction within a web of social relationships. While each event appears to involve decision-making, the intentionality of each linked action is often ambiguous. For example, entry into sexual activity may be sought after, welcome, unwelcome, or violently coerced. Using contraception properly, insufficiently, or not at all is shaped by a woman's access to (adequate) information, her financial means, and her capacity to use contraception within

her sexual relationship. A woman's capacity to act and decide among the various options is further shaped by her family status because the dominant moral ideology restricts sexual activity to the marital sphere. Despite differing access to formal contraceptive counselling for married and unmarried women, both commonly share contraceptive information among people in their social networks. As a result, women's contraceptive situations vary greatly (WHO 1997: 5). If contraception fails, the pregnancy is unintended and frequently, but not inevitably, perceived as unwanted. When a woman defines a pregnancy as unwanted, her decision to keep the pregnancy or to undergo an abortion is driven by her socioeconomic conditions, the illegality of the procedure, moral condemnation of abortion, and whether her pregnancy is before, in, or out of marriage. This context shapes to whom she reveals her situation, and who she trusts to keep the abortion secret. Her financial means and knowledge of a (safe) provider, both often closely intertwined with her social network, determine her access to safe abortion. Finally, to prevent future unintended pregnancies, contraceptive counselling is a frequent standard where abortion is legal, but rare in an illegal context like Cameroon. Each step in the contraception-abortion process becomes a vital conjuncture, prompting the woman to coordinate life course events, closing off some potential futures while enabling others (Johnson-Hanks 2006). At each step the woman reveals her worries and intentions to some and keeps them secret from others.

Secrecy, Revelation, and Social Network Involvement Along the Contraception-Abortion Process

When we think of decision-making for contraception and abortion, we generally assume that the pregnant woman is the decision-maker. Indeed, the discourse on reproductive and sexual health in North America and Europe focuses on women's reproductive autonomy (e.g. Ginsburg 1989). In countries where abortion is permitted the health-care system offers abortion services and relevant information that can be easily accessed; in Cameroon, where abortion is legally restricted and morally condemned, governmental and non-governmental abortion services are severely limited. Moreover, an abortion only remains without sanction for the individual woman if it is performed secretly and remains secret. Beyond financial constraints, the wish for secrecy motivates women's choice of provider and

method (Schuster 2005) and determines a woman's quest for information and advice from her social network. *Whom* she confides in depends upon network partners' knowledge and trustworthiness in keeping secrets confidential. Trustworthiness likewise shapes *how* she mobilizes her network, whether in a concrete situation regarding concrete needs or as information sharing in an informal conversation.

Social network involvement provides emotional, financial, and logistical support for women considering abortion. Just as in any quest for therapy (Janzen 1978), a number of social actors become involved in diagnosing the situation (e.g. that the pregnancy is unwanted), and deciding upon a therapy (e.g. terminating the unwanted pregnancy), a method (e.g. vacuum aspiration, D & C, or herbal abortifacients), and a provider. These social actors may serve as a conduit for information, give advice, provide escort and solace, and/or finance the abortion. Awareness of yet other social actors' anticipated support or condemnation may also factor into a woman's decision-making process, quest for therapy, and desire for secrecy. Furthermore, these very same actors may have been involved in the woman's earlier decisions regarding contraception, leading to the unintended pregnancy in the first place. The pregnant woman decides about abortion under the influence of negotiations with others, anticipated reactions from her social environment, and occasionally the coercion of sexual partners or parents. Although our interviewees stated that "no one knows" or "I told no one," they themselves referred to a small number of people in whom they confided and who influenced their reproductive decisions.

Social Network Influence Among Cameroon Grassfields Women

Consultations with health-care providers constitute only one form of social interaction shaping the insufficient implementation of family planning policy, leading to the low use of contraception and frequent recourse to abortion. A woman's male partners, parents, female friends, and members of her voluntary associations (e.g. churches, rotating savings and credit groups) exchange ideas about fertility control, spread opinions regarding the side effects and efficacy of contraceptive methods, and provide informational, material, and emotional resources in the face of an unintended pregnancy.

A small but growing body of literature addresses the role of social networks in women's decision-making about contraception (Aglobitse et al. 2005; Watkins et al. 2002) and abortion (Rossier 2007) in a variety of

sub-Saharan African locales. This literature has largely focused on the social influence and social learning that occurs in women's conversational networks, helping to construct local understandings of the safety and appropriateness of contraceptive use. Women choose their contraceptive methods based upon imperfect information gathered from members of their conversational networks and voluntary associations (Kohler 1997). A multiethnic study of contraceptive behaviour and voluntary associations in Cameroon's capital, Yaoundé, finds "a strong association between specific methods of contraception used by a respondent and those used by her network partners" (Valente et al. 1997: 677). Cameroonian women of Grassfields origin have a well-developed tradition of voluntary associations; near universal association membership has become an ethnic marker among Grassfields women living among the Beti-dominated population of Yaoundé.

Networks and Contraceptive Decision-Making

Male partners often influence contraceptive decisions indirectly; when women anticipate conflict, they are tempted to keep their contraceptive decisions secret. "You do not want to become pregnant and he wants a baby," outlines a major conflict of interest between men and women, determined by changing social goals, the gendered division of labour, and scarce economic resources. Subsequently, a "major strategy that women use to protect their interests and to maintain peaceful family relationships is the secret use of contraceptives" (Bawah et al. 1999: 59).

Couples' communication about contraception is fraught with difficulties. A 30-year-old mother of five, hospitalized after an unsafe abortion, reported that her husband refused to talk with her about contraception. Other women do not speak with their partners about contraception due to their husband's pro-natalist attitudes and perception that contraception encourages infidelity (Ezeh 1993: 164; Biddlecom and Fapohunda 1998: 366). As one married teacher expressed, "If you don't want to get your wife pregnant, why do you marry her? If a wife doesn't want any children, throw her out." Another mother of five asked, "The father of my husband has 46 children. Why shall I talk with my husband about family planning?" But the opposite can be true as well, that the male partner is more knowledgeable or encouraging about contraception but the woman's concerns about expense and side effects make her stop contracepting.

In Grassfields locales, rotating savings and credit associations—*njangis* (Pidgin) or *tontines* (French)—provide an alternate setting in which both contraception and abortion are discussed. Women in one interviewee's *njangi* conversed about self-help, provider choice, and health risks of abortion when facing an unwanted pregnancy, "so we discussed many things like this which concern only women." In the urban Grassfields diaspora, walks to and from association meetings provided occasions for considerable exchange of information, experiences, and advice. In the network surveys, elite women present themselves as independent, with only 17% influenced by their network members, contrasting with non-elite women who claimed that association members influenced their contraceptive decisions about half the time, usually encouraging them to start or keep using "modern" methods. Consistent with elite conjugal strategies regarding abortion, elite women deny covert use of contraception, while 16% of non-elite women assumed that their network members hid contraceptive use from their husbands.

Grassfields women actively decide for or against contraceptive use in situations of enormous economic, cultural, and social constraint. They learn about contraceptive methods, and negotiate their risks and meanings, in interaction with their male partners as well as with female friends, neighbours, and relatives with whom they share an associational life. Sometimes the combination of economic constraints, difficult access, fear of side effects, and the discouragement or even rejection of their male partners mitigates against (sufficient) contraceptive use. When unwanted pregnancy occurs, the same social actors influence a woman's decision-making regarding abortion.

Networks and Abortion Decision-Making

Judging Male Partners' Trustworthiness

Male partners exert variable influence on women facing unintended pregnancy. Some support the woman's decision to seek an abortion, or even coerce an abortion by refusing to take responsibility for the pregnancy. They may finance the abortion, as in elite women's conjugal strategies, or when an unmarried couple's relationship is based upon the exchange of sex and companionship for gifts and money (Silberschmidt and Rasch 2001). At other times, both married and unmarried male partners may oppose abortion, "claiming their rights" as fathers.

Women's images of their male partners determine whether women reveal or hide their pregnancy. Women weigh both the current quality and the likely future of the relationship, distinguishing among desirable and undesirable partners using criteria regarding financial reliability, intellectual compatibility, and intimate partner violence. If a woman suspects her partner will "claim his rights" or if she mistrusts promises of marriage or child support, she may decide—on her own—to perform an abortion. One 21-year-old Grassfields woman, a secondary school graduate who sold *mimbo* (homebrew) in the street, had a two-year relationship with a 30-year-old married clerk. He had supported her financially and promised to take responsibility for the child, but had already fathered children by another woman. She considered his promise empty—"It is just by mouth"—and decided to abort.

Married women who decide to abort also cite husbands' lacking financial support for existing children. A 30-year-old married mother of five declared: "I do not want to have more than five children, since I can only care for so many. I'm mainly the one who looks after the children and who works. My husband doesn't work." A 28-year-old hospitalized mother of five hid her abortion from her husband, telling him that she had suffered a miscarriage. She stated, "If he found out about the abortion, he would be angry, but not too angry, since there is no money and another child would hurt our existing children."

Both unmarried and married women are concerned about intimate partner violence, and loathe keeping a batterer's child (Alio et al. 2011). A hospitalized 21-year-old unmarried university student stated she would refuse to marry her boyfriend and keep his child, regardless of whether he took financial responsibility, because he was too violent. In Yaoundé, a married mother of eight decided to abort her last pregnancy from her alcoholic husband. Although rendered sterile by her abortion, she is happy because she wanted to "retire" from childbearing for "a drunkard" who "didn't give [her] money for food or water and electricity bills."

Young, unmarried mothers face stigma and narrowed life changes, making male partners' emotional and/or financial support crucial in women's choice of a safe practitioner and abortion method (Calvès 2002). Stable relationships decrease the likelihood of aborting; a woman in Yaoundé had multiple abortions until stabilizing her relationship and bearing several children "for" her common-law husband. In sum, male partners' involvement in abortion decision-making among non-elite women in the Grassfields and urban Grassfields diaspora is quite variable. Both married

and unmarried women might keep their pregnancies and abortions secret, seek their partners' financial support, or be pressured into keeping or aborting the pregnancy. These patterns contrast sharply to the rationales invoked and husbands' involvement in abortion decision-making among married women of the urban educated elite.

Abortion as a Conjugal Strategy: Elite Women

Although elite women of the urban Grassfields diaspora have more means and greater knowledge of new contraceptive technologies, they make frequent use of abortion. Urban elite women are able to seek abortions in medically safe conditions and have less to fear from the consequences of abortion. Anecdotal evidence suggests that women of all walks of life who can afford safe abortion services use them frequently. Elite women in our Yaoundé sample have immediate access to professional abortion services through gynaecological specialists within their immediate social networks. One elite woman received an abortion from a family friend, a gynaecologist and frequent visitor in the family's home. Abortions performed in well-equipped private clinics (run by physicians considered trustworthy due to their Grassfields origin) afford elite women both medical safety and protection from socially and legally risky public exposure.

Urban elite Grassfields women's husbands were the most significant and trusted people providing social support and advice surrounding their unplanned pregnancy and influencing their abortion decision. Their decisions were part of long-term conjugal strategies towards educational and career advancement, fulfilling their vision of the ideal modern family. Elite couples established marital legitimacy by having two or three children before pursuing advanced training abroad, completing desired family size after reuniting in Cameroon. Elite women in our sample faced an unwanted pregnancy and turned to abortion during the gap before the fourth child. One elite mother of three became pregnant just before her husband left for higher education overseas, after she herself had recently secured admission to Yaoundé's renowned École Normale Supérieure. Her husband encouraged her decision to have an abortion; they conceived their fourth child after completing their degrees and reuniting in Yaoundé. When faced with an unintended pregnancy, elite women seek to coordinate the life events of marriage, education, career, and childbearing by drawing upon their husbands and a close social network to seek an abortion.

Mothers and Female Friends

Mothers play two distinct roles in a woman's abortion decisions. Mothers are rarely informed about a married woman's abortion. As one married

elite woman stated, "Parents always want you to have as many children as possible." Mothers', fathers', and mothers-in-law's pro-natal ideology and interest in expanding lineage size militate against abortion. Married women seeking abortion thus usually keep their pregnancies and intentions secret. In contrast, younger unmarried women may receive their mothers' emotional and practical support. One mother supported her daughter's pregnancy termination to insure "no bad name on the girl." The parents of another 16-year-old girl, first pregnant at age 14, took her to a relative, a hospital employee, and paid for the abortion.

Female friends often serve as confidantes and sources of advice, revealed by "I told no one, only my girlfriend." One urban non-elite woman found the secrecy surrounding her first abortion traumatic. Faced with a second unwanted pregnancy, a female friend referred and escorted her to a doctor at a hospital. An 18-year-old apprentice in the Grassfields asked a nursing student to buy medications for an abortion; their close friendship established her trustworthiness to keep the abortion secret. Sometimes female friends create pressure to seek an abortion; a hospitalized single mother of two children blamed the advice of her "bad friends" for her unsafe abortion.

Grassfields women from all walks of life seek social, practical, and financial support from their male partners, kin, and female friends. Where abortion is illegal, as in Cameroon, the unintentionally pregnant woman must mobilize her social network and gather information and support informally. Where abortion is legal, these same tasks are often institutionalized through mandated pre-abortion counselling performed by health professionals. Thus, Cameroonian women are not only disadvantaged in terms of a restricted abortion law and limited access to safe abortion but also face an additional burden of actively seeking out advice, information, and support in abortion decisions and management.

Post-Abortion Family Planning

Clinical encounters are yet another social interaction contributing to decisions along the contraception-abortion process. Clinical encounters mediate between sexually active women and the national policies, and enable or constrain women's reproductive health and autonomy. The hospital family planning service illustrates this interface. While young, unmarried women suffered the most from abortion-related morbidity and mortality, they formed a miniscule 4.2% of the 940 patients registered with the hospital-based family planning service, 77.9% of whom were married women with children (Schuster 2005). In light of young unmarried women's high

abortion rates and exceedingly poor outcomes, this discrepancy between married and unmarried women is alarming indeed.

Moreover, women hospitalized with medical complications following an induced abortion rarely left the hospital "armed with the knowledge and the means to avoid repeating the process of unwanted pregnancy, and unsafe abortion" (WHO 1997: 1). The hospital studied had no routine practice to refer women who had aborted to hospital-based family planning services. Lack of signage directing clients to the family planning clinic constituted a further barrier, negating discretion by requiring women and girls to enquire.

When women did access the family planning service, the quality of client–provider interaction and communication profoundly impacted women's decisions regarding post-abortion contraception. While communication between service providers and clients is essential in the delivery of family planning services (Abdel-Tawab and Roter 2002: 1357), clients and providers bring very different expectations and personal attitudes towards abortion and sexuality to the consultation. For example, a 17-year-old single woman, hospitalized with medical complications after an unsafe abortion, attended a consultation at the family planning clinic together with a married mother with no known history of induced abortion. With four nurses in training, an additional staff member, and the researcher attending this consultation, and other family planning clients popping in, this teen's post-abortion contraceptive counselling session was anything but private. The provider repeatedly mentioned the young woman's induced abortion in a reproachful and disparaging tone, but treated the married woman respectfully. Before explaining a variety of contraceptive methods, the provider made clear that it would be best for the young woman to remain abstinent. The provider then asked if she would choose a method now or wait. The girl, embarrassed, answered that she would wait and left without contraception. In contrast, the married woman immediately received her first package of oral contraceptives. This example reflects how the provider's moral conceptions shape post-abortion counselling and the unmarried client's access to and decisions regarding contraception.

Conclusions

Despite significant changes over the past three decades in national policy regarding contraception in Cameroon, contraceptive usage remains low and the incidence of induced abortion high. How can we best understand a situation in which women turn to abortion frequently despite severe legal restrictions? Our contribution suggests first that we must look at

the entire contraceptive-abortion process rather than addressing separate components, and must contextualize women's actions within their social surroundings. For example, in Cameroon, with its highly restricted abortion law, the health-care system fails to provide routine post-abortion contraceptive counselling to prevent future unintended pregnancies, which is often a standard component of abortion-related health care in countries where abortion is legal. Hospital-based research conducted in countries where abortion is illegal rarely considers post-abortion counselling (Rasch and Lyaruu 2005; Fasubaa and Ojo 2004).

Second, abortion is often discussed in terms of women's right to autonomy, but even the most autonomous being is embedded in a variety of social networks. Both contraception and abortion are contested—and enabled—by close personal associates (sexual partners, kin, friends, and neighbours). A woman rarely decides first, and only afterward faces the constraints of her social environment and contesting advice of people close to her. Instead, decisions defining the state and intentionality of early pregnancies, and how to act on the basis of these decisions, are constructed in interaction with networks and social environments. Moreover, women's autonomy, "freedom of choice," and "informed consent" for contraceptive decision-making are "products of Western liberal philosophy," implying and necessitating the "individual being free, socially, economically and politically to make such choices, fully informed" (Russell and Thompson 2000: 13), ignoring how women's choices are complexly embedded in social networks and "local moral worlds" (Kleinman 1992).

Third, variations in social network influence reflect differences in the vulnerability felt by young unmarried women, by married non-elites, and by married women of the urban educated elite. Recognizing women's heterogeneity is central to understanding how networks affect women's strategies of preventing and managing unwanted pregnancies along the entire contraception-abortion process. Despite shared cultural values, elite and non-elite women in the Cameroon Grassfields and its urban diaspora make their reproductive decisions in vastly different contexts. While non-elite married women often prefer methods which they could use covertly, elite women make conjugal decisions. Non-elites seek abortion particularly at both ends of their reproductive careers, while elites' abortions interrupt family formation to accommodate career goals. Poor women must often rely on unsafe abortion procedures despite known risks, while wealthy women have access to medically safe and therefore socially discreet abortions. These differences serve as a strong reminder that women facing induced abortion should not be assumed to be a "homogenous" group

in Cameroon or elsewhere in sub-Saharan Africa. Research could help develop differentiated programmes and family planning services sensitive to the varied needs of women with an induced abortion.

Fourth, within numerous fields of social interaction, from health-care providers to confidantes, social network members play varied roles. Pregnant women assess the quality of their social relationships and the reactions they expect from them. Women's assessment affects their choices to reveal their unintended pregnancies and planned abortions in search of advice and support, or to keep this secret from even the closest of ties. The roles of male sexual partners, mothers, female friends, and members of associational life may be active—marked either by encouragement or discouragement—or passive—marked by the spectre of exposure and shame if others discover a woman's abortion. The small amount of research that addresses how women's social networks shape their contraception and abortion decision-making focuses on information sharing and influence within social networks, and thus on *revelation*. In contrast, the structuring of *secrecy* within social networks is crucial for understanding women's contraception and abortion decision-making and practice.

Attending to network ties transforms the way we look at data on contraception and abortion, helping us to better understand *who* is involved in decision-making processes, and *how*. Differences in relationship status, education, and wealth highlight discrepancies in women's reproductive health needs, the ability of their social networks to address those needs, and patterns of revelation and secrecy among network members. The contradictory and difficult circumstances in which women mobilize their social networks reveal an aspect of global inequity and stratified reproduction which has yet to be addressed.

CHAPTER 16

The End of Feminist Abortion Counseling? Examining Threats to Women's Health

Elyse Ona Singer and Bayla Ostrach

In-depth and unhurried abortion counseling emerged as a key component of clinic-based abortion care during the women's health movement of the 1970s to address perceived emotional, moral, and psychological needs related to abortion that physicians felt unprepared to handle (Joffe 2013). Although there has been considerable variation in styles of abortion counseling (Perrucci 2012; Baker 2009), three components are typical: obtaining informed consent, patient education about the procedure, and offering support related to the decision (Joffe 2013). Abortion counseling as an occupation underwent significant changes since it first emerged, in accordance with the rise of the anti-abortion movement and apparent changing emotional and psychological needs on the part of those seeking abortion (Joffe 2013). Self-described feminist abortion counselors historically disagreed about the appropriate elements of and approaches to counseling in

E.O. Singer (✉)
Sociocultural Anthropology, Washington University, St. Louis, MO, USA

B. Ostrach
Department of Family Medicine, Boston University School of Medicine, Boston, MA, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_16

clinic settings, which some regarded as paternalistic when it went beyond informed consent about medical aspects. While the earliest models of abortion counseling (referred to as the "political advocacy" approach) were highly politicized, positioning the counselor (and all clinic workers) as a patient advocate inside the clinic, a subsequent and more explicitly professionalized approach (called the "head and heart" approach) privileged women's emotions and emphasized resolving decisional conflict around the procedure and/or affirming and supporting women's right to seek a contested, widely stigmatized procedure (Joffe 2013). Despite divergences, most staff trained in these traditions maintain that abortion is distinct from other medical procedures by virtue of its politicized status, and that institutional woman-to-woman support in navigating what can be a highly stigmatized process is crucial (Baker 2009; Ostrach and Cheyney 2014). A failure to offer the option of in-depth counseling for patients who desire it, by unbiased and experienced counseling staff, according to many of those in the field, constitutes subpar care.

In this chapter we reiterate a brief background on the origins and development of abortion counseling in stand-alone clinics and examine current threats to comprehensive counseling, particularly in independent clinics, as well as the implications of these changes for patient care and work environments. In our original and auto-ethnographic research we observed a shift in the field of abortion care in the United States over the last decade, in which unhurried and unbiased counseling is under threat—all too often being phased out of abortion care, and instead being replaced with the bureaucratic formality of obtaining the minimum legally required informed consent, and little else (state-mandated biased "counseling" sessions notwithstanding).[1] We propose that these changes are the

[1] Many US states have seen a massive increase in abortion restrictions. One mandate requires so-called mandatory counseling, (often combined with waiting periods) that delay women from obtaining care and increase costs for women and providers. According to the Guttmacher Institute (State Policies in Brief: Counseling and Waiting Periods for Abortion), 35 states now "require that women receive counseling [sic] before an abortion is performed," twenty-seven of these states "detail the information a woman must be given." Twenty-six of these states "require women to wait a specified amount of time—most often 24 hours—between the counseling and the abortion." Ten states "require that counseling be provided in person and that the counseling take place before the waiting period begins, thereby necessitating two separate trips to the facility." To distinguish from this type of mandatory, biased counseling that promotes disproven myths about abortion safety, in this chapter we use the term "abortion counseling," and "counseling" primarily to refer to patient-centered, unbiased, evidence-based information, and support offered as part of normal clinical practice.

result of a confluence of overlapping political, regulatory, and financial factors externally, and internal conflicts between the roots of patient-centered approaches and business models now prevalent due to industry competition. Abortion providers in the United States continue to be subject to a political climate in which they are under constant threat from exponentially growing legislative restrictions,[2] receiving less funding due to reduced Medicaid reimbursements, and health insurance coverage limits. Freestanding abortion clinics are subjected to arbitrary physical plant requirements and regulatory constraints not applied to other similar outpatient surgical procedures. These various pressures, in our view and in accordance with the abortion counselors and patients whose accounts we analyze here, contribute to the devaluation of counseling in the clinic setting as, to use our participants' words, the "medical model" of care predominates over a "feminist model" of care. At the same time, increased competition from a large national reproductive health chain results in decreased availability of funds for independent providers and the slashing of workers' hours within independent clinics, which typically provide a wider spectrum of care, and which are also widely reported by participants who have worked in both settings to spend more time on counseling.

As Ostrach and Cheyney (2014: 1007) remind us:

> research suggests that women who perceive adequate social support during the process of seeking abortion care report feeling less affected by stigma, and suffer fewer negative physical and mental health effects resulting from abortion-related stigma.

Social support is identified as a crucial component in the ability to overcome obstacles to abortion and an integral factor in reducing effects of abortion-related stigma (Kumar et al. 2009). We argue that the trend toward reducing counseling and limiting counselors' time spent talking with patients may increase risks for those already vulnerable to structural abortion stigma, especially as political attacks on abortion mount.

We propose that understanding the value, and protecting the role of, comprehensive abortion counseling is critical not only to patient dignity

[2] In the last decade the United States has experienced a dramatic increase in restrictive abortion laws, particularly in states in the Midwest and Southern regions of the country (Gold and Nash 2013).

and quality of care, but also to reproductive health. Both authors worked directly in abortion clinics and extensively research abortion care and women´s experiences in the United States and internationally.[3] We each received training in models of abortion counseling that grew out of the women's self-help/health movements of the 1970s[4] (Morgen 2002). Our own bias is toward in-depth, patient-centered counseling, independent of the named ideology of the approach—as applied medical anthropologists, this is the lens we explicitly bring to our research. However, we documented and systematically analyzed what clinic staff said about what made for a supportive experience for their patients, as well as a rewarding work environment. Here we describe the troubling development in abortion care in the United States: a reduction in in-depth, unhurried, "feminist" abortion counseling. We argue that this type of counseling is an irreplaceable component of quality abortion care. We call on providers and advocates to ensure that it is not eliminated or further diminished.

The Birth of the Freestanding Abortion Clinic

Beginning in the 1950s, physicians in the United States, motivated by their direct and regular exposure to patients suffering medical complications due to self-induced or illegally procured abortions, spearheaded the movement for abortion reform (Joffe et al. 2004; Ginsburg 1998; Luker 1984; Morgen 2002; Ehrenreich and English 2005). With the rise of a mainstream, predominantly White middle-class feminist movement in the 1970s, tensions began to mount between pro-choice physicians seeking moderate abortion reform and feminist activists who sought wholesale repeal of existing abortion restrictions. Despite the noble intentions of many activist-physicians, some expressed concern that complete legalization would eradicate physician control over abortion. Women would newly determine when and for what reasons they could obtain abortion, and doctors feared that they would be reduced to mere "technicians," robbed of their diagnostic capacities (Joffe et al. 2004).

[3] At the time this chapter was first drafted in 2012, the authors had 16 years of combined work experience in independent clinics, and seven years of combined experience in clinic-based abortion research.

[4] The first author was trained in the more professionalized model and the second author in the more politicized model, discussed above.

The budding women's health movement was characterized by the twin goals of eradicating medical paternalism and democratizing the doctor–patient relationship, and brining reproductive health care back into women's "own hands" (Morgen 2002). Women had begun to take hold of their own reproductive processes even prior to abortion decriminalization (Bart 1987). In 1969, activists organized the *Jane Collective*, an underground abortion referral network in Chicago where women in search of safe abortion could turn for safe and reliable abortion counseling and procedures prior to federal legalization of first-trimester abortion. Jane activists teamed up with a sympathetic man whom they believed to be a trained physician. When it was revealed that he, in fact, had no formal training, the activists learned how to provide safe, clandestine abortions, literally taking abortion care into their own hands (Bart 1987), in but one example of such networks and clinic movements nationwide.

Although the passage of *Roe v. Wade* in 1973 should have ushered in a new era of expanded abortion care, in the years after the ruling, most medical-professional organizations did *not* establish abortion care guidelines or implement obligatory training in abortion provision for medical students (Joffe et al. 2004). Independent abortion clinics began to emerge to fill the void. These clinics were established through what Joffe et al. (2004: 775) call an "uneasy [alliance]" between pro-choice physicians and feminists who, despite political differences, agreed that first-trimester abortion should be available and accessible. Although feminist/independent clinic workers were dependent, in many cases, on (male) physicians to carry out procedures, they were careful to ensure that the medical services provided were acceptable according to their feminist standards. Pre- and post-abortion counseling, carried out by feminist activists, many of whom had experienced illegal abortion pre-*Roe*, was established as part of the commitment to woman-centered care (Joffe 2013).

Forty years after *Roe v. Wade*, most abortion procedures in the United States are conducted in freestanding clinics dedicated to abortion and other reproductive health care (Finer and Henshaw 2003). Since the inception of these clinics, several factors have threatened their existence. The separation of abortion care from other medical services means that anti-abortion activists can more easily target clinics and their clients, leading to an ongoing surge of violence against abortion clinics and providers beginning in the 1980s. Such attacks on clinics and clinic workers include the assassination of doctors and staff, sabotage and destruction of facilities, and on-site harassment and blockades to prevent patients and staff from

entering (Cozzarelli and Major 1994; Kumar et al. 2009). In addition to the direct violence all too often visited on or threatened against clinic staff, protestors regularly gather outside of abortion clinics, harassing, threatening and shaming patients and staff as they enter, or even blocking entrances—producing a climate of fear and stigma for women (Cozzarelli and Major 1994; Kumar et al. 2009).

In recent years, anti-abortion forces further organized to shut down clinics by leveraging the clause of *Roe v. Wade* that in the second trimester the state's interest in protecting "maternal" life allows it to regulate the environment in which abortions are performed. Many anti-abortion groups focus energies and monies toward reducing abortion access and hampering abortion providers by requiring clinics to meet standards of ambulatory surgical centers rarely applied to other comparable minimally invasive medical procedures such as vasectomies and Magnetic Resonance Imaging (MRIs) (Manian 2013). When clinics cannot meet these rigid standards, which often have very little to do with the provision of abortion, they are required to close down.

In this hostile political and cultural climate, and increasingly unstable economic climate, one consequence of the increasing financial and regulatory difficulties for independent clinics, in particular, has unfortunately been a de-prioritization of in-depth counseling. In an environment in which independent clinics are literally fighting to survive, time-consuming counseling is often seen by administrators as a luxury they cannot afford. As both authors work(ed) in and studied independent clinics, in the rest of this chapter we outline how political and other pressures impacted one-on-one counseling in these clinics, according to our coworkers and participants we previously interviewed, as well as based on the analysis of our field notes and auto-ethnographic experiences. First, we discuss our research methods, and then present case studies from clinics where we worked and conducted research.

Methods

We re-analyzed qualitative interview and participant-observation data collected in earlier institutional review board (IRB)-approved research on various aspects of abortion care in the United States. We re-analyzed transcripts and field notes with a focus on clinic workers' narratives about their intake or abortion counseling, as well as (in the case of the second author) re-analyzing interviews with women seeking abortion care for any mention of their

thoughts about clinic-provided counseling. Our combined data-sets[5] produced a total *n* of 33 transcripts. Experiences from a larger sample of women seeking abortion were also reflected in the transcripts we reviewed, in addition to accounts workers shared from other clinics where they had worked. Our inclusion criteria consisted of transcripts and field notes addressing aspects of the intake or counseling process. To enrich and triangulate our data, we auto-ethnographically (Spry 2001) drew on our own 16 years of experience in abortion work and research, respectively, as a counselor (first author), and as a medical assistant, counselor, and security director (second author) in various independent abortion clinics to code field notes and journals.

We engaged and sought to identify salient themes in clinic workers, "women seeking abortion," and our own accounts of clinic intake and counseling. Throughout the process we compared emerging themes and illustrative quotes to measure our degree of agreement or disagreement in the data-sets. We sought concept saturation on the topic of abortion counseling, re-coding all data until neither new themes nor new relationships between themes emerged, and discussed areas of divergence, to develop and refine our argument.

Results: The Need for In-Depth, Patient-Centered Abortion Counseling

Data for this section are drawn from research on occupational stress and stigma in abortion work conducted by the first author between 2011 and 2013. She conducted participant-observation and in-depth interviews with current and former counselors in a privately owned abortion clinic referred to as the Bay Clinic. Opened in 1974 in an industrial section of a Midwestern city, the Bay Clinic is one of few in the region providing full-spectrum abortion care up to 24 weeks' gestation. Anywhere from 5000 to 6000 women from across the United States seek abortion there annually. During the period of initial data collection, the Bay Clinic endured dramatic structural changes that had significant implications for the work of counselors, and for patient care. As these changes began to unfold, counselors' narratives shifted from a focus on stigma produced outside of the clinic, to workplace tensions within clinic walls—the lead author's research focus, and findings, changed accordingly.

[5] Respectively: first author's $n = 10$ (convenience sampling); second author's $n = 23$ (opportunistic, convenience and expert sampling).

The Bay Clinic had for years operated under what the former director of counseling called a "feminist model of care" and gained national acclaim for its deeply personal counseling style. Due to rising financial constraints, however, in 2013, the clinic abruptly adopted a new and whittled-down model of abortion counseling. The former director of counseling at the Bay Clinic, Ella Snow (pseudonym), trained in the "head and heart" model of abortion counseling, which emphasized the resolution of any existing conflict between a woman's choice to abort and her feelings (Joffe 2013). Ella went on to become a leader in the professionalized field of abortion counseling, innovating a model of second evaluations for women who expressed ambivalence about seeking abortion. She authored a book and several articles on abortion counseling. Ella described the Bay Clinic's approach to counseling as follows:

> The feminist model has to do with the respect of that woman … treating her holistically as a person who has emotions and may have a spiritual part of her. You want to give [her] as much empowerment and as many choices about how she is going to experience this process of ending the pregnancy [as possible]. You think about her as a whole person and not just as a … uterus that needs to be cleaned out.

According to Ella's interpretation of the "feminist model," the counseling protocol in the Bay Clinic included several elements: assessing emotional readiness for the procedure (including a second evaluation if necessary); exploring any emotional issues on the part of the patient if present; addressing spiritual or religious concerns if disclosed; helping the patient cope with statistically rare feelings of guilt, sadness or shame; explaining logistical details of the procedure and after-care instructions; providing referrals for mental health issues or other services if needed; discussing birth control options if relevant; and overseeing the process of informed consent. Importantly, built into this approach was the recognition that some women experience no conflict with regards to their abortion decision and thus receive truncated counseling sessions that are largely logistical. Ella related the benefits of this comprehensive model in an interview:

> It's always seeing and feeling the woman's demeanor change from frightened, anxious, ashamed, to after the counseling session … seeing that shift in her posture, in her eyes and in her voice. Sometimes you can even hear the voice go from very quiet and then louder until she's found her voice. And it's like I've helped validate what she's about to do.

The average counseling session lasted between 30 to 60 minutes. On a typical day, a counselor would see anywhere from three to six patients, depending on patient load and individual needs. Ella designed protocols to ensure that a counselor could provide as much time as needed for each patient, within reason. Counselors were not meant to feel rushed and addressing emotional, spiritual and other needs of the patient was primary.

One of the abortion counselors interviewed spoke to the importance of this approach in terms of ensuring emotional readiness for abortion, noting:

> I think it's important to have this counseling. I don't think you can just [have a patient] sign a consent form and go because you have people who don't know what they want [sic]. They think [abortion] is what they want until they start talking about it, or they have someone telling them that's what they want, and until someone actually listens to them, without anyone pushing them one way or another, they may not know what they want, or they may know but are too afraid to say it. I think it's important to take the time to discuss what they want.

In addition to tacitly acknowledging that clinic staff, in an unhurried intake, sometimes are in a position to discern coercion or familial/pattern pressure to abort when a patient does not in fact want to, as in cases of abuse, this quote also hints at what was lost in the transition to what clinic staff subsequently called the "medical model" when it was introduced to counselors as a way to accelerate clinic "flow," speeding up the progression of appointments ostensibly so that patients would not be kept waiting. Without this time, patients who desired to discuss the dynamics surrounding their abortions were denied this space to reflect with an unbiased listener. However, Ella and certain counselors understood the clinical transition as a strategy for the administration to cut expenses by shortening staff hours. Ella explained:

> In order to stay a viable entity, to be able to continue to provide the abortion procedure for people, administrators have to look at what ways we can cut overhead. It seems like the administrator looks at what isn't absolutely necessary for a woman to have an abortion … and it usually comes down to the counseling, the emotional, spiritual aspects of that experience. [The reason is] we can still get her through, more quickly, the fewer employees we have, so if we can't keep increasing our fees … we are going to see what else we can cut.

She continued, "Physical and medical [aspects] and efficiency are the hallmarks of the 'medical model' … getting into the person's emotions or spirituality isn't *time efficient* [emphasis implied in tone]."

With new pressures, administrators instructed counselors to eliminate discussion of spiritual and religious concerns, scale back discussion of emotional concerns and skip in-depth explanations of birth control options—to save time. Prior to these changes a typical counselor's shift lasted between five and six hours depending on patient load. After the changes were implemented, counselor shifts became two to three hours. Some counselors left the clinic and sought other employment—they could no longer earn enough to survive.

One counselor who had worked at Bay Clinic for three years explained, "Sometimes I get sad thinking about how expanded [this] clinic used to be and it seems like it has just gotten down to the bare bones and I wonder about the future and what that is going to look like." This worker was preoccupied not only with the impact of counseling cuts on her own hours and workload, but also with how the cuts affected patients' experiences. She outlined the role of the counselor:

> I try to validate people's feelings … because abortion isn't talked about, it has such a stigma … Some people don't even think they're allowed to feel [sad] … I think we are the best advocates for the patients. We are explaining everything … other parts of the building [other staff] don't necessarily sit down with patients and explain things in detail but we do, so we are probably the group that binds everything together ….

Other counselors expressed concerns that reducing counseling would produce harmful outcomes. Without the ability to discuss emotions, anxieties resulting from abortion stigma, and any other concerns prior to the procedure, they argued that women could be tenser in the operating room and might be at greater risk of moving during the procedure (risking uterine perforation from surgical instruments). The director of counseling noted rather grimly that without counseling:

> … patients are going to carry all of that angst with them and fear [that a counseling session could have assuaged] and they are going to … be more frightened, more scared, will therefore feel more pain, the whole thing will be a more negative experience than it needs to be.

In other words, according to many counselors at the Bay Clinic, counseling worked not only to ease the emotional concerns of patients; the effects

of counseling flow into the operating room to ensure that procedures are safer because patients are calmer. Discussions with staff members indicate that this perceived benefit of counseling is under-recognized by administrators or the physician(s) directly performing the surgeries.

Not every counselor regarded structural changes as wholly negative. Two counselors, though they regretted the diminishment of counseling, understood the changes as a way to keep the clinic open amid financial straits. They reasoned that by making changes the clinic would be able to help women on a broad scale rather than close its doors completely. One of these two noted that she did not feel the quality of patient care was compromised once administration implemented structural changes. She explained she continued to provide the care that she felt each patient needed, while trying to move faster. That not all counselors were on the same page about this issue underscores ongoing divisions among abortion counselors with regards to counseling protocols and approaches that have characterized the occupation since its inception, following *Roe v. Wade*.

In short, structural changes within the clinic, driven by external economic, political and legal pressures fundamentally altered the work of counselors, and according to the majority of those interviewed, have negative implications for the quality of patient care. Although some noted that shortening the time spent in counseling was a strategic way to keep the clinic financially viable and help more women overall, others explained that the option of in-depth, unhurried abortion counseling is an imperative component of respectful abortion care. Ella Snow, the director of counseling at the Bay Clinic and the first author's key informant, had worked in abortion counseling for nearly four decades and gained national recognition for her contributions, but resigned from her post in clinic the day these structural changes were announced to staff. She explained, through bouts of sobbing, that she could no longer work in a clinic that provided what was, in her professional opinion, subpar care while knowing all the while that they could do better.

Women and Clinic Staff Value Time to Talk to Each Other

In the earliest studies reviewed for this project (data collected 2008–2010, follow-up data collected 2012), the second author engaged in more than two years of ethnographic field work in an independent clinic in the Pacific Northwest that was, at that time, the only provider of second-trimester abortion services for most of one state and a provider for women seeking later care in a wider region for several more. It was the only independent

clinic outside of the largest metropolitan area in the region. Clinic staff were interviewed for two studies on obstacles to abortion access (Ostrach and Cheyney 2014; Ostrach 2014). Some of them had been trained in or by employees of explicitly feminist clinic founded by members of the 1970s feminist "self-health" movement (Morgen 2002), discussed the importance of abortion counseling/the intake conversation in helping patients feel supported while seeking care. However, staff discussed this part of the abortion appointment both directly and obliquely, and not always favorably. Harkening back to the earlier debates over "head and heart" versus a "political advocacy" approach to counseling (Joffe 2013), a medical assistant who had worked in the practice the longest argued that women arrived at the clinic already sure of their decision, and insisted that assuming patients need to talk about their abortion decision can seem paternalistic: "By the time women are here they don't want to rehash it. They're here, this is the end of the road, and whether it's a good end, or a bad end, it's here, and they're ready for it to just be over with!" However, this same counselor described the tension and pressure of feeling she could not spend enough time talking with patients about all the information they might need, and mentioned both "time and training" as critical to providing high-quality care.

Another medical assistant/counselor with the unique perspective of having come to the clinic in earlier years as a patient, now working there, discussed that women who came to this facility were treated with "dignity and respect," and mentioned her personal choice to include her own abortion experiences in the counseling she provided:

> I think that in a lot of intake situations I calm a nervous patient down by telling her, "this was my experience, and this is what I felt." I use that 70% of the time, I say it all the time, especially to really nervous people, women who haven't had previous abortions, younger women who are really worried. At first I didn't know if it was appropriate, to say whether or not I'd had an abortion, but you know a lot of women's questions, it gives them a real sense of peace when I can answer them from my own [abortion] experience[s].

This medical assistant's comments underscore the critical value of in-depth, unhurried care, and bespeak the importance of having sufficient time for nuanced conversations if patients desire this, where anxieties can be addressed, whatever the source may be.

Women seeking care at the clinic reported an array of reactions to clinic-based counseling, despite not being directly asked about this topic in either of the second author's studies at the site. About half of women interviewed did not mention counseling either directly or peripherally. The women who did discuss it primarily talked about how much it helped them feel at-ease, more comfortable, less nervous and so on. All women who mentioned their medical assistant by name or description talked about her being "nice," "patient" and "supportive. " Women who mentioned their assigned counselor consistently did so in the context of how they felt more supported during the overall process of seeking care, because of the counselor. "Madeleine," (pseudonym, as are all names in this chapter) a 20-year-old college student, mentioned how nice her counselor was, and how she told her (the patient), "everything I needed to hear." Another young college student, Evangeline, said of her counselor, "She made it really easy. She was really positive and understanding … as simple as, she smiled all the time."

A woman who had been to this clinic more than once made a point of complimenting one particular counselor:

> I've always gone to the same clinic, this last time, the lady that helped us was so great. She … made it feel like she cared and that she was really supportive, really informative, just really personable. We were more at-ease with the situation, just because of how she was.

In a follow-up study conducted two years later (Ostrach 2014), further research was conducted with staff at the same clinic. They all spontaneously mentioned increased pressure to see more patients in the same amount of time, and an overall drop in business, following the recent nearby opening of an expanded branch of a national reproductive healthcare chain which had not previously offered abortion care in the area, and a resulting siphoning-off of early, uncomplicated first-trimester patients. The counselors at the independent clinic that had been in the town for many years described how precipitously their business had fallen as a result, and reported a high level of anxiety about their clinic's ability to stay open with lower patient volume, when it had already been operating only two days per week but effectively meeting demand in the area while offering full-spectrum care from 4 to 24 weeks' gestation. Counselors described frustrations with spending less time with each patient addressing questions or concerns the patient might have, because of the pressure to see people

more quickly, needing to see more patients in less time, to be competitive and to save money. The clinic director's strategy for staying open in the face of sudden increased competition was to have clinic staff see as many patients during fewer staff hours.

The crux of this issue, whether to see more patients more quickly, or spend enough time with each patient to provide the highest quality of care, set up in this falsely dichotomous way, was also at the heart of an independent clinic closure that occurred in the same Pacific Northwest a decade before. As an employee of that clinic at the time, the second author auto-ethnographically documented rising tensions preceding the closure, as clinic increasingly expressed concerns to management about the impact on quality of care as the schedule was adjusted to see many more women each clinicday without increasing staff time. Counselors talked with each other, and with external union representatives, about the impact on patients when counselors were put in the position of seeing twice as many patients in the same amount of time. Within a week of the staff asking for an audience with the Executive Board, the facility abruptly closed, all staff were fired and patients were turned away without notice, and without follow-up medical care. While this situation was not directly reflected in the interview transcripts we reviewed, the earlier experience with expressing concerns about the impact of curtailed counseling time on patients resulting in firings and a clinic closure palpably informed some participants' sense of possibility for resisting similar pressures to reduce time spent with patients, about a decade later. Even those clinic workers who had not worked at the earlier clinic had been trained by counselors who had, or been trained by counselors trained by that earlier generation. The collective memory of a clinic being shut down after workers complained about reductions in staffing hours lingered in participants' conversations with each other, as reflected in the second author's fieldnotes.

Throughout, two themes emerged: those seeking abortion valued respectful, unhurried care and staff described an awareness of tension between seeing more patients, more quickly, because of external and internal pressures related to funding, political attacks, and increased competition from a national chain. Clinic staff and patients reported quality care includes adequate time, kind, patient, supportive counselors (as detailed by women seeking care); unhurried clinic staff who can answer all patients' questions without having to rush to the next procedure (as valued by clinic staff). As opposed

to complaining about times when they did *not* receive enough counseling, or get enough time with clinic staff, women highlighted what they *did* value about patient-centered, in-depth time with their intake counselors.

Illustrating how much this non-rushed attention from frontline clinic staff means to patients, one woman interviewed by the second author did complain that the doctor "barely looked at [her]" but then described in much greater detail how thoughtful and affirming the medical assistant who counseled her was: "she was really sweet, she took the time … she just made me feel better … even though I was at the clinic alone." Overall, the larger studies from which data were re-analyzed for this chapter found that social support helps women overcome obstacles to abortion access (Ostrach and Cheyney 2014; Ostrach 2014): in-depth, patient-centered counseling is a key form of that crucial support.

Discussion and Recommendations

We argue that structurally driven competition between seeing patients quickly versus providing quality care, exacerbated by the impacts of continuing external competition from business-model clinics, along with legislative pressures from a hostile political climate, together create a tension that is the driving force in reducing counseling time budgeted per patient in ever-dwindling independent abortion clinics. Staff in the clinical settings considered for this chapter place a high level of importance on the social support and unbiased information they provide through comprehensive counseling. Staff perceive that their counseling work helps women, and find reductions in the time they are allowed to spend counseling patients negatively affects not only their own working conditions but also the quality of care they provide. Concerns and tensions about the conflict between spending enough time on counseling and seeing more patients in less time had significant effects on workplace morale, and in one instance, likely contributed to the closure of one of the few abortion clinics in the state.

Our work further documents tensions between efficiency (driven by a capitalist desire for cost-savings), and quality care, seen in other health contexts (Castro and Singer 2004). This plays out particularly in independent abortion clinics that face unique budget constraints related to a multitude of external attacks and regulatory pressures from the political right, and competition from within their own industry. Notably, even

within clinics that have long offered comprehensive counseling, some workers feel patients will ask for the support they need, and that assuming all women need to be counseled on emotional aspects of abortion is presumptuous as per earlier debates among feminists about counseling. Yet, all clinic staff members interviewed agreed that pressure on intake/counseling time places patients at greater risk for stressful appointments or even emotional and physical complications—a fear borne out in the literature on physical and mental health risks of abortion-related stigma and the role of counseling and social support in mitigating effects of stigma (Kumar et al. 2009; Upadhyay et al. 2010). These tensions potentially affect not only staff, and those who seek care, but may also have downstream impacts on other health professionals. Future research is needed to determine whether various care providers encounter patients dealing with lingering negative effects of abortion-related stigma after undergoing abortion care *without* the option for unhurried, supportive counseling for patients who desire it.

None of these potential deleterious impacts, of course, would be the result of having an abortion per se, but rather are the result of the larger context of a cultural and sociopolitical environment in which the decision to determine when, with whom, and under what circumstances they feel equipped to carry a pregnancy to term are stigmatized, politicized, and under constant threat. All the more reason then that abortion providers, and those concerned with reproductive and public health, be empowered to ensure that people seeking abortion care have the option to speak with a trained, unbiased, clinic-based counselor who can spend as much time as needed with patients, in the face of persistent structural abortion stigma that increases reproductive morbidity risk (Kumar et al. 2009; Kumar 2013). It is our empirically and experientially based recommendation that, if abortion providers are to provide the highest quality care, unhurried, in-depth counseling time with patients must not be downsized or eliminated, especially in a political era in which threats to abortion are mounting precipitously and those seeking abortion confront increased stigma. In this embattled climate, the importance of maintaining and protecting time for in-depth abortion counseling grounded in the feminist history of reproductive health movements is all the more pressing.

CHAPTER 17

True Threats: Wanted Posters, Stalking, and the First Amendment

Mark Dorosin

On July 1, 2011, anti-abortion activist Phillip Benham was convicted in Mecklenburg County, North Carolina, Superior Court for misdemeanor stalking. In February 2010, Benham began distributing posters displaying the photograph, name, and address of Dr. Curtis Lee Flood, a Charlotte obstetrician and gynecologist working in three area medical clinics. The posters stated that Dr. Flood was "WANTED: by Christ, to Stop Killing Babies." Benham and others distributed and displayed the posters at the clinics and offices where Dr. Flood worked, as well as in his neighborhood and near his residence. The posters were very similar to the ones circulated in Wichita, Kansas, naming Dr. George Tiller, an abortion provider who was murdered in 2009 shortly after the posters appeared there. In 1993,

Since this article was first written, the US Supreme Court decided Elonis v. US (2015). The Court revisited the true threats doctrine, and concluded that the objective, reasonable person standard is insufficient to establish criminal liability, which it held requires evidence of some subjective intent to threaten. This new standard is expected to narrow the true threat exception to the First Amendment, thereby making it harder to prosecute cases like the one against Philip Benham.

M. Dorosin (✉)
University of North Carolina Center for Civil Rights, Chapel Hill, NC, USA

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3_17

the distribution of nearly identical "wanted" posters in Pensacola, Florida, was quickly followed by the murder of Dr. David Gunn, who had been specifically identified on the flyer.

Phillip Benham's conviction was overturned on a technicality by the North Carolina Court of Appeals in August 2012, but his lawyer had asserted that the conviction violated his First Amendment right to free speech. The court rejected Benham's claim, noting that "the First Amendment's protections are not absolute," and that constitutional protection does not extend to "true threats" (*State of North Carolina v. Phillip Benham*). Benham and others continue to argue that their protests and organizations are peaceful, that the "wanted" posters do not constitute a threat and cannot be causally linked to the violent actions of other individuals, and that the distribution of leaflets is the quintessential expressive activity protected by the First Amendment.

The tactical focus of anti-abortion activists of targeting individual doctors has broadened the scope of abortion-related litigation from substantive regulations on medical practices and procedures to the free speech implications of anti-harassment and stalking statutes, under which such targeting has been challenged. Abortion opponents contend that their actions, including the publication and dissemination of "wanted" posters that contain the names, addresses, phone numbers, and pictures of doctors, are protected by the First Amendment. Abortion rights advocates argue that because the circulation of these posters has been integrally related to violence committed against providers, their use is a "true threat," a category of expression that lies outside the constitutional protections of the First Amendment.

Courts considering the question of whether the use of "wanted" posters constitutes a "true threat" have focused on a contextual analysis to determine the key legal question: Was the target of these posters reasonably in fear of harm? In that sense, these cases turn on the "true" aspect of the threat. Given the history of violence (including murder) against doctors and abortion providers named in the posters, their use creates objectively reasonable fear among those persons identified, and therefore constitutes a true threat. Despite the fact that the posters themselves may contain no explicit threat and that these criminal actions were undertaken by third parties and not the individuals who published them, the use of such posters, viewed in the appropriate legal context, is not constitutionally protected speech.

The Limits of Free Speech

The US Supreme Court has consistently held that the First Amendment's guarantee of the right of freedom of speech sweeps broadly and, to function effectively, must necessarily protect speech that is controversial, unpopular, and offensive. "Constitutional protection does not turn upon the truth, popularity or social utility of the ideas and beliefs which are offered" (*New York Times v. Sullivan*). Additionally, the Court has specifically noted that "Speech concerning public affairs is more than self-expression; it is the essence of self-government" (*Garrison v. Louisiana*). Political speech—which relates particularly to matters of general public concern—is central to the foundational principle of free expression and should be accorded even greater deference.

Despite the generally expansive judicial interpretation of the First Amendment, free speech is not without limitations. The Court has consistently held that reasonable "time, place and manner" restrictions can be imposed on otherwise constitutionally protected speech (*Ward v. Rock Against Racism*). In the abortion rights context, these restrictions are manifest in limitations on how close abortion protesters can get to clinic entrances, where posters or other displays can be set up, the use or level of sound amplification in demonstrations, and specified hours for picketing (especially in residential neighborhoods) (*Madsen v. Women's Health Center*).

In addition to these restrictions, there are several categories of speech that are considered exceptions to the First Amendment and not entitled to its legal protection. These include defamation, obscenity, incitement, fighting words, and true threats. While the legal issues surrounding the targeting of abortion providers and doctors often encompass time, place, and manner restrictions, the questions expressly related to the dissemination of "wanted" posters focus primarily on the true threats doctrine, and necessarily, its relation to the jurisprudence of incitement.

Incitement

In *Brandenburg v. Ohio*, a leader of the local Ku Klux Klan was convicted of violating Ohio's "anti-syndicalism" law for making a speech advocating breaking the law and the use of violence. In reversing the conviction (and declaring the statute unconstitutional), the Court unanimously stated that the First Amendment does "not permit a State to forbid or proscribe

advocacy of the use of force or of law violation except where such advocacy is directed to inciting or producing imminent lawless action and is likely to incite or produce such action" (*Brandenburg v. Ohio*).

The Brandenburg decision expanded constitutional protection to speech expressly advocating violence provided that, given an analysis of the context of the speech, it was unlikely to incite immediate violent activity. Following Brandenburg, the determination of any incitement based encroachment on the First Amendment would no longer rely merely on whether the speaker advocated violence or criminal activity, but rather on a close review of the circumstances surrounding the advocacy, including the setting, the language, the speaker's intent, and the audience.

True Threats

At an anti-Vietnam War protest in 1967, Robert Watts publicly announced that if he were forced to carry a rifle "the first man I want to get in my sights is L.B.J." (*Watts v. United States*). Although the statement elicited laughter from his fellow demonstrators, Watts was subsequently convicted of violating a federal statute that prohibits making any threat to harm the President of the United States. In its consideration of the case, the Supreme Court first established that true threats were not entitled to First Amendment protection. "What is a threat must be distinguished from what is constitutionally protected speech" (*Watts v. United States*). The Court then went on to analyze whether Watts's conduct constituted a true threat, and ultimately determined that it did not and was therefore within the bounds of the First Amendment. Examining the context of the purported threat, the Justices concluded that the speech was crude political hyperbole and that "regarding the expressly conditional nature of the statement and the reaction of the listeners, we do not see how it could be interpreted otherwise" (*Watts v United States*).

What is most significant about the holding in Watts is the Court's highlighting of the inherent tension between the true threats doctrine it affirmed and the First Amendment, and the concomitant need to view this exception closely and narrowly. Accordingly, "a statute such as this one, which makes criminal a form of pure speech, must be interpreted with the commands of the First Amendment clearly in mind" (*Watts v. United States*). In effect, the Court emphasized the "true" component, recognizing that some otherwise facially or generally threatening speech would nonetheless be entitled to constitutional protection.

Although focused on independent exceptions to the First Amendment protections for free speech, both Brandenburg and Watts reflect a narrowing of their respective doctrines and a parallel expansion of this fundamental right. Each decision recognizes that an appropriate analysis of the exception at issue must look beyond the mere language or content of the expression and consider external factors, including the context of the statement and its actual or anticipated impact on other parties.

These common elements have led many courts to blur the distinction between the two doctrines. There are some critical differences to keep in mind, however. Incitement does not necessarily target an individual (it can be directed at property, for example). Additionally, incitement requires the involvement of a third party (the party to be incited into action) and generally must include some aspect of immediacy or imminence. True threats doctrine, on the other hand, focuses on whether the communication of the speaker invokes reasonable fear in the targeted victim. The issues of immediacy or the role of third parties may inform the question of whether the fear is reasonable, but are not fundamental elements of a true threat. While Watts clearly established that true threats were not protected by the First Amendment, it took subsequent decisions by the Supreme Court and the federal appellate courts to more effectively define the line between a true threat and constitutionally protected advocacy. Later rulings also helped clarify the intent and scope of the true threats doctrine.

In *R.A.V. v. City of St. Paul* the Court explained that the exclusion of true threats from the shelter of the First Amendment is based on society's responsibility in "protecting individuals from the fear of violence, from the disruption that that fear engenders, and from the possibility that the threatened violence will occur" (*R.A.V. v. City of St. Paul*). In a later case reviewing the constitutionality of a Virginia statute that prohibited cross-burning, the Court explained that "true threats" encompass those statements where the speaker "means to communicate a serious expression of an intent to commit an act of unlawful violence to a particular individual or group of individuals" (*Virginia v. Black*).

The courts of appeal are divided over whether Black created a new, higher standard of proof for true threats. The Fourth Circuit Court of Appeals (whose jurisdiction includes North Carolina) explained that to determine whether the speech at issue constitutes a true threat, the state needs to show: first, the defendant had the general intent to transmit the communication; and second, a reasonable person familiar with the context of the speech would interpret it as a threat of physical harm or danger.

The court considered and expressly rejected a more narrow interpretation that would have required that the statement be communicated "with the specific intent" that the intended target subjectively feel threatened. Although not as restrictive, the court held that the general intent of the speaker and the objective "reasonable person" standard for the recipient satisfied the constitutional limitations of the First Amendment (*United States v. White*).

Other appellate cases provide further guidance on true threats, determining that a threat need not include specific intent to harm or injure ("The fact that a threat is subtle does not make it less of a threat.") (*United States v. Gilbert*); that there is no requirement that the defendant actually intended to carry out the threat (*United States. v. Hoffman*); or that the threat need not identify any specific person (*United States v. Cox*). While acknowledging the critical First Amendment issues at the core of true threats cases, "*even where the threat is made in the midst of what may be other protected political expression* … the threat itself may affront such important social interests that it is punishable absent proof of a specific intention to carry it into action" (emphasis added) (*United States v. Kelner*).

Despite these and other judicial attempts to more clearly identify the line between true threats and protected speech, several critical questions remain, many of which highlight the overlapping aspects of the doctrines of incitement and true threats. Must there be some time limitation or imminence component for a statement to be reasonably perceived as a threat? Can true threats encompass potential harm or injury by third parties, or is the doctrine limited to perceived harm caused by the party making the statement? These questions became the central focus of the landmark abortion protest litigation, *Planned Parenthood of the Columbia/Williamette Inc. v American Coalition of Life Activists* (hereinafter "*ACLA*").

The Freedom of Access to Clinic Entrances Act and True Threats

The Freedom of Access to Clinic Entrances Act (FACE) was adopted in 1994 and established "criminal penalties and civil remedies for certain violent, threatening, obstructive and destructive conduct that is intended to injure, intimidate or interfere with persons seeking to obtain or provide reproductive health services" (U.S. Pub. Law No. 103–259 §2). The legislation provided that "the term 'intimidate' means to place a

person in reasonable apprehension of bodily harm to him or herself or to another" (18 U.S.C. § 248(e)(3)). The law also specifically states that it cannot "prohibit any expressive conduct … [or] create new remedies for interference with activities protected by" the First Amendment (§ 248(d)(1) and (2)).

FACE was adopted in response to increasingly aggressive anti-abortion protests and demonstrations designed to block access to clinics and, more significantly, in response to violence and criminal activity targeting abortion clinics and providers. In the years immediately preceding the adoption of FACE, incidents of annual clinic violence, including vandalism, death threats, bombings, and arson, increased from approximately 95 to 452 (National Abortion Federation; Sneirson 640). The year 1993 also marked a tragic milestone in anti-abortion violence: the March 10th murder of Dr. David Gunn, a Florida abortion provider who had been the target of a sustained campaign of harassment that included the circulation of "wanted" posters featuring his photo, phone number, and work schedule (Baird-Windle & Bader, 110).

United States v. Dinwiddie was one of the first cases to consider the constitutionality of FACE. Long-time anti-abortion protestor Regina Dinwiddie was convicted of violating several elements of FACE, including the prohibition on threats against providers. Dinwiddie publicly, and often through a bullhorn, issued warnings to Dr. Robert Crist, at one time advising him to "remember Dr. Gunn. … This could happen to you. … He is not in this world anymore." She also told the executive director of the local Planned Parenthood "you have not seen violence until you see what we do to you," and had previously advocated for the use of deadly force to prevent doctors from providing abortion services (*United States v. Dinwiddie*).

Dinwiddie challenged her conviction on the grounds that FACE violated her First Amendment rights. In determining whether Dinwiddie's statements constituted true threats, and thus were not protected free speech, the court reviewed the specific facts of the case: that the threatening statements were not conditional; that they were communicated directly to the victims; that they had been repeated in various forms and numerous times; and that Dr. Crist took the threats seriously and reasonably feared bodily harm (he began wearing a bullet-proof vest). Dinwiddie argued that because she never expressly said to Dr. Crist "I am going to hurt you," his fear of harm was unreasonable and that her statements could not be considered threats. The court disagreed, relying on the

overall context in which the threatening statements were made. "The fact that Mrs. Dinwiddie did not specifically say … that *she* would injure him does not mean that … [the] comments were not threats of force" (*United States v. Dinwiddie*).

Dr. Crist was also one of a group of doctors and clinics that brought a groundbreaking lawsuit under FACE against several anti-abortion organizations and activists, claiming that the dissemination of a series of "guilty" and "wanted" posters, and the creation of a Web site which identified abortion providers and tracked violence against them, violated the statute's prohibition on intimidation and threats. Following a jury trial which found in favor of the doctors, and a reversal of that verdict by a three-judge panel of the Ninth Circuit Court of Appeals, the full appellate court reinstated the jury verdict and decisively established the applicability of the true threats doctrine to "wanted" posters and other implicit threats. Dissenting opinions in the case also clarified the ongoing First Amendment issues true threat claims present (*ACLA*).

In January 1995, the ACLA defendants released a "Dirty Dozen" poster captioned "Guilty of crimes against humanity," and identifying the plaintiff doctors. The poster included the doctors' names and home addresses, and offered a $5000 reward "for information leading to arrest, conviction and revocation of license to practice medicine." In the 22 months preceding the release of the Deadly Dozen poster, abortion providers Dr. David Gunn, Dr. George Patterson, and Dr. John Britton had been murdered. Prior to each of the murders, "wanted" posters similar to the ones now published by the defendants had been disseminated in the doctors' respective communities. The defendants also helped publish and promote the Nuremberg Files Web site, which listed approximately 200 names under the heading "Abortionists: the Shooters." The Web site included a legend: "Black font (working); Greyed-out Name (wounded); Strikethrough (fatality)." Drs. Gunn, Patterson, and Britton all appeared on the list, crossed out (*ACLA*). The jury found that neither the posters nor the Web site was protected under the First Amendment and ruled in favor of the plaintiffs.

The defendants' core argument began with the premise that none of the expression at issue contained direct or explicitly threatening language. It was therefore improper for the court to transform what was fundamental political advocacy into unprotected threatening speech by imputing to that speech a context of external violence or the independent actions of third parties (i.e., the murders of the other doctors). The defendants

also argued that, because there was no specific threat in either the posters or on the Web site, the proper judicial doctrine under which to evaluate their First Amendment claims was not true threats but incitement, which would clearly demonstrate that the speech was constitutionally protected. In evaluating and ultimately rejecting this argument, the appellate court first reaffirmed the controlling definition of a true threat: "a statement which, in the entire context and under all the circumstances, a reasonable person would foresee would be interpreted by those to whom the statement is communicated as a serious expression of intent to inflict bodily harm upon that person" (*ACLA*). As to the appropriateness of considering context, the court reviewed the true threats precedents and determined that "context is critical in a true threats case and history can give meaning to the medium" (*ACLA*).

Having decided that examining the context of the speech at issue was appropriate, the court then noted that, while the very first "wanted" poster may have been a purely political statement when issued, because of the history of the murders of abortion providers following the release of posters specifically identifying them, "the poster format itself had acquired currency as a death threat for abortion providers" (*ACLA*). Further, the court concluded that the defendant intentionally included the plaintiffs' names on a nearly identical poster to intimidate them. The court also held that the listing of the doctors' names on the Nuremberg Trials Web site, along with the annotations for providers who had been wounded or murdered, was not purely political speech protected by the First Amendment. "In conjunction with the 'guilty' posters, being listed on a Nuremberg Files scorecard for abortion providers impliedly threatened physicians with being next on a hit list" (*ACLA*).

Conceding that the posters did not contain expressly threatening language, the court nonetheless recognized that the "poster pattern" (where a poster naming a specific doctor appeared and that doctor was subsequently killed) constituted a true threat. The speech was specifically targeted, and was not conditional, casual, or extemporaneous, nor could it be considered mere political hyperbole. The posters were a true threat because "they connote something they do not literally say, yet both the actor and the recipient get the message. To the doctor who performs abortions, these posters meant "'You're Wanted or You're Guilty; You'll be shot or killed'" (*ACLA*). The speech was thus outside the protections of the First Amendment and the verdict against the anti-abortion activists affirmed.

The court of appeals was closely split, 6–5, with dissenting opinions by Judges Stephen Reinhardt, Alex Kozinski, and Marsha Berzon, all of whom argued that the majority opinion punished constitutionally protected speech. Judge Reinhardt wrote that "public speech in a public arena" is fundamentally different than private speech aimed at an individual, and that the former places a higher burden on the state to prove the need to regulate such speech. He also suggested that the true threats exception to the First Amendment is limited to "private threats delivered one-on-one" (*ACLA*). Judge Kozinski argued that a statement cannot be a true threat unless it "warns of violence or other harm *that the speaker controls*" (*ACLA*, emphasis added). He also challenged the majority's "poster pattern" theory, noting that, beyond the posters themselves, there is no evidence that the defendants intended to or took any steps to harm the plaintiffs, and that given that the posters do not make a specific, explicit threat, they are protected political advocacy. While not discounting the evidence that the plaintiffs were put in actual fear by the actions of the defendants, Judge Kozinski asserts that this was a general fear from being publicly singled out and identified, and that such reaction cannot change the nature of the speech at issue. "From the point of view of the victims, it makes little difference whether the violence against them will come from the makers of the posters or from unrelated third parties; bullets kill their victims regardless of who pulls the trigger. But it makes a difference for purposes of the First Amendment" (*ACLA*). Judge Berzon also argued that the majority's reading of true threats is simply too broad. Specifically, she concluded that speech is much more likely to be a true threat when communicated directly to the target (as opposed to being part of a public protest). In the narrow class of cases involving true threats and public speech (like the abortion protests), Judge Berzon (and Judge Kozinski) would impose a higher intent standard than the majority's "reasonable speaker," and require a finding that "the defendant subjectively intended the specific victims to understand the communication as an unequivocal threat that the speaker or his agents or coconspirators would physically harm them" (*ACLA*).

ACLA highlights the inherent challenge in applying the true threats exception in cases involving substantive political advocacy. At bottom, the divergent opinions in the case turn on the fundamental question of the intent of the speaker. Judge Rymer's majority opinion reaffirmed the use of an objective standard, one that requires only that the speaker could reasonably foresee that the statement would be interpreted by the listener

(with consideration of the relevant context) as communicating an intent to harm. The dissenting opinions consider this too broad for cases involving political speech, arguing instead for a subjective standard, requiring proof that the speaker specifically intended that the listener would consider the speech a threat. Given the evidentiary challenges in determining a speaker's state of mind however, such proof would likely be limited to explicitly threatening statements conveyed directly to the intended target, thereby substantially narrowing the true threats exception. Despite the closely split appellate decision and the ongoing First Amendment questions inherent in evaluating implicit threats, the US Supreme Court refused to review the case (*ACLA*). The circuit courts of appeal continue to struggle with the appropriate standard, particularly in light of the ambiguous language in *Virginia v. Black*.

Stalking

In addition to the legal protections provided by federal law pursuant to FACE, state anti-stalking laws can also be used to address the use of flyers and other aggressive tactics of anti-abortion protestors. The US Department of Justice Office for Victims of Crime defines stalking as "a course of conduct directed at a specific person that involves repeated visual or physical proximity; nonconsensual communication; verbal, written, or implied threats; or a combination of these actions that would cause a reasonable person to feel fear." While the specific provisions of anti-stalking laws vary by state, this generally applicable definition encompasses two critical aspects related to the use of "wanted" posters by abortion protestors: the inclusion of implicit threats, and the reasonableness of the victim's reaction to the communication.

North Carolina's anti-stalking statute begins with an acknowledgment that stalking "causes a long-lasting impact on the victim's quality of life and creates risks to the security and safety of the victim and others" (N.C.G.S. § 14–277.3A(a)). This language echoes the prevailing jurisprudence regarding the legal rationale for excluding true threats from First Amendment protection (see, e.g., *R.A.V. v. St. Paul*). The introductory section of the North Carolina law also states that it is designed to "hold stalkers accountable for a wide range of acts, communications and conduct … regardless of the means" (N.C.G.S. § 14–277.3A(a)).

In describing the elements of the offense itself, North Carolina law requires that a defendant willfully, on more than one occasion, harasses or

engages in a course of conduct, *without legal purpose*, that the defendant knows or should know would cause a reasonable person to fear for their safety or suffer extreme emotional distress (N.C.G.S. § 14–277.3A(c)) (emphasis added). The statutory definitions of both "harasses" and "course of conduct" include written and verbal communications, and thereby potentially encroach on the First Amendment (as opposed to statutes that only refer to prohibited conduct (e.g., following, monitoring, surveillance, or observation) (see, N.C.G.S. § 14–277.3A(b)(1) and (2)). The requirement that the actions of the defendant are without legal or legitimate purpose, however, is designed to ensure that any otherwise constitutionally protected conduct is not subject to criminal liability (Sneirson 660). Additionally, most stalking statutes attempt to comport with the First Amendment by including a requirement that the challenged actions would cause "a reasonable person" to be placed in fear (N.C.G.S. § 14–277.3A(c). See also, e.g., O.C.G.A. § 16-5-90, "placing a person in reasonable fear" by behavior "which serves no legitimate purpose" (Georgia); Fla. Stat. §784.048, conduct that "serves no legitimate purpose" and places a person "in reasonable fear" for their safety; NY CLS Penal § 120.45, conduct that "for no legitimate purpose … is likely to cause reasonable fear of material harm").

With the constitutionally necessary inclusion of provisions that the defendant's actions be without legal purpose, state stalking statutes indirectly incorporate the true threats doctrine into any case involving expressive activity. As a result, despite the broad goals and potentially streamlined legal process offered by anti-stalking statutes, in an abortion protest/"wanted" posters scenario, these cases still require some detailed consideration of the First Amendment impacts.

Michael Ross challenged the constitutionality of Montana's anti-stalking statute following his conviction in 1993. Over a two-month period, Ross sent over 60 letters to Dr. Susan Wicklund, the owner and operator of the Mountain Country Women's Medical Clinic. These letters repeatedly referred to Dr. Wicklund as a "mass murderer" and a "butcher." The day after the murder of abortion provider Dr. David Gunn, Ross sent another letter to Dr. Wicklund, writing, "Too bad about Dr. Gunn in Florida. I wonder, could it happen in Bozeman? I wonder …" Dr. Wicklund testified that these letters caused her to substantially fear for her safety, leading her to hire a security guard and to purchase a bullet-proof vest and a handgun (*State v. Ross*).

In rejecting the defendant's First Amendment argument, the Montana Supreme Court began with an analysis of the statute, which had been

amended following a federal court decision finding that the previous version was overbroad and encroached on free speech. The revised statute, the court noted, specifically included language that the threat of harm be made "under circumstances which reasonably tend to produce a fear that it will be carried out" (*MCA* 45-5-203), and that this narrowing language ensured that the statute was constitutional as written (*State v. Ross*). Then considering both the text of the letters to Dr. Wicklund and "the context of the abortion debate in this country" (which included the recent arson of another Montana clinic), the court ruled that the letters went beyond mere advocacy and met the statutory criterion that the fear their contents invoked be "reasonable." The court thus concluded that "the totality of Ross's letters, taken in the context in which they were written, constitute threats … not protected speech under the First Amendment" (*State v. Ross*).

Analyzing a similar constitutional challenge to Oregon's anti-stalking statute, the appellate court there held that to comply with the First Amendment, the law could only circumscribe expression that specifically represents a threat such that an "objectively reasonable person … would fear for his or her personal safety." The court ultimately reversed a ruling against the anti-abortion activists, asserting that the statements and actions in question did not constitute a threat (*Hanzo v. deParrie*). At issue were a series of incidents and actions targeting the executive director of the All Women's Health Center in Portland. The protests were led by Paul deParrie, the leader of the anti-abortion organization Advocates for Life Ministries, who had previously signed statements calling the murders of abortion providers "morally defensible" and "justifiable," and who called a woman who shot and wounded another doctor "a hero" (*Hanzo v. deParrie*). The challenged actions included several demonstrations in front of Ms. Hanzo's home; the delivery of a magazine to her home that referred to abortion providers as "child killers"; a postcard sent to Ms. Hanzo featuring a fetus on a cross with the note "Please stop killing kids"; and the mailing of a flyer entitled "The Abortionists Have Been Exposed!" that included the pictures, names, addresses, and phone numbers of several abortion providers, including Ms. Hanzo (*Hanzo v. deParrie*).

In assessing these contacts and communications, the Oregon court rejected the prevailing legal trend regarding the consideration of context of anti-abortion protests and violence against providers. The court discounted both the external evidence of increasing violence aimed at providers and the public statements of the defendant endorsing such violence.

Instead, the court took a restrictive posture, emphasizing that none of the communications in question advocated the use of violence against providers and highlighting the absence of any evidence that the defendants themselves had previously engaged in violence or encouraged others to do so (interestingly, the court's opinion cited Brandenburg rather than any of the true threats cases). The court concluded that none of the actions or communications constituted a threat, and were therefore protected by the First Amendment (*Hanzo v. deParrie*).

State v. Benham

Although the North Carolina Court of Appeals overturned the defendant's stalking conviction on a technicality, *State v. Benham* provides a comprehensive review of the intersection among anti-stalking legislation, the use of "wanted" posters, and the scope of the First Amendment. Phillip "Flip" Benham has been a national leader of the anti-abortion movement since the mid-1990s, when he served as the national director of both Operation Rescue and later Operation Save America (OSA). In summer 2009, OSA began a series of protests at the clinics of Dr. Curtis Lee Flood, a provider of a range of reproductive health services, including abortion. On one visit, Benham left a "wanted" poster with Dr. Flood's picture, name, and office address, and warned the assistant that the posters would be publicly distributed if Dr. Flood continued to perform abortions (*State v. Benham*). In early 2010, Benham and others began distributing the "wanted" posters throughout the office building and in the parking deck, and around Dr. Flood's neighborhood. Believing that the posters were a "call for [his] death," Dr. Flood contacted the Charlotte police, who charged Benham with misdemeanor stalking. Benham was convicted and given 18 months of probation and ordered to stay away from Dr. Flood's home or offices, to not produce or distribute any "wanted" posters or other literature referencing Dr. Flood, and to remove any references to the doctor from the OSA Web site (*State v. Benham*). Among the evidence introduced at trial was testimony about the murder of Dr. George Tiller, a Kansas abortion provider who was killed in May 2009, shortly after "wanted" posters were distributed in his community. The "wanted" poster of Dr. Tiller itself was also introduced as evidence in the trial.

On appeal, Benham challenged his conviction on First Amendment grounds, and specifically contested the trial court's admission of any evidence related to the murder of Dr. Tiller (*Brief of Defendant-Appellant,*

State v. Benham). Although the court reversed the conviction and ordered a new trial on technical grounds, it determined that the constitutional questions were likely to be raised again and so undertook a detailed First Amendment review. The court focused on *Virginia v. Black* and whether the ruling established a strict intent standard for true threats (i.e., whether the speaker is required to have subjectively intended to communicate a threat and induce fear in the target). Relying on the Fourth Circuit ruling in *United States v. White*, the North Carolina Court of Appeals adopted an objective standard of review, examining whether a reasonable recipient familiar with the context would be put in fear of harm (a "reasonable hearer" standard). The court noted that under the anti-stalking statute, the state had the additional burden to prove that the defendant knew or should have known that his actions would cause the target to fear for his safety.

The court then considered the evidence, beginning with the "wanted" poster, which it said "is beyond an ordinary leaflet" (*State v. Benham*). Relying on Benham's testimony about his involvement with the anti-abortion movement and his familiarity with the history of similar posters and the related murders of abortion providers, the court concluded that "he knew, or should have known, that by communicating the message to Dr. Flood through a WANTED poster would place Dr. Flood in fear" (*State v. Benham*). Turning to the question of whether Dr. Flood's reaction to the posters was reasonable, the court looked to context, and specifically at the fact that three other doctors had been murdered after the circulation of similar posters. The court also noted that following the publication of the posters, Dr. Flood's behavior demonstrated that he had been placed in fear—he changed his route to work, tinted the windows of his car, and avoided rooms in his home with large windows (Dr. Barnett Slepian had been killed by a long-range rifle through the window of his home).

The issue of whether Dr. Flood's reaction to the "wanted" poster was reasonable also provided the basis for the court's determination that the admission of evidence related to Dr. Tiller was appropriate. Although Benham argued that OSA was a non-violent organization and that the "guilt by association" of crimes committed by others was overly prejudicial, the court disagreed. "The purpose of the Tiller poster was to show that WANTED posters in the past had resulted in violence and therefore, it was relevant to prove the reasonableness of Dr. Flood's concern about the possibility of violence against him" (*State v. Benham*). The court's statement about the Tiller poster distills the essence of all true threat cases and particularly those involving implicit threats (e.g., the "wanted" post-

ers): that consideration of context is critical in making the reasonableness determination upon which the constitutionality of the true threats doctrine rests. As the Ninth Circuit noted, the very first "wanted" poster may not have met the true threats standard, because absent the context of violence, any fear experienced by the person named would likely not be considered reasonable. In making the reasonableness determination in Benham's case, "[I]t was relevant for the jury to learn that the WANTED posters in the past resulted in violence" (*State v. Benham*).

The court's analysis of true threats and the First Amendment effectively resolved the statutory requirement that the defendant's actions be "without legal purpose" (N.C.G.S. § 14–277.3A(c)). Despite Benham's assertion that his actions were protected not only by the free speech but also the free exercise of religion provision of the First Amendment, the court's determination that the posters constituted a true threat meant their distribution was not a constitutionally protected activity. Citing *Chaplinksy v. State of New Hampshire*, "Even if the activities … could be viewed as religious in character …, they would not cloak him with immunity for the legal consequences for concomitant acts committed in violation of a valid criminal statute." Similarly, the fact that Benham had secured municipal permits for the demonstrations outside Dr. Flood's clinic did not insulate him from liability for stalking.

Conclusion

Anti-abortion activism focused on reducing the availability of medical services by targeting doctors and providers has shifted the constitutional debate from the fundamental right to abortion to the scope of the First Amendment. Free speech protections, while broad, nonetheless exclude certain categories of expression which "are of such slight social value as a step to truth that any benefit that may be derived from them is clearly outweighed by the social interest in order and morality" (*Chaplinksy v. New Hampshire*). True threats—those expressive communications of potential harm or injury that would cause reasonable person to fear for their safety—are among those excluded categories. The challenge for courts is determining when aggressive and controversial political advocacy crosses the line from constitutionally protected speech and becomes a true threat. This issue is at the core of prosecutions of abortion protesters not only under federal clinic access legislation, but also under state anti-stalking statutes.

The use of "wanted" posters by anti-abortion activists highlights the legal challenges inherent in the true threats analysis. Abortion opponents argue that the posters themselves contain no explicitly threatening language, and that their free speech rights cannot be constrained based on potential criminal actions of third parties over whom they have no control. Abortion rights advocates contend that the repeated murders of doctors named in the posters following their dissemination makes their use a true threat and thus beyond the protection of the Constitution. Most cases that have examined this issue have determined that, because context is an essential element to analyzing whether the recipient was reasonably in fear of harm or injury, the violence surrounding the circulation of these posters can properly be considered by the courts. As the North Carolina Court of Appeals emphasized in the Benham case, both the defendant and the doctor were aware of the history and relationship between the "wanted" posters and violence; that awareness is what makes the posters so intimidating and the fear they created so reasonable and foreseeable. Thus, "[t]he WANTED poster … is beyond an ordinary leaflet"; it is a true threat.

Bibliography

(1833). *Report of the Examination of David Gibbs, Fanny Leach and Eliza P. Burdick for the Alleged Murder of Sally Burdick at Coventry, RI, on the 18th Feb. 1833*. Hartford: Hanmer and Comstock.

(1871). *The Trunk Tragedy: Or, The Late Mysterious Murder in New York of the Young and Lovely Miss Alice A. Bowlsby, of Patterson, N.J.* Philadelphia: C. W. Alexander.

(1892). Report from the Select Committee on Midwives Registration: Reports, Proceedings, Evidence, Appendix, and Index. *Parliamentary Papers, XIV*(289), 1–182.

(1896). *The Mysterious Murder of Pearl Bryan, Or, The Headless Horror*. Cincinnati: Barclay & Co.

(1898, March). *Old Bailey Proceedings Online* (version 7.0), trial of AMELIA HOLLIS.

(1898, March 11). Central Criminal Court A. *The Times*, p. 3. *Times Digital Archive*.

(1899, February 10). Central Criminal Court B. *The Times*, p. 3. *Times Digital Archive*.

(1903, December). *Old Bailey Proceedings Online* (version 7.0), trial of AMELIA HOLLIS and FREDERICK WILLIAM THOMPSON (30).

(1905, August 14). The Police Courts. *The Times*, p. 12.

(1906, July). *Old Bailey Proceedings Online* (version 7.0), trial of HOLLIS, Amelia (51, midwife).

(1908). Report from the Joint Select Committee on Lotteries and Indecent Advertisements; with the Proceedings of the Committee, Minutes of Evidence, Appendices, and Index. *Parliamentary Papers, IX*(275), 375–512.

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3

(1909a). Report of the Departmental Committee to Consider the Working of the Midwives' Act, 1902. Vol. 1: Report and Appendices. *Parliamentary Papers, XXXIII*, 19–76.
(1909b). Report of the Departmental Committee to Consider the Working of the Midwives' Act, 1902. Vol. 2: Minutes of Evidence and Index. *Parliamentary Papers, XXXIII*, 77–339.
(1911, May). *Old Bailey Proceedings Online* (version 7.0), trial of SADLER, Annie Marion (43, midwife).
(1911, June). *Old Bailey Proceedings Online* (version 7.0), trial of SADLER, Annie Marion (43, midwife).
(1911, June 9). Charge against a Nurse. *Daily Mail*, p. 6.
(1914, January 16). Illegal Operations. *The Times*, p. 46.
(1914). Report from the Select Committee on Patent Medicines; with the Proceedings of the Committee, Minutes of Evidence, Appendices, and Index. *Parliamentary Papers, IX*(414), 1–949.
(1925, July 21). Judge on Birth Control. *The Times*, p. 11. *Times Digital Archive*.
(1929, April 14). Film Actress's Death. *The Observer*, p. 22.
(1929, April 15). Piece of Paper at Inquest. *Daily Mail*, p. 9.
(1937). *Yttrande i abortfrågan. Avgivet av Befolkningskommissionen*. Stockholm: Statens offentliga utredningar, 6.
(1964). *New York Times v. Sullivan*. 376 U.S. 254. United States Supreme Court.
(1972). National Right to Life Committee: Statement of Purpose. *The American Citizens Concerned for Life Papers*. Gerald Ford Memorial Library, University of Michigan.
(1972, July 19). Outline and Redraft of "Roe v. Wade." *Harry Blackmun Papers*. Library of Congress.
(1973). *Vashti's Voice, 4, 3*.
(1974). Abortion. *Vashti's Voice 7*.
(1976a). *Investigations of Allegations Concerning Indian Health Services*. Washington, DC: Government Printing Office.
(1976b). *Singleton v. Wulff*, 428 U.S. 106. United States Supreme Court.
(1979, March 22). Lusher Calls for a Rational Debate on Abortion. *Sydney Morning Herald*, p. 2.
(1980). *Harris v. McRae*, 448 U.S. 297. United States Supreme Court.
(1983). *Familjeplanering och abort. Erfarenheter av en ny lagstiftning. Betänkande av 1980 års abortkommitté*. Stockholm: Statens offentliga utredningar, 31.
(1985). Abortion Rights: Silent No More. *The NARAL Pro-Choice Massachusetts Papers*. Schlesinger Library, Harvard University.
(1986). R v Bayliss and Cullen. 8 Qld Lawyer Reps.
(1991). RU Ready for Abortion? *Couchman Over Australia*. Australian Broadcasting Corporation.
(1992). *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 805 U.S. 833. United States Supreme Court.

(1994). *Access Denied: Origins of the Hyde Amendment and Other Restrictions on Public Funding for Abortion*. American Civil Liberties Union.
(1997). So I Lied: Whatever Happened to the Abortion Lobbyist Who Repented? *The Progressive, 11*, 32.
(1998). Notes on Messaging for NARAL Strategy Meeting. *The NARAL Pro-Choice Massachusetts Papers*. Schlesinger Library, Harvard University.
(2007, April 18). ACLU and National Abortion Federation Criticize Decision by U.S. Supreme Court Upholding Federal Abortion Ban. *United States Federal News*.
(2013, June 10). House of Abortion Horror. *Daily Sun*, p. 13.
(2013). Mystery Trunk Murder, 1879. *Celebrate Boston*.
Abortion Laws Worldwide. *Women on Waves*. Retrieved, July 19, 2016, from www.womenonwaves.org/en/page/460/abortion-laws-worldwide
Annie Sadler. The National Archives, CRIM 1/120/8.
Abdel-Tawab, N., & Roter, D. (2002). The relevance of client-centered communication to family planning settings in developing countries: Lessons from the Egyptian experience. *Social Science & Medicine, 54*, 1357–1368.
Abortfrågan. (1953). *Betänkande avgivet av 1950 års abortutredning*. Stockholm: Statens offentliga utredningar, 29.
Abrahams, R. G. (1967). The peoples of greater Unyamwezi, Tanzania (Nyamwezi, Sukuma, Sumbwa, Kimbu, Konongo). In D. Forde (Ed.), *Ethnographic survey of Africa*. London: International African Institute.
Abu-Lughod, L. (1993). *Writing women's worlds: Bedouin stories*. Berkeley and Los Angeles: University of California Press.
Adams, D. W. (1995). *Education for extinction: American Indians and the boarding school experience, 1875–1928*. Lawrence, KS: University Press of Kansas.
Adewole, I. F., Orji, N. C., & Oye-Adeniran, B. A. (2008). Unsafe abortion and development: A strategic approach. *IDS Bulletin, 39*(3), 47–54.
African National Congress. (1994). *A national health plan for South Africa*. Retrieved, January 29, 2013, from http://www.africa.upenn.edu/Govern_Political/ANC_Health.html
African National Congress. (1996, October 29). Parliamentary bulletin: Termination of Pregnancy Bill. Retrieved, September 5, 2012, from http://www.anc.org.za/show.php?id=2760
Aglobitse, P., Casterline, J. B., & Agyeman, D. K. (2005). Social interaction and reproductive behaviour: Evidence from the Cape Coast study. In *Reproductive change in Ghana: Recent patterns and future prospects*. Accra: University of Ghana Press.
Ahmed, S. (1998). *Differences that matter: Feminist theory and postmodernism*. Cambridge: Cambridge University Press.
Ahmed, S. (2004). *The cultural politics of emotion*. New York: Routledge.
Ainley, R. (Ed.). (1998). *New frontiers of space, bodies and gender*. London: Routledge.

Alanes, Z. (1995). *El aborto en Bolivia: Mitos y realidades*. La Paz: The Population Council and the Servicio de Información para el Desarrollo (SID).

Albistur, M., & Armograthe, D. (1977). *Histoire du féminisme Français*. Tome 2. Paris: Editions des Femmes.

Albury, R. (1979). Attacks on abortion rights: The latest round. *Scarlet Woman, 9*, 21–24.

Albury, R. (1981). Abortion news update. *Scarlet Woman, 11*, 22.

Albury, R. (1999). *The politics of reproduction*. Sydney: Allen and Unwin.

Alexander, M. J., & Mohanty, C. T. (Eds.). (1996). *Feminist genealogies, colonial legacies, democratic futures*. New York: Routledge.

Aliaga Bruch, S., Prado, M. Q., & Gisbert, M. E. (2000). *Veinte historias, un mismo tema: El aborto*. La Paz: The Population Council and the Taller de Estudios Sociales (TES).

Alio, A., Salihu, H. M., Philip, N. N., Clayton, H. B., Mbah, A. K., & Philip, M. J. (2011). Association between intimate partner violence and induced abortion in Cameroon. *International Journal of Gynecology and Obstetrics, 112*, 83–87.

Allen, J. (1990). *Sex & secrets: Crimes involving Australian women since 1880*. Melbourne: Oxford University Press.

ALRA. "Interview procedure for counsellors, Problem Pregnancy Counselling Service", Box 21. Wainer Papers, MS134636, State Library of Victoria.

ALRA. *ABRA* 1–6 (1969–1972).

ALRA. (1970a, June 23). ABRA/Abortion law reform association 2.

ALRA. (1970b, September 3). ABRA/Abortion law reform association 3.

ALRA. (1972a). Newsletter (abortion law reform association) (Winter 1972).

ALRA. (1972b, August). Newsletter (abortion law reform association).

ALRA. (1972c). ABRA/Abortion law reform association 4 (11 November 1970).

ALRA. *Newsletter of the Abortion Law Reform Association* (1972–1974).

ALRA. (1974). "Membership Form, ALRA." Box 17. Wainer Papers, MS134636, State Library of Victoria.

Althaus, F. A. (2000). Work in progress: The expansion of access to abortion services in South Africa following legalization. *International Family Planning Perspectives, 26*(2), 84–86.

Ames, E., Klotz, M., & Wildenthatl, L. (2005). *Germany's colonial pasts*. Lincoln: University of Nebraska Press.

Amin, S., & Chakrabarty, D. (Eds.). (1996). *Subaltern studies no. 9: Writings on South Asian history and society*. Delhi: Oxford University Press.

Anderson, W. (2000). The third-world body. In R. Cooter & J. Pickstone (Eds.), *Medicine in the twentieth century* (pp. 235–245). Amsterdam: Harwood Academic Publishers.

Angus, H. C. (1898). A year in Azimba and Chipitaland: The customs and superstitions of the people. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 27*, 316–325.

Anonymous. (1899). Conference at Likoma: The bishop's address. *Central Africa*.
Applications for abortion 1956 and 1958, Socialpsykiatriska nämnden, Medicinalstyrelsens arkiv, Riksarkivet/The National Archives of Sweden.
Archivo Histórico de La Paz (ALP). Instituto Nacional de Maternidad "Profesor Dr. Natalio A. Aramayo" (INA) Collection, 1954–1983.
Arditti, R., Klein, R. D., & Minden, S. (1984). *Test tube women: What future for motherhood?* London: Pandora Press.
Arilha, M., & Barbosa, R. M. (1993). Cytotec in Brazil: 'At least it doesn't kill'. *Reproductive Health Matters, 1*(2), 41–52.
Arnold, D. (Ed.). (1988). *Imperial medicine and indigenous societies.* Manchester: Manchester University Press.
Asetoyer, C. (2005). Interviewed by Joyce Follett. Sophia Smith Collection, Voices of Feminism Oral History Project.
Ashcroft, B., Griffiths, G., & Griffin, H. (Eds.). (1995). *The post-colonial studies reader*. New York: Routledge.
Australia. (1973, May 10). Parliamentary debates: House of representatives. Official Hansard, 1957–2001.
Australia. (1979a, March 21). Parliamentary debates: House of representatives. Official Hansard, 963–1009.
Australia. (1979b, March 22). Parliamentary debates: House of representatives. Official Hansard, 1061–1126.
Axenfeld, K. (1913). Vom Arbeitsfelde der Ärztlichen Mission. *Mitteilungen des Berliner Vereins für Ärztliche Mission, 6*(5), 1–24. Federal German Archives: R1001/6038.
Bagwell, S. (1996). Let's hear it from the women MPs. *Financial Review*.
Bailey, P., et al. (1988). Estudio hospitalario del aborto ilegal en Bolivia. *Boletín de la Oficina Sanitaria Panamericana, 104*(2), 144–158.
Baird, B. (1996). 'The incompetent, barbarous old lady round the corner': The image of the backyard abortionist in pro-abortion politics. *Hecate, 22*(1), 7–26.
Baird, B. (1998). *'Somebody was going to disapprove anyway': Re-thinking histories of abortion in South Australia, 1937–1990.* PhD thesis, Flinders University.
Baird, B. (2013). Abortion politics during the Howard years. *Australian Historical Studies, 44*(2), 245–261.
Baird-Windle, P., & Bader, E. J. (2001). *Targets of hatred: Anti-abortion terrorism*. New York, NY: Palgrave for St. Martin's.
Baker, A. (1995). *Abortion and options counseling: A comprehensive reference*. Granite City: Hope Clinic for Women.
Barber, K. (Ed.). (2006). *Africa's hidden histories: Everyday literacy and making the self*. Bloomington: Indiana University Press.
Barnes, A. (1866). *Notes, critical, explanatory, and practical, on the book of the prophet Isaiah* (Vol. 1). London: George Routledge and Sons.

Bart, P. B. (1987). Seizing the means of reproduction: An illegal feminist abortion collective-how and why it worked. *Qualitative Sociology, 10*(4), 339–357.

Bashford, A., & Levine, P. (2010). *The Oxford handbook of the history of eugenics.* Oxford: Oxford University Press.

Basu, A. M. (Ed.). (2003). *The sociocultural and political aspects of abortion: Global perspectives.* Westport: Praeger Publishers.

Bawah, A. A., Akweongo, P., Simmons, R., & Phillips, J. F. (1999). Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana. *Studies in Family Planning, 30*(1), 54–66.

Bayart, J.-F. (1993). *The state in Africa: The politics of the belly.* London: Longman.

Bazelon, E. (2010, August 1). The New Abortion Providers. *New York Times*, p. 8.

Becker, F. (Ed.). (2004). *Rassenmischehen—Mischlinge. Zur Politik der Rasse im Deutschen Kolonialreich.* Stuttgart: Franz Steiner Verlag.

Bedford, J. (1996). *Who should deliver babies? Models of nature in the midwifery debate in England, c.1800–1886.* PhD dissertation, University of London.

Beidelman, T. O. (1967). *The matrilineal peoples of Eastern Tanzania (Zaramo, Luguru, Kaguru, Ngulu, etc.).* London: International African Institute.

Beier, L. (2008). *For their own good: The transformation of English working-class health culture, 1880–1970.* Columbus: Ohio State University Press.

Beije, I. (1955). *Saliga äro de ofruktsamma.* Stockholm: Medén.

Beisel, N., & Kay, T. (2004). Abortion, race, and gender in nineteenth-century America. *American Sociological Review, 69*(4), 498–518.

Bell, D., & Klein, R. (1996). *Radically speaking: Feminism reclaimed.* Melbourne: Spinifex.

Benatar, D. (2010). Indiscretion and other threats to confidentiality. *South African Journal of Bioethics and Law, 3*(2), 59–62.

Benedetto, C. R. (2013). The missing mill girl: A tale of life and death in Antebellum New England. *American Ancestors, 14*(1), 26–29.

Benitez, R., & Elizabet, M. S. (2000). *El tortuoso camino de la mujer con aborto complicado: Entre la ley y los servicios de salud.* Licensure thesis, Sociología, Universidad Mayor de San Andrés (UMSA).

Bertaux, D., Linhart, D., & Le Wita, B. (1988). Mai 1968 et la formation de générations politiques en France. *Le Mouvement Social, 143* (April–June).

Best, A. (2005). Abortion rights along the Irish-English border and the liminality of women's experience. *Dialectical Anthropology, 29*, 423–437.

Betänkande i Abortfrågan. (1944). *Avgivet av 1941 års befolkningsutredning.* Stockholm: Statens offentliga utredningar, 51.

Betts, K. (2004). Attitudes to abortion in Australia: 1972 to 2003. *People and Place, 12*(4), 22–27.

Beverley, J. (2004). *Testimonio: On the politics of truth.* Minneapolis: University of Minnesota Press.

Bhabha, H. K. (1994). *The location of culture.* New York: Routledge.

Biccum, A. (2002). Interrupting the discourse of development: On a collision course with postcolonial theory. *Culture, Theory and Critique, 43*, 33–50.

Biddlecom, A., & Fapohunda, B. M. (1998). Covert contraceptive use: Prevalence, motivations, and consequences. *Studies in Family Planning, 29*(4), 360–372.

Birks, T. R. (1871). *Commentary on the book of Isaiah: Critical, historical and prophetical; including a revised English*. London: Rivingtons.

Björk, M. (2011). *Problemet utan namn? Neuroser, stress och kön i Sverige från 1950 till 1980*. Uppsala: Uppsala Studies in History of Ideas.

Blandford, J. W. (2011). *Known criminals: Nineteenth-century US crime literature and the epistemology of notoriety*. PhD dissertation, Indiana University.

Bledsoe, C. (2002). *Contingent lives: Fertility, time and aging in West Africa*. Chicago: University of Chicago Press.

Bledsoe, C., & Pison, G. (Eds.). (1994). *Nuptiality in Sub-Saharan Africa: Contemporary anthropological and demographic perspectives*. Oxford: Clarendon Press.

Blewitt, N. (1979, March 21). *Commonwealth Parliamentary Debates (CPD)*, House of Representatives (HR), 1113.

Blystad, A. (1999). 'Dealing with men's spears': Datooga pastoralists combating male intrusion on female fertility. In H. L. Moore, T. Sanders, & B. Kaare (Eds.), *Those who play with fire: Gender, fertility and transformation in East and Southern Africa* (pp. 187–223). London and New Brunswick: The Athlone Press.

Boahen, A. (1996). Africa: Colonialism and independence. In R. Uwechue (Ed.), *Africa today* (pp. 137–150). London: Africa Books.

Bone, P. (1994, July 30). A fight for control of reproduction. *The Age*, p. 26.

Borsay, A., & Hunter, B. (Eds.). (2012). *Nursing and midwifery in Britain since 1700*. Basingstoke: Palgrave Macmillan.

Boyle, M. (1997). *Re-thinking abortion: Psychology, gender, power and the law*. London and New York: Routledge.

Bradford, H. (1991). Herbs, knives and plastic: 150 Years of abortion in South Africa. In T. Meade & M. Walker (Eds.), *Science, medicine, and cultural imperialism* (pp. 120–147). London: Palgrave Macmillan.

Brandenburg v. Ohio. (1969). 395 U.S. 444. United States Supreme Court.

Brave Bird, M., & Erdoes, R. (1990). *Lakota woman*. New York: G. Weidenfeld.

Brave Bird, M., & Erdoes, R. (1993). *Ohitika woman*. New York: Grove Press.

Brief as Amicus Curiae for the National Right to Life Committee. (1980). *Williams v. Zbaraz*. U.S. 358.

Brief of Defendant Appellant. *State of North Carolina v. Phillip Lance Benham*.

Briggs, L. (2002). *Reproducing empire: Race, sex, science, and US imperialism in Puerto Rico*. Berkeley: University of California Press.

Brookes, B. (1988). *Abortion in England, 1900–1967*. London: Croom Helm.

Brough, J. (1996, June 26). Foreign aid ban on funding for abortions. *Sydney Morning Herald*, p. 10.

Browder, C. (1998). *The wickedest woman in New York: Madame Restell, the abortionist*. Hamden: Archon Books.

Brown, K. (1996). *Good wives, nasty wenches, and anxious patriarchs: Gender, race, and power in colonial Virginia*. Chapel Hill: University of North Carolina Press.

Brown, W. (2000). Suffering rights as paradoxes. *Constellations, 7*(2), 208–229.

Browne, M. E. (1979). *The empty cradle: Fertility control in Australia*. Kensington, NSW: NSW University Press.

Bruchhausen, W. (2003). Practising hygiene and fighting the natives' diseases. Public and child health in German East Africa and Tanganyika Territory, 1900–1960. *DYNAMIS, 23*, 85–113.

Bruchhausen, W. (2006). *Medizin Zwischen den Welten. Geschichte und Gegenwart des Medizinischen Pluralismus im Südöstlichen Tansania*. Göttingen: V&R unipress.

Bureau of Immigration, Multicultural and Population Research. (1995). *The third national immigration and population outlook conference*. Carlton: Bureau of Immigration, Multicultural and Population Research.

Burgman, V. (2003). *Power, profit and protest: Australian social movements and globilisation*. Crows Nest, NSW: Allen & Unwin.

Burns, S. (2002). The body as text: Confucianism, reproduction, and gender in Tokugawa, Japan. In B. Elman, J. B. Duncan, & G. Ooms (Eds.), *Rethinking confucianism: Past and present in China, Japan, Korea, and Vietnam*. California: UCLA Asia Institute.

Bury, L., Bruch, S. A., Barbery, X. M., & Garcia, F. (2012). Hidden realities: What women do when they want to terminate an unwanted pregnancy in Bolivia. *Journal of Gynecology and Obstetrics, 118*, 54–59.

Byrd, J. (2011). *The transit of empire: Indigenous critiques of colonialism*. Minneapolis: University of Minnesota Press.

Cahill, C. (2011). *Federal fathers and mothers: A social history of the United States Indian service, 1869–1933*. Chapel Hill: University of North Carolina Press.

Calder, A. B. (1912). *Lectures on midwifery for junior students and midwives* (2nd ed.). London: Bailliere, Tindall and Cox.

Calvès, A. (2002). Abortion risk and decision-making among young people in urban Cameroon. *Studies in Family Planning, 33*(3), 249–260.

Cameron, C. (1979, March 21). *CPD*, HR, 988.

Cannold, L. (2002). Understanding and responding to anti-choice women-centered strategies. *Reproductive Health Matters, 10*(19), 171–179.

Cannold, L. (2006). *The Australian pro-choice movement and the struggle for legal clarity, liberal laws and liberal access: The extended Australian report of the 'The Johannesburg Initiative.'*

Caron, S. M. (2008). *Who chooses?: American reproductive history since 1830*. Gainesville: UP of Florida.

Caron, S. M. (2009). 'I have done it and I have got to die': coroners' inquests of abortion deaths in Rhode Island, 1876–1938. *The History of the Family, 14*, 1–18.

Carpio, M. V. (2004). The lost generation: American Indian women and sterilization abuse. *Social Justice, 31*(4), 40–53.

"Case 2/89." The Wellcome Library, Archives and Manuscripts. Papers of Sir Bernard Spilsbury. PP/SPI/1.

Case Study: Morgentaler Clinic. (1999). *The Claire Keyes Papers.* Bingham Library, Duke University.

Castro, M., Dolores, M., & Mülder, S. S. (2004). *Avances y retrocesos en un escenario cambiante: Reforma en salud, mortalidad materna y aborto en Bolivia, 2000–2002.* La Paz: CIDEM.

Castro, A., & Singer, M. (2004). *Unhealhty health policy: A critical anthropological examination.* New York: Altamira Press.

CB1-8. (1918). Mbweni Logbook, CB Series, Universities' Mission to Central Africa. Zanzibar National Archives.

Central Classified Files. (1907–1939). Record Group 75. Bureau of Indian Affairs, National Archives and Records Administration, Labriola National American Indian Data Center, Arizona State University.

Chalker, R., & Downer, C. (1992). *A woman's book of choices abortion, menstrual extraction, RU-486.* New York: Four Walls Eight Windows.

Chamberlain, M., & Richardson, R. (1983). Life and death. *Oral History, 11*(1), 31–43.

Chan, G. (1996). Harradine Denies Vote Links to Abortion Issue. *The Australian*, p. 2.

Chaperon, S. (2000). *Les années beauvoir, 1945–1970.* Paris: Fayard.

Chaplinksy v. State of New Hampshire. (1942). 315 U.S. 568. United States Supreme Court.

Chappell, L. (2001). Federalism and social policy: The case of domestic violence. *The Australian Journal of Public Administration, 60*(1), 59–69.

Chappell, L., & Costello, M. (2011). Australian federalism and domestic violence policy making. *The Australian Journal of Political Science, 46*(4), 633–650.

Chiba, T. (1983). *Mabiki to Mizuko* [Infanticide and Mizuko]. Tokyo: Nōson Gyoson Bunka Kyōkai.

Chisholm, S. (1969). NARAL Press Release. *Lawrence Lader Papers.* Countway Medical Library, Harvard University.

Choisir. (1975). *Abortion: The Bobigny affair, a law on trial.* Trans. Beryl Henderson. Sydney: Wild and Woolley.

Chorell, T. G. (Ed.). (2010). *In på bara huden. Medicinhistoriska studier tillägnade Karin Johannisson.* Nora: Nya Doxa.

Clarke, A., & Olesen, V. (Eds.). (1999). *Revisioning women, health and healing: Feminist, cultural, and technoscience perspectives.* New York: Routledge.

Coghlan, D. (1971). The Contraceptive Train. *The Irish Times.*

Cohen, D. A. (1997). The beautiful female murder victim: Literary genres and courtship practices in the origins of a cultural motif, 1590–1850. *The Journal of Social History, 31*(2), 277–306.

Colander, Pat. (1974). In Illinois. *Chicago Tribune*, p. C1.

Coleman, K. (1991). *Discourses on sexuality: The modern abortion debate*. PhD thesis, Macquarie University.

Coleman, K. (1998). The politics of abortion in Australia: Freedom, church and state. *Feminist Review, 29*, 75–97.

Collins, P. H. (1990). *Towards an afrocentric feminist epistemology*. New York: Routledge.

Collins, P. H. (2004). *Black sexual politics: African Americans, gender, and the new racism*. New York: Routledge.

Colwell, A. S. (2001). *Vision and revision: Demography, maternal and child health development and the representation of native women in colonial Tanzania*. PhD thesis, University of Illinois, Urbana.

Connelly, A. (1999). Women and the constitution of Ireland. In Y. Galligan, E. Ward, & R. Wilford (Eds.), *Contesting politics women in Ireland, North and South* (pp. 18–37). Boulder: Westview Press.

Connell, J. (2013). Contemporary medical tourism: Conceptualisation, culture and commodification. *Tourism Management, 34*, 1–13.

Conrad, K. A. (2004). *Locked in the family cell: Gender, sexuality, and political*. Madison: The University of Wisconsin Press.

Conrad, S. (2004). 'Eingeborenenpolitik' in Kolonie und Metropole. 'Erziehung zur Arbeit' in Ostafrika und Ostwestfalen. In S. Conrad & J. Osterhammel (Eds.), *Das Kaiserreich Transnational. Deutschland in der Welt 1871–1914* (pp. 107–128). Göttingen: Vandenhoeck & Ruprecht.

Conrad, S., & Osterhammel, J. (Eds.). (2004). *Das Kaiserreich Transnational. Deutschland in der Welt 1871–1914*. Göttingen: Vandenhoeck & Ruprecht.

Cook, F. C. (Ed.). (1888). *The Holy Bible, according to the authorized version (A.D. 1611), with an explanatory and critical commentary and a revision of the translation, by Bishops and other clergy of the Anglican church* (Vol. 5). New York: Charles Scribner's Sons.

Cook, K. (2005, October 26–27). Interviewed by Joyce Follett. Sophia Smith Collection, Voices of Feminism Oral History Project.

Cook, M. (Ed.). (1994). *The new imperialism: World population and the Cairo conference*. Sydney: Little Hills Press.

Cook, R. J., Erdman, J. N., & Dickens, B. M. (Eds.). (2014). *Abortion law in transnational perspective: Cases and controversies*. Philadelphia: University of Pennsylvania Press.

Cooper, F. (1980). *From slaves to squatters: Plantation labor and agriculture in Zanzibar and Coastal Kenya, 1890–1925*. New Haven: Yale University Press.

Cooper, D., et al. (2004). Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status. *Reproductive Health Matters, 12*(24), 70–85.

Cooter, R., & Pickstone, J. (Eds.). (2000). *Medicine in the twentieth century*. Amsterdam: Harwood Academic Publishers.

Corea, G. (1985). *The mother machine: Reproductive technologies from artificial insemination to artificial wombs*. New York: Harper and Row.

Cornwall, A., Standing, H., & Lynch, A. (2008). Introduction: Putting unsafe abortion on the development agenda. *IDS Bulletin, 39*(3), 1–9.

Cory, H. (1953). *Sukuma law and custom*. London: Oxford University Press.

Coulthard, G. (2014). *Red skin, white masks: Rejecting the colonial politics of recognition*. Minneapolis: University of Minnesota Press.

Cowell, B., & Wainwright, D. (1982). *Behind the blue door: The history of the royal college of midwives, 1881–1981*. London: Bailliere Tindall.

Cozzarelli, C., & Major, B. (1994). The effects of anti-abortion demonstrators and pro-choice escorts on women's psychological responses to abortion. *Journal of Social and Clinical Psychology, 13*(4), 404–427.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum, 140*, 139–167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *The Stanford Law Review, 43*(6), 1241–1299.

Crist, T. (2004). A model for a youth family planning clinic in a community without a university. *Takey Crist Papers 2004-098*, Box 5. Sallie Bingham Center for Women's History and Culture, Duke University.

Crist, T. A. (2005). Babies in the privy: Prostitution, infanticide, and abortion in New York City's five points district. *Historical Archaeology, 39*(1), 19–46.

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry, 13*(2), 144–153.

CWLU herstory project. (n.d.a). Abortion: A woman's decision, a woman's right. *Jane informational pamphlet*.

CWLU herstory project. (n.d.b). Doing more of the abortions themselves leads to new challenges for the service. *Hyde Park Kenwood Voices*.

CWLU herstory project. (n.d.c). The service learns how to obtain medical instruments and drugs while trying to avoid police attention. *Hyde Park Kenwood Voices*.

Dale, D. (1975, October 1). Abortion: How to get one and what it's going to involve. *The National Times*.

Dale, G. (1896). An account of the principal customs and habits of the natives inhabiting the Bondei Country, compiled mainly for the use of European missionaries in the country. *The Journal of the Anthropological Institute of Great Britain and Ireland, 25*, 181–239.

Dale, P., & Fisher, K. (2009). Implementing the 1902 Midwives Act: Assessing problems, developing services and creating a new role for a variety of female practitioners. *Women's History Review, 18*(3), 427–452.

Daryll, F. (Ed.). (1967). *The peoples of greater Unyamwezi, Tanzania (Nyamwezi, Sukuma, Sumbwa, Kimbu, Konongo)*. London: International African Institute.

Daulaire, N., et al. (2002). *Promises to keep: The toll of unintended pregnancies on women's lives in the developing world*. Washington, DC: Global Health Council.
Davidson, R., & Hall, L. A. (Eds.). (2001). *Sex, sin and suffering. Venereal disease and European society since 1870*. London and New York: Routledge.
De Wolfe, E. A. (2007a). Storytelling, domestic space, and domestic knowledge in the murder of Berengera Caswell. *Storytelling, 6*(2), 121–129.
De Wolfe, E. A. (2007b). *The murder of Mary Bean and other stories*. Kent: The Kent State UP.
De Zordo, S., & Mishtal, J. (2011). Physicians and reproductive health provision: Political participation and conflicts on the ground in Brazil and Poland. *Women's Health Issues, 12*(3S), 32–36.
Decle, L. (1898). *Three years in savage Africa*. New York: Mansfield.
Deer, S. (2015). *The beginning and end of rape: Confronting sexual violence in Native America*. Minneapolis: University of Minnesota Press.
Dejong, D. (2008). *'If you knew the conditions': A chronicle of the Indian Medical Service and American Indian Health Care, 1908–1955*. Lanham, MD: Lexington Books.
Del Pozo, E., & Bravo, J. L. A. (2007). *Marcando un hito en Bolivia: Experiencia. Atención de las hemorragias de la primera mitad del embarazo en servicios de primer nivel de atención*. La Paz: Ipas.
Demographic and Health Survey. (2013). Results from the demographic and health survey: Cameroon 2011. *Studies in Family Planning, 44*(2), 223–232.
Department of Health. (2002). *National Contraception Policy Guidelines*. Pretoria: Republic of South Africa. Retrieved September 8, 2015, from http://www.doh.gov.za/docs/factsheets/guidelines/contraception/contraception01.pdf
Der Professorenrat des Hamburgischen Kolonialinstituts. (1913). Koloniale Preisaufgabe. *Archiv für Schiffs- und Tropen-Hygiene, 17*(16), 567.
Dernburg, B. (1907). *Zielpunkte Des Deutschen Kolonialwesens*. Berlin: Ernst Siegfried Mittler und Sohn.
Desai, G., & Nair, S. (Eds.). (2005). *Postcolonialisms. An anthology of cultural theory and criticism*. New Brunswick: Rutgers University Press.
Deuser, P. (2010). Genderspezifische Entwicklungspolitiken und Bevölkerungsdiskurse. Das Konzept der Sexuellen und Reproduktiven Gesundheit und Rechte aus Postkolonialer Perspektive. *Peripherie, 30*(120), 427–451.
Deutsch, H. (1944–1945). *The psychology of women: A psychoanalytic interpretation* (Vol. 1–2). New York: Grune & Stratton.
Deutsch-Ostafrika, G. V. (1909). Anregung des Frauen-Vereins, ein Wöchnerinnenheim für farbige Frauen in Dar zu errichten. Federal German Archives: R1001/6032/13.
Deutsche Gesellschaft für Eingebornenschutz. (1914a). Das 'aussterbende Afrika'. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 4*, 228.

Deutsche Gesellschaft für Eingebornenschutz. (1914b). Eingebornenschutz. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 1*, 1–5.

Deutsche Gesellschaft für Eingebornenschutz. (1914c). Eingabe der Deutschen Gesellschaft für Eingebornenschutz an den Reichstag und das Reichs-Kolonialamt. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 3*, 129–132.

Deutscher Frauenverein für Krankenpflege in den Kolonien. (1909, August 13). Schreiben an den Staatssekretär des Reichskolonialamtes. Federal German Archives: R1001/6032/13.

DeWaard, J. (2002). 'Indelicate exposure': Sentiment and law in *Fall River*: *An authentic narrative*. *American Literature, 74*(2), 373–401.

Dickson, K., et al. (2003). Abortion service provision in South Africa three years after liberalizaiton of the law. *Studies in Family Planning, 34*(4), 277–284.

Dienel, C. (1993). Das 20. Jahrhundert (I). Frauenbewegung, Klassenjustiz und das Recht auf Selbstbestimmung der Frau. In R. Jütte (Ed.), *Geschichte der Abtreibung: von der Antike bis zur Gegenwart* (pp. 140–168). München: C. H. Beck.

Dionne, E. J. (1989, July 21). Abortion rights backers adopt tactics of politics. *New York Times*, p. A6.

Dixon, M. J. (1898). *Forensic Medicine & Toxicology* (2nd rev. ed.). London: Charles Griffin & Co.

Dobson, S. (1991). *Transcultural nursing: A contemporary imperative*. London: Scutari Publishing.

Donchin, A. (2010). Reproductive tourism and the quest for global gender justice. *Bioethics, 24*(7), 323–332.

Dongmo, J.-L. (1981). *Le Dynamisme Bamiléké (Cameroun). Vol. 1, La Maîtrise de l'espace agraire. Vol. 2, La Maîtrise de l'espace urbain*. Yaoundé: Université de Yaoundé.

Donnison, J. (1988). *Midwives and medical men* (2nd ed.). London: Historical Publications.

Donovan, B. (1997, December 5). IHS careful about sterilizations. *Navajo Times*, p. 2.

Douglas, C. (2005). *Barren states: The population implosion in Europe*. New York: Berg Publishers.

Drife, J. O. (2010). Historical perspective on induced abortion through the ages and its links with maternal mortality. *Best Practice & Research Clinical Obstetrics & Gynecology, 24*(4), 431–441.

Drixler, F. (2013). *Mabiki: Infanticide and population growth in Eastern Japan, 1660–1950*. Berkeley: University of California Press.

Duchen, C. (1986). *Feminism in France: From May '68 to Mitterrand*. New York: Routledge.

Duden, B. (1993). *Disembodying women: Perspectives on pregnancy and the unborn*. Cambridge: Harvard University Press.

Dumble, L. (1994, September 22). Population control—A legacy of shame. *The Age*, pp. 18, 22.

Dumble, L. (1997). The new testament according to the Lyons forum: An Australia bereft of abortion rights? *Political Environments, 5*.

Dundas, C. (1921). Native laws of some Bantu Tribes of East Africa. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 51*, 217–278.

Eckart, W. (1997). *Medizin und Kolonialimperialismus: Deutschland 1884–1945*. Paderborn-München-Wien-Zürich: Ferdinand Schöningh.

Ehrenreich, B., & English, D. (2005). *For her own good: Two centuries of the experts advice to women*. New York: Anchor Books.

Ekblad, M. (1955). *Induced abortion on psychiatric grounds. A follow-up study of 479 women*. Stockholm: Acta Psychiatrica et Neurologica Scandinavica Supplementum, 99.

Elbourne, E. (2002). *Blood ground: Colonialism, missions, and the contest for Christianity in the Cape Colony and Britain, 1799–1853*. Montreal: McGill-Queen's University Press.

Elderton, E. M. (1914). *Report on the English Birth Rate: Part I, England North of the Humber*. London: Dulau and Co. Limited.

Elman, A. R. (Ed.). (1996). *Sexual politics and the European Union*. Providence: Bergham Books.

Elman, B. A., Duncan, J. B., & Ooms, H. (Eds.). (2002). *Rethinking confucianism: past and present in China, Japan, Korea, and Vietnam*. California: UCLA Asia Institute.

Elonis v. United States. (2015). 575 U.S., 135 S.Ct. 2001. United States Supreme Court.

Emmerich, L. (1987). 'To respect and love and seek the ways of white women': Field matrons, the Office of Indian Affairs, and civilization policy, 1890–1938. PhD Dissertation, University of Maryland, College Park.

Emmerich, L. (1997). 'Save the babies!': American Indian women, assimilation policy, and scientific motherhood, 1912–1918. In *Writing the range: Race, class, and culture in the women's West*. Norman, OK: University of Oklahoma Press.

Enderby, K. (1973, May 10). *CPD*, HR, 1989.

Engle, U., Erdmann, G., & Mehler, A. (Eds.). (2000). *Tanzania revisited: Political stability, aid dependency and development constraints*. Hamburg: Institut für Afrikakunde.

Epprecht, M. (2008). *Heterosexual Africa? The history of an idea from the age of exploration to the age of AIDS*. Athens: Ohio University Press.

Eschle, C., & Maiguashca, C. (Eds.). (2005). *Critical theories, international relations and 'the anti-globalisation movement': The politics of global resistance*. New York: Routledge.

Espinoza, J. (1996, March 20). El aborto, un gran dolor de cabeza para la salud pública. *La Razón*, p. A11.

Evatt, E. (1977). *Elizabeth Evatt, Final Report: Royal Commission on Human Relationships*. Canberra: Australian Government Publishing Service.

Everett, M. (2006). Doing bioethics: Challenges for anthropology. *Human Organization, 65*(1), 46–54.

Ewing, T. (1994, August 20). Ready for this? *Sydney Morning Herald*, p. 17.

Executive Committee Meeting Minutes. (1969). *The NARAL Papers, Carton 1*. Schlesinger Library, Harvard University.

Ezeh, A. (1993). The influence of spouses over each other's contraceptive attitudes in Ghana. *Studies in Family Planning, 24*(3), 163–174.

Falkenberg, N. (1985, March 20). To Members of the Media. *The NARAL Pro-Choice Massachusetts Papers*. Schlesinger Library, Harvard University.

Falkenberg, N. (1985, May). To NARAL Leadership. *The NARAL Pro-Choice Massachusetts Papers*. Schlesinger Library, Harvard University.

Fanon, F. (1989). *Studies in a Dying Colonialism*. London: Earthscan.

Fasubaa, O., & Ojo, O. (2004). Impact of post-abortion counselling in a semi-urban town of Western Nigeria. *Journal of Obstetrics and Gynaecology, 23*(4), 298–303.

Faught, C. B. (2003). *The Oxford movement: A thematic history of the Tractarians and their times*. University Park, PA: Pennsylvania State University Press.

Faust, B. (1972). What should the law do? The jurisprudence of abortion. In T. McMichael (Ed.), *Abortion: The unenforceable law: The reality of unwanted pregnancy and abortion in Australia* (pp. 28–31). Melbourne: ALRA (VIC).

Federici, S. (2004). *Caliban and the witch: Women, the body and primitive accumulation*. New York: Automedia.

Feierman, S. (1995). A century of ironies in East Africa (c. 1780–1890). In P. Curtin, S. Feierman, L. Thompson, & J. Vansina (Eds.), *African history: From earliest times to independence* (2nd ed., pp. 352–376). New York: Pearson.

Feierman, S., & Curtin, P. (Eds.). (1995). *African history: From earliest times to independence* (2nd ed.). New York: Longmann.

Feldmann, H. (1923). Die Erhaltung Und Vermehrung Der Eingeborenen-Bevölkerung. In *Abhandlungen Aus Dem Gebiet Der Auslandskunde. Wissenschaftliche Beiträge Zur Frage Der Erhaltung Und Vermehrung Der Eingeborenen-Bevölkerung. Ergebnisse Der Eduard-Woermann-Preisaufgabe* (Vol. 13, pp. 83–148). Hamburg: L. Friederichsen & Co.

Feldman-Savelsberg, P. (1999). *Plundered kitchens, empty wombs: Threatened reproduction and identity in the Cameroon grassfields*. Ann Arbor: University of Michigan Press.

Feldman-Savelsberg, P., & Ndonko, F. T. (2002). Is infertility an unrecognized public health problem? An emic view from the grassfields of Cameroon. In M. Inhorn & F. van Balen (Eds.), *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies* (pp. 215–232). Berkeley: University of California Press.

Feldman-Savelsberg, P., Ndonko, F. T., & Yang, S. (2006). The Social Management of Fetal and Infant Death: Dual Disruptions to Reproductive Lives and Discourses. *Curare, 29*(1), 7–15.

Feldman-Savelsberg, P. (2016). *Mothers on the move: Reproducing belonging between Africa and Europe*. Chicago: University of Chicago Press.

Felix, R. A. (1991). Beyond the physician's office—The medical mall. *College Review, 8*(2), 30–57.

Fenna, A. (2009). Federalism. In R. A. W. Rhodes (Ed.), *The Australian study of politics* (pp. 146–159). Houndmills and New York: Palgrave Macmillan.

Ferguson, A. H. (2005). *Should a doctor tell?: Medical confidentiality in interwar England and Scotland*. PhD dissertation, University of Glasgow.

Finer, L. B., & Henshaw, S. (2003). Abortion incidence and services in the United States in 2000. *Perspectives on Sexual and Reproductive Health, 35*(1), 6–15.

Finer, L., & Fine, J. B. (2013). Abortion law around the world: Progress and pushback. *American Journal of Public Health, 103*(4), 585–589.

FINRRAGE (Australia). Newsletter 1998. Web. 9 September 2014.

Fischer, K. (2002). *Suspect relations: Sex, race, and resistance in Colonial North Carolina*. Ithaca, NY: Cornell University Press.

Fitzsimmons, R. (1999). To certain abortion providers. *The National Coalition of Abortion Providers Papers*. Bingham Library, Duke University.

Fixico, D. (1986). *Termination and relocation: Federal Indian Policy, 1945–1960*. Albuquerque: University of New Mexico Press.

Forde, D. (Ed.). (1967). *The matrilineal peoples of Eastern Tanzania (Zaramo, Luguru, Kaguru, Ngulu, etc.)*. London: International African Institute.

Foucault, M. (1976). *Histoire de la sexualité: Vol. 1. La Volonté de savoir*. Paris: Gallimard.

Foucault, M. (1978). *Dispositive der Macht. Über Sexualität, Wissen und Wahrheit*. Berlin: Merve.

Foucault, M. (1989). *Der Wille zum Wissen. Sexualität und Wahrheit* (Vol. 1). Frankfurt/Main: Suhrkamp.

Francome, C. (2004). *Abortion in the USA and the UK*. London: Ashgate Publishing, Ltd.

Franklin, S., & Ragoné, H. (Eds.). (1999). *Reproducing reproduction: Kinship, power, and technological innovation*. Philadelphia: University of Pennsylvania Press.

Freedman, L. (2010). *Willing and unable: Doctors' constraints in abortion care*. Nashville: Vanderbilt University Press.

Freedom of Access to Clinic Entrances Act. (1994). Pub. Law No. 103–259, 18 U.S.C. § 248.

Fried, M. G. (2000). Abortion in the United States: Barriers to access. *Health and Human Rights, 4*, 174–194.

Fried, M. G. (2013). Reproductive rights activism in the post-Roe era. *American Journal of Public Health, 103*(1), 10–14.

Friedan, B. (1969). Abortion as a woman's civil right. *The Betty Friedan Papers*. Schlesinger Library, Harvard University.

Friedman-Rudovsky, J. (2007, August 9). Abortion Under Siege in Latin America. *Time Magazine*.

Friedrichsmeyer, S., Lennox, S., & Zantop, S. (Eds.). (1998). *The imperialist imagination. German colonialism and its legacy*. Michigan: University of Michigan Press.

Fuller, L. (2005). Religion, politics, and socio-cultural change in twentieth-century Ireland. *The European Legacy, 10*(1), 41–54.

Gaines, A. D., & Juengst, E. T. (2008). Origin myths in bioethics: Constructing sources, motives and reason in bioethic(s). *Culture, Medicine and Psychiatry, 32*, 303–327.

Gajdušek, P. (2004). Quickening doctrine. *Common Law Review*, Issue 5.

Galligan, Y., Ward, E., & Wilford, R. (1999). *Contesting politics women in Ireland, North and South*. Boulder: Westview Press.

Gann, L. H. (1987). Marginal colonialism: The German case. In A. J. Knoll & L. H. Gann (Eds.), *Germans in the tropics. Essays in German colonial history* (pp. 1–17). New York: Greenwood.

Garcia-Guadilla, N. (1981). *Libération des femmes, le MLF*. Paris: Presses Universitaires de France.

Garflied, J. (Ed.). (1984). *Abortion and moral and legal perspectives*. Amherst: University of Massachusetts Press.

Garrison v. Louisiana. (1964). 379 U.S. 64. United States Supreme Court.

Georges, E. (2008). *Bodies of knowledge: The medicalization of reproduction in Greece*. Nashville: Vanderbilt University Press.

Geschiere, P. (2007). Regional shifts—Marginal gains and ethnic stereotypes. *African Studies Review, 50*(2), 43–56.

Giago, T. (2006). Oglala Sioux President on State Abortion Law. *Indianz.com*. Retrieved March 21, 2006, from http://www.indianz.com/News/2006/013061.asp

Gilcher-Hotley, I. (1998). May 1968 in France: The rise and fall of a new social movement. In C. Fink et al. (Eds.), *1968: The world transformed*. Cambridge: Cambridge University Press.

Gilmartin, M., & White, A. (2011). Interrogating medical tourism: Ireland, abortion, and mobility rights. *Signs, 36*(2), 275–280.

Ginsburg, F. (1989). *Contested lives: The abortion debate in an American community*. Berkeley: University of California Press.

Ginsburg, F. (1998). *Contested lives: The abortion debate in an American community* (updated edition). Berkeley: University of California Press.

Ginsburg, R. B. (1985). Some thoughts on autonomy and equality in relation to Roe v. Wade. *North Carolina Law Review, 63*, 375–386.

Gisbert, M. E., & Prado, M. Q. (1992). *Mujer sub-urbana y prácticas del aborto en la ciudad de El Alto de La Paz*. La Paz, Bolivia.

Glassman, J. (1995). *Feasts and riot: Revelry, rebellion, and popular consciousness on the Swahili Coast, 1856–1888*. London: James Currey.

Glazebrook, M. G. (1910). *Studies in the book of Isaiah*. Oxford: Clarendon Press.

Gleeson, K. (2011). Tony Abbott and Abortion: Miscalculating the Strength of the Religious Right. *Australian Journal of Political Science, 46*(3), 473–488.

Gleeson, K. (2013a). From suck magazine to corporate Paedophilia. Feminism and pornography—Remembering the Australian way. *Women's Studies International Forum, 38*, 83–96.

Gleeson, K. (2013b, January 24). Tankard reist explain yourself. *The Age*, 13.

Gleeson, K. (2014a, March 9). Abortion and choice in the neoliberal aftermath. *Politics and Culture*.

Gleeson, K. (2014b). The limits of choice: Abortion and entrepreneurialism. In M. Nash (Ed.), *Reframing Reproduction* (pp. 69–83). London: Palgrave.

Gluck, S. B., & Patai, D. (1991). *Women's words: The feminist practice of oral history*. New York: Routledge.

Goldberg, M. (2009). *The means of reproduction: Sex power and the future of the world*. New York: Penguin.

Goold, I., & Kelly, C. (Eds.). (2009). *Lawyers' medicine: The legislature, the courts & medical practice, 1760–2000*. Oxford: Hart.

Gordon, L. (1994). *Pitied but not entitled: Single mothers and the history of welfare, 1890–1935*. New York: Free Press.

Gorney, C. (2004). Gambling with abortion: Why both sides think they have everything to lose. *Harper's Magazine*.

Gouaze, J., Mouillard, M., Severin, E., & Tetu, J. F. (1979). *La Loi de 1920 et l'avortement: Stratégies de la presse et du droit au process de Bobigny*. Lyon: Presses Universitaires de Lyon.

Green, M. (1999). Women work is weeping: Constructions of gender in a Catholic community. In H. Moore, T. Sanders, & B. Kaare (Eds.), *Those who play with fire: Gender, fertility and transformation in East and Souther Africa* (pp. 255–280). London and New Brunswick: The Athlone Press.

Greer, G. (1984). *Sex and destiny: The politics of human fertility*. London: Harper and Co.

Gregory, R. (2005). Corrupt cops, crooked docs, prevaricating pollies and 'mad radicals': A history of abortion law reform in Victoria, 1959–1974. PhD thesis, RMIT University, Melbourne.

Grewal, I., & Kaplan, C. (2001). Global identities: Theorizing transnational studies of sexuality. *A Journal of Lesbian and Gay Studies, 7*(4), 663–679.

Grey, D. J. R. (2012). 'Almost unknown amongst the Jews': Jewish women and infanticide in London 1890–1918. *The London Journal, 37*(2), 122–135.

Grimes, D., et al. (2006). Unsafe Abortion: The Preventable Pandemic. *The Lancet, 368*(9550), 1908–1919.

Grosse, P. (2000). *Kolonialismus, Eugenik und Bürgerliche Gesellschaft in Deutschland 1850–1918*. Frankfurt/Main and New York: Campus.

Grossman, D., et al. (2011a). Surgical and medical second trimester abortion in South Africa: A cross-sectional study. *MBC Health Services Research, 11*(224), 1–9.

Grossman, D., Grindlay, K., Todd, R. M., Lane, K., & Blanchard, K. (2011b). Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics & Gynecology, 118*(2), 296–303.

Gurr, B. (2015). *Reproductive justice: The politics of healthcare for Native American women*. New Brunswick: Rutgers Press.

Gustafon, D. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science, 28*(2), 2–16.

Guttmacher Institute. (2016a, May). In Brief: Fact Sheet: Facts on Induced Abortions Worldwide. http://www.guttmacher.org/pubs/fb_IAW.html

Guttmacher Institute. (2016b, May). In Brief: Facts on Abortion in Latin America and the Caribbean. http://www.guttmacher.org/pubs/IB_AWW-Latin-America.pdf

Gwan, A. (1985). Origins and elements of the population policies of Cameroon Republic. *Social Science Series, 3*, 116–128.

Hagopian, F. (Ed.). (2009). *Religious pluralism, democracy, and the Catholic Church in Latin America*. Notre Dame, IN: University of Notre Dame Press.

Halimi, G. (1977). *The right to choose*. Trans. Rosemary Morgan. St. Lucia: University of Queensland Press.

Hall, L. (2013). *Sex, gender and social change in Britain since 1880* (2nd ed.). Basingstoke: Palgrave Macmillan.

Halling, T., Shäfer, J., & Vögele, J. (2005). Volk, Volkskörper, Volkswirtschaft—Bevölkerungsfragen in Forschung Und Lehre von Nationalökonomie Und Medizin. In R. Mackensen & J. Reulecke (Eds.), *Das Konstrukt 'Bevölkerung' Vor, Im Und Nach Dem 'Dritten Reich'* (pp. 388–428). VS Verlag für Sozialwissenschaften: Wiesbaden.

Halttunen, K. (1998). *Murder most foul: The killer and the American gothic imagination*. Cambridge: Harvard University Press.

Hanzo v. deParrie. (1998). 152 Or. App 525. Court of Appeals of Oregon.

Hardacre, H. (1997). *Marketing the menacing fetus in Japan*. Berkeley: University of California Press.

Harlow, V., & Chilver, E. M. (Eds.). (1965). *History of East Africa*. Oxford: Oxford University Press.

Harradine, B. (1983, December 17). Sex Discrimination Bill 1983. *Senate Hansard*.

Harradine, B. (1996, May 8). Therapeutic Goods Amendment Bill 1996 (No. 2). *Senate Hansard*.

Harries, J., et al. (2012). The challenges of offering public second trimester abortion services in South Africa: Health care providers' perspectives. *Journal of Biosocial Sciences, 44*, 197–208.

Harries, J., Stinson, K., & Orner, P. (2009). Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *Biomedical Central Public Health, 9*, 1–11.

Haruko, W., & Susan, B. (Eds.). (1994). *Jendā no Nihonshi Jō* [Gender and History of Japan]. Vol. 1. Tokyo: Tokyo Daigaku Shuppankai.

Hauck, C. (2003). Abortion and the individual talent. *ELH, 70*(1), 223–226.

Hauck, G. (2003). *Die Gesellschaftstheorie und ihr Anderes. Wider den Eurozentrismus der Sozialwissenschaften*. Münster: Westfälisches Dampfboot.

Hayami, T. (1973). *Kinsei Nōson no Rekishi Jinkōugaku teki Kenkyū* [A Historical Demographic Study on Farming Villages in Early Modern Society]. Tokyo: Toyo Keizai Shinposha.

Hayden, K. R. (1989). The delivery of medical services in a retail shopping mall: A strategy for growth. *College Review, 6*(2), 12–29.

Heitlinger, A. (1999). *Émigré Feminisms: Transnational Perspectives*. Toronto: University of Toronto Press.

Hesselink, L. (2011). *Healers on the colonial market: Native doctors and midwives in the Dutch East Indies*. Leiden: KITLV Press.

"Home Office Printed Memoranda." The National Archives, HO 347/18.

hooks, bell. (2000). *Feminism is for everybody: Passionate politics*. Cambridge: South End Press.

Hill, B. J. (2009). Reproductive rights as health care rights. *Columbia Journal of Law and Gender, 18*, 501–547.

Hobley, C. W. (1910). *Ethnology of A-Kamba and other East African tribes*. Cambridge: Cambridge University Press.

Hockey, J., & Draper, J. (2005). Beyond the womb and the tomb: Identity, (dis) embodiment and the life course. *Body & Society, 11*, 41–57.

Hodes, R. (2013a). The medical history of abortion in South Africa, c. 1970–2000. *Journal of Southern African Studies, 39*(4), 527–542.

Hodes, R. (2013b). 'You know what a bad person you are?' HIV, abortion, and reproductive health care for women in South Africa. In R. A. Smith (Ed.), *Global HIV/AIDS politics, policy and activism: Persistent challenges and emerging issues*. Santa Barbara: Praeger.

Hodes, R. (2016). The culture of illegal abortion in South Africa. *Journal of Southern African Studies, 42*(1), 79–93.

Hoffman, M., et al. (2006). The status of legal termination of pregnancy in South Africa. *South African Medical Journal, 96*(10), 1056.

Holder, A. (1892). Gynecic notes taken among the American Indians. *American Journal of Obstetrics and Diseases of Women and Children, 26*.

Holmstedt, Y. (1953). Psykiatriska synpunkter på abortsituationen. Bilaga V*: Abortfrågan. Betänkande avgivet av 1950 års abortutredning*. Stockholm: Statens offentliga utredningar, no. 29.

Holmström, R. (1947). Krig gynekologer—psykiatriker? *Svenska läkartidningen, 44*, 1237–1240.

Hospital de la Mujer (HM). (1994–1998). Gynecological and obstetrical statistics.
Hospital de la Mujer (HM). (2000–2007). Gynecological and obstetrical statistics.
Hospital de la Mujer (HM). (1994–2010). Gynecological and obstetrical patient medical records.
Hospital Municipal Boliviano-Holandés. (2005–2007). Gynecological and obstetrical patient medical records.
Hospital Municipal Boliviano-Holandés. (2006–2008). Gynecological and obstetrical statistics, 2006–2008.
Houck, M. M. (2009). *Science versus crime*. New York: Infobase Publishing.
Hoxie, F. (1984). *A final promise: The campaign to assimilate the Indians, 1880–1920*. Lincoln: University of Nebraska Press.
Hoxie, F. (1995). *Parading through history: The making of the Crow Nation in America, 1805–1935*. Cambridge: Cambridge University Press.
Hultin, M., & Ottosson, J. (1962). Klinisk observation av abortsökande kvinnor. En undersökning av 166 kvinnor som av Medicinalstyrelsen hänvisats till observation på psykiatrisk avdelning. *Svenska läkartidningen, 59*, 1365–1407.
Human Rights Watch. (2005). International Human Rights Law and Abortion in Latin America. https://www.hrw.org/legacy/backgrounder/wrd/wrd0106/wrd0106.pdf
Human Rights Watch. (2010). *A state of isolation: Access to abortion for women in Ireland*. New York: Human Rights Watch.
Hunt, N. (1999). *A colonial Lexicon. Of birth ritual, medicalization, and mobility in the Congo*. Durham and London: Duke University Press.
Hyman, A., et al. (2013). Misoprostol in women's hands: A harm reduction strategy for unsafe abortion. *Contraception, 87*(2), 128–130.
Iijima, Y. (1987). Folk culture and the liminality of children. *current Anthropology, 28*(4), 41–48.
Iliffe, J. (1969). *Tanganyika under German rule 1905–1912*. Cambridge: Cambridge University Press.
Inglis, T. (1998). *Moral monopoly: The rise and fall of the Catholic Church in modern Ireland*. Dublin: University College Dublin Press.
Inglis, T. (2007). Catholic identity in contemporary Ireland: Belief and belonging to tradition. *Journal of Contemporary Religion, 22*(2), 205–220.
Inhorn, M., & Balen, F. (Eds.). (2002). *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*. Berkeley: University of California Press.
Instituto Nacional de Estadística. (2008). *Encuesta Nacional de Demografía y Salud (ENDSA)*. La Paz, Bolivia: Instituto Nacional de Estadística.
Ipas. (2010). *Misoprostol and medical abortion in Latin America and the Caribbean*. Chapel Hill, NC: Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI) and Ipas.

Isambert, F. A., & Ladrière, P. (1979). *Contraception et avortement: Dix ans de débat dans la presse (1965–1974)*. Paris: Editions du Centre National de la Recherche Scientifique.

Isecke, H. (2010). *The Sojourner truth story*. Huntington Beach: Teacher Created Materials, Inc.

Ittameier, C. (1923). Die Erhaltung und Vermehrung der Eingeborenen-Bevölkerung. In *Abhandlungen aus dem Gebiet der Auslandskunde. Wissenschaftliche Beiträge zur Frage der Erhaltung und Vermehrung der Eingeborenen-Bevölkerung. Ergebnisse der Eduard-Woermann-Preisaufgabe* (Vol. 13, pp. 1–82). Hamburg: L. Friederichsen & Co.

Jacobs, M. (2009). *White Mother to a Dark Race: Settler Colonialism, Maternalism, and the Removal of Indigenous Children in the American West and Australia, 1880–1940*. Lincoln: University of Nebraska Press.

Jacobs, M. (2014). *A generation removed: The fostering and adoption of Indigenous children in the postwar world*. Lincoln: University of Nebraska Press.

Jacoby, J. (1997, March 4). The partial truth abortion debate. *Boston Globe*, p. A5.

James, D. (2000). *Doña Maria's story: Life history, memory, and political identity*. Durham: Duke University Press.

Jameson, E., & Armitage, S. (Eds.). (1997). *Writing the range: Race, class, and culture in the women's West*. Norman: University of Oklahoma Press.

"Jane White." The National Archives, HO 144/563/A60814.

Janzen, J. (1978). *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press.

Jeffreys, S. (1993). *The Lesbian heresy: A feminist perspective on the lesbian sexual revolution*. North Melbourne: Spinifex.

Jenkins, H. (1979, March 21). *CPD*, HR, 982.

Jennings, K. (2010). *Trouble. Evolution of a radical. Selected writings 1970–2010*. Melbourne: Black Inc.

Jewkes, R., et al. (2002). Prevalence of morbidity associated with abortion before and after legalisation in South Africa. *British Medical Journal, 324*, 1252–1253.

Jewkes, R., et al. (2005). Why are women still aborting outside designated hospital facilities in South Africa? *British Journal of Obstetrics and Gynecology, 112*, 1236–1242.

Jewkes, R., & Rees, H. (2005). Dramatic decline in abortion mortality due to the Choice on termination of Pregnancy Act. *South African Medical Journal, 95*(4), 250.

Jewkes, R., Wood, K., & Maforah, N. (1997). Backstreet abortion in South Africa. *South Afrian Medical Journal, 87*(4), 417–418.

Joffe, C. (2013). The politicization of abortion and the evolution of abortion counseling. *American Journal of Public Health, 103*(1), 57–65.

Joffe, C., Weitz, T. A., & Stacey, C. L. (2004). Uneasy allies: Pro-choice physicians, feminist health activists and the struggle for abortion rights. *Sociology of Health and Illness, 26*(6), 775–796.

Johnson, D. (2003, September 1). Discredited myths about partial birth abortion—and some journalist who won't let go of them. *National Right to Life News*, p. 12.

Johnson-Hanks, J. (2002). The lesser shame: Adolescent abortion in Cameroon. *Social Science & Medicine, 55*(8), 1337–1349.

Johnson-Hanks, J. (2006). *Uncertain honor: Modern motherhood in an African crisis*. Chicago: University of Chicago Press.

Johnson-McGrath, J. (1995). Speaking for the dead: Forensic pathologists and criminal justice in the United States. *Science, Technology, and Human Values, 20*(4), 438–459.

Jolly, M. (1998). Introduction. Colonial and postcolonial plots in histories of maternities and modernities. In K. Ram & M. Jolly (Eds.), *Maternities and modernities: Colonial and postcolonial experiences in Asia and the pacific* (pp. 1–25). Cambridge: Cambridge University Press.

Jones, M. H. (2014). *Knowledge, power, and black politics: Collected essays*. Albany: State University of New York Press.

Jütte, R. (Ed.). (1993). *Geschichte der Abtreibung: Von der Antike bis zur Gegenwart*. München: C. H. Beck.

Kantrowitz, R. (2011, Decmeber 1). Commentary: Beautiful cigar girl gets snuffed. *Massachusetts Lawyers Weekly*.

Kaufmann, S., & Morgan, L. (2005). The anthropology of the beginnings and ends of life. *Annual Review of Anthropology, 34*, 317–341.

Kennedy, R. (2011). An Australian archive of feelings: The sorry books campaign and the pedagogy of compassion. *Australian Feminist Studies, 26*(69), 257–279.

Kenny, C. (2006). Abortion—A reproductive right. In *Women's reproductive rights* (pp. 17–32). London: Palgrave Macmillan.

Kenny, M. (2001, May 13). The day we drove the condom train straight through de Valera's Ireland. *Independent.ie*.

Kenworthy, E. (Ed.). (1999). *Embodied geographies: Spaces, bodies and rites of passage*. London: Routledge.

Keown, J. (1988). *Abortion, doctors and the law. Some aspects of the legal regulation of abortion in England from 1803 to 1982*. Cambridge: Cambridge University Press.

Kevin, C. (2003). A genealogy of pregnancy in medicine and the law: Australia 1945–2000. PhD thesis, The University of Sydney, Sydney.

Kevin, C. (2004). *A genealogy of pregnancy in medicine and the law: Australia 1945–2000*. PhD thesis, University of Sydney.

Kevin, C. (2005). Maternity and freedom: Australian feminist encounters with the reproductive body. *The Australian Feminist Studies, 20*(46), 3–15.

Kikuchi, Y. (1997). Shichikashuku Sekishi Yōiku Seido Kankei Bunsho: Chihō Bunsho ni miru Shussan to Yōiku [Historical Materials from Shichikakshuku on Taking Care of Infants: Birth and Childrearing Observed in Collection in a

Rural Area]. In O. Motoko (Ed.), *Kinsei Nihon Mabiki Kanko Shiryo Shūsei* [Historical Materials on Mabiki in Early Modern Japan] (pp. 129–222). Tokyo: Tōsui Shobō.

Kimball, N. (2013). *An open secret: The hidden history of unwanted pregnancy and abortion in highland Bolivia, 1952–2010.* PhD dissertation, University of Pittsburgh.

King, D. K. (1988). Multiple jeopardy, multiple consciousness: The context of a black feminist ideology. *Signs: Journal of Women in Culture and Society, 14*(1), 42–72.

Kingston, M. (1994, October 27). Trial and terror. *Sydney Morning Herald*, p. 17.

Kito, H. (2000). Jinkō Kara Yomu Nihon no Rekishi [Reading the History of Japan through *Population*]. Kodansha Gakujutsu Bunko (Japanese Edition). Tokyo: Kodansha.

Kjekshus, H. (1996). *Ecology Control and Economic Development in East African History: The Case of Tanganyika 1850–1950.* London: James Currey.

Klausen, S. (2014). 'The trial the world is watching': The 1972 prosecution of Derk Crichton and James Watts, abortion, and the regulation of the medical profession in apartheid South Africa. *Medical History, 58*(2), 210–229.

Klein, R. (1994). Reflections on Cairo: empowerment rhetoric—But who will pay the price? *FINRRAGE.*

Klein, R. (2006). Submission to the Senate Community Affairs Committee Inquiry into the Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005. Web. 9 September 2014.

Klein, R. (2008). From test-tube women to bodies without women. *Women's Studies International Forum, 31*, 157–175.

Klein, R., & Hawthorne, S. (2012, January 25). The authentic feminism of Melinda Tankard Reist. *ABC Religion and Ethics–ABC Radio.*

Klein, R., Raymond, J. G., & Dumble, L. J. (1991). *RU 486: Misconceptions, myths and morals.* Melbourne: Spinifex Press.

Kleinman, A. (1992). Local worlds of suffering: An interpersonal focus for ethnographies of illness experience. *Qualitative Health Research, 2*, 127–134.

Kleinman, A. (Ed.). (1995). *Writing at the margin: Discourse between anthropology and medicine.* Berkeley: University of California Press.

Kligman, G. (1998). *The politics of duplicity: Controlling reproduction in Ceauşescu's Romania.* Berkeley: University of California Press.

Kluchin, R. (2009). *Fit to be tied: Sterilization and reproductive rights in America, 1950–1980.* New Brunswick, NJ: Rutgers University Press.

Klugman, R. (1979, March 21). *CPD*, HR, 1004.

Knecht, M. (1994). Zwischen Reproduktionstechnologie und Neuer Mütterlichkeit. Verschiebungen und Umbrüche in der Abtreibungsdebatte. In

C. Wichterich (Ed.), *Menschen Nach Maß. Bevölkerungspolitik in Nord und Süd* (1st ed., pp. 107–128). Göttingen: Lamuv.

Knight, P. (1977). Women and abortion in Victorian and Edwardian England. *History Workshop Journal, 4*, 57–62.

Knoll, A., & Gann, L. H. (Eds.). (1987). *Germans in the tropics. Essays in German colonial history*. New York: Greenwood.

Koblitz, A. H. (2014). *Sex and herbs and birth Control: Women and fertility regulation through the ages*. Seattle: Kovalevskaia Fund.

Kößler, R., & Melber, H. (2004). Deutscher Kolonialismus. Vergangenes in der Gegenwart. Kontinuitäten des Deutschen Kolonialismus. *Sopos* 2.

Kohler, H. (1997). Learning in social networks and contraceptive choice. *Demography, 34*, 43–58.

Kongnyuy, E., Ngassa, P., Fomulu, N., Wisonge, C., Kouam, L., & Doh, A. (2007). A survey of knowledge, attitudes and practice of emergency contraception among university students in Cameroon. *BMC Emergency Medicine 7*. Retrieved September 3, 2015, from http://www.biomedcentral.com/1471-227X/7/7

Konings, P., & Nyamnjoh, F. B. (1997). The Anglophone problem in Cameroon. *Journal of Modern African Studies, 35*(2), 207–229.

Koponen, J. (1994). *Development for exploitation. German colonial policies in Mainland Tanzania, 1884–1914*. Hamburg: LIT.

Kößler, R., & Henning, M. (2004). Deutscher Kolonialismus. Vergangenes in der Gegenwart. Kontinuitäten des Deutschen Kolonialismus. *Sopos 2*.

Koster-Oyekan, W. (1998). Why Resort to Illegal Abortion in Zambia? Findings of a Community-based Study in Western Province. *Social Science & Medicine, 46*, 1303–1312.

Külz, L. (1913). Die seuchenhaften Krankheiten des Kindesalters der Eingeborenen und ihre Bedeutung für die koloniale Bevölkerungsfrage. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 6*, 321–330.

Kumar, A., Hessini, L., & Mitchell, E. (2009). Conceptualising abortion stigma. *Culture, Health and Sexuality, 11*(6), 625–639.

Kumar, A. (2013). Everything is not abortion stigma. *Women's Health Issues, 23*(6), 329–331.

Kure, S., & Fujikawa, Y. (1898). *Nihon Sanka Sōsho* [Classics in Obstetrics in Japan]. Kyoto: Shibunkaku.

Lagercrantz-Asklund, L. (1941). Abortfrågan—ett försök att minska dess omfattning. *Sexualfrågan, 3*(2), 18–22.

Lakota People's Law Project. (2013, January 22). Reviewing the facts: An assessment of the accuracy of NPR's *Native Foster care: Lost children, shattered families*. Report to Congress.

Landau, P. (1999). 'Religion' and Christian conversion in African history: A new model. *The Journal of Religious History, 23*(1), 8–30.

Langwick, S. (2011). *Bodies, politics, and African healing. The matter of maladies in Tanzania*. Bloomington: Indiana University Press.

Larmour, C. (1994). *Population policies: Family planning and reproductive rights.* Canberra: Commonwealth of Australia.

LaRocque, E. (2010). *When the other is me: Native resistance discourse, 1850–1990.* Winnipeg: University of Manitoba Press.

Larsson, I. L. (1951). *Vide ung.* Stockholm: Wahlström & Widstrand.

Latham, M. (2002). *Regulating reproduction: A century of conflict in Britain and France.* Manchester: Manchester University Press.

Lawrence, J. (2000). The Indian health service and the sterilization of native American women. *American Indian Quarterly, 24*(3), 400–419.

Le Naour, J. Y., & Valenti, C. (2003). *Histoire de l'avortement, XIXe–XXe siècle.* Paris: Editions Seuil.

Leap, N., & Hunter, B. (1993). *The midwife's tale: An oral history from handywoman to professional midwife*. London: Scarlet Press.

Lee, E. (2003). *Abortion, motherhood, and mental health: Medicalizing reproduction in the United States and Great Britain*. New York: Aldine de Gruyter.

Lennerhed, L. (1994). *Frihet att njuta. Sexualdebatten i Sverige på 1960-talet.* Stockholm: Norstedt.

Lennerhed, L. (2002). *Sex i folkhemmet. RFSUs tidiga historia*. Uppsala: Gidlunds.

Lennerhed, L. (2008). *Historier om ett brott. Illegala aborter i Sverige på 1900-talet*. Stockholm: Atlas.

Lennerhed, L. (2013a). En besvärlig människa. Om Elisabet Sjövall, sexualiteten och kvinnligheten. *Tidskrift för genusvetenskap 4.*

Lennerhed, L. (2013b). Sherri Finkbine's choice: Abortion, sexliberalism and feminism in Sweden in the 1960s and 1970s. *Women's History Magazine, 73*, 13–18.

Leidholt, D., & Raymond, J. G. (Eds.). (1990). *The sexual liberals and the attack on feminism*. New York: Pergamon Press.

Leininger, M., & McFarland, M. (2002). *Transcultural nursing: Concepts, theories, research, and practice*. New York: McGraw Hill Education.

Levada, W., & Ladaria, L. F. (2008, June 20). Instructions Dignitas Personae on Certain Bioethical Questions. Vatican document.

Lewin, E. (Ed.). (2005). *Feminist anthropology: A reader*. Malden, MA: Wiley-Blackwell Publishing.

Lindgren, Y. (2013). The rhetoric of choice: Restoring Healthcare to the abortion right. *Hastings Law Journal, 64*, 385–421.

Lion, A. (1909). Die hygienische Erziehung des Negers. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 7*, 413–426.

Litoff, J. B. (1978). *American midwives, 1860 to the present.* Westport, CT: Greenwood Press.

Löbner, M. H. (1914). Zur Evölkerungsfrage Unyamwezis. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 11*, 267–270.

Lomawaima, K. T. (1994). *They called it prairie light: The story of Chilocco Indian School*. Lincoln: University of Nebraska Press.

Lomawaima, K. T. (2001). *Bodies exploring fluid boundaries*. London: Routledge.

López, K., Saavedra, L. L., & Bailey, P. (1986). *Investigación de los aspectos sociales y médicos de la pérdida de embarazo; análisis de resultados*. La Paz, Bolivia: Sociedad Boliviana de Ginecología y Obstetricia and Family Health International.

Lorde, A. (1984). *Sister outsider: Essays and speeches by audre lorde*. Trumansburg, NY: Crossing Press.

Lovett, L. L. (2007). *Conceiving the future: Pronatalism, reproduction, and the family in the United States, 1890–1938*. Chapel Hill: University of North Carolina Press.

Lowry, T. (2004). *Venereal disease and the Lewis and Clark expedition*. Lincoln: University of Nebraska Press.

Lues, L., & Africa Christian Action. (2012). It's my body! I can choose what I want to do with it. And abortion is legal… But What Is Legal Isn't Necessarily Right. Retrieved June 20, 2016, from http://www.aboverubies.co.za/articles/devotionals/its-my-body.html

Luker, K. (1984). *Abortion and the politics of motherhood*. Berkeley, Los Angeles and London: University of California Press.

Luna, Z. (2009). From rights to justice: Women of color changing the face of US reproductive rights organizing. *Societies Without Borders, 4*, 343–365.

Lusher, S. (1978). Contributed article by Stephen Lusher on abortion. *National Right to Life Newsletter, 6*(4), 14.

Lusher, S. (1979, March 21). *CPD*, HR, 963.

Lynch, P. (1979, March 21). *CPD*, HR, 1997.

MacKinnon, C. A. (1990). Liberalism and the Death of Feminism. In D. Leidholt & J. G. Raymond (Eds.), *The sexual liberals and the attack on feminism*. New York: Pergamon Press.

MacPhee, I. (2001, March 21). *CPD*, HR, 1081.

Maddox, M. (2005). *God under Howard: The rise of the religious right in Australian politics*. Sydney: Allen and Unwin.

Madley, B. (2015). Reexamining the American genocide debate: Meaning, historiography, and new methods. *The American Historical Review, 120*(1), 98–139.

Madsen v. Womens' Health Center. (1994). 512 U.S. 753. United States Supreme Court.

Maehle, A., & Pranghofer, S. (2010). Medical confidentiality in the late nineteenth and early twentieth centuries: An Anglo-German comparison. *Medizinhistorisches Journal, 45*, 189–221.

Maher, M. (1971). Sowing the seeds. *The Irish Times*.

Maisha Eggers, M., et al. (Eds.). (2005). *Mythen, Masken und Subjekte. Kritische Weißseinsforschung in Deutschland*. Münster: Unrast.

Mangham, A., & Depledge, G. (2011). *The female body in medicine and literature*. Liverpool: Liverpool University Press.

Manian, M. (2013). Lesson's from personhood's defeat: Abortion restrictions and side-effects on women's health. University of San Francisco School of Law Research Paper No. 2013–13.

Mann, N., & Reardon, D. C. (2002). *Aborted women: Silent no more*. Acorn Publishing.

Maracle, L. (1988). *I am woman*. North Vancouver: Write-On Press Publishers.

Marland, H., & Rafferty, A. M. (Eds.). (1997). *Midwives, society and childbirth: Debates and controversies in the modern period*. London: Routledge.

Martin, L. J. (2014). *Reproductive tourism in the United States: Creating family in the mother country*. New York: Routledge.

Marx, C. (2004). Siedlerkolonien in Afrika. In F. Becker (Ed.), *Rassenmischehen—Mischlinge: Zur Politik der Rasse im deutschen Kolonialreich* (pp. 82–96). Stuttgart: Franz Steiner Verlag.

Mbele, A., Snyman, L., & Pattinson, R. (2006). Impact of the Choice on Termination of Pregnancy Act on maternal morbidity and mortality in the west of Pretoria. *South African Medical Journal, 96*(11), 1196–1198.

Mbembe, A. (2001). *On the postcolony*. Berkeley, Los Angeles and London: University of California Press.

McClive, C. (2002). The hidden truths of the belly: The uncertainties of pregnancy in early modern Europe. *Social History of Medicine, 15*(2), 209–227.

McCormack, M. (1978, July 4). Women's Week. *Honi Soit*, p. 9.

McDonald, H. (2011, July 20). Irish Prime Minister attacks Vatican. *The Guardian*.

McDonnell, O., & Allison, J. (2006). From biopolitics to bioethics: Church, state, medicine and assisted reproductive technology in Ireland. *Sociology of Health & Illness, 28*(6), 817–837.

McIntosh, T. (2000). 'An Abortionist City': Maternal mortality, abortion and birth control in Sheffield, 1920–1940. *Medical History, 44*(1), 75–96.

McIntosh, T. (2012). *A social history of maternity and childbirth: Key themes in maternity care*. New York: Routledge.

McKenzie, D. (1973, May 10). *CPD*, HR, 1963.

McLaren, A. (1977). Abortion in England, 1890–1914. *Victorian Studies, 20*(4), 379–400.

McLaren, A. (1993). Privileged communications? Medical confidentiality in late Victorian Britain. *Medical History, 37*(2), 129–147.

McMahon, E., & Olubas, B. (Eds.). (2006). *Women making time: Contemporary feminist critique and cultural analysis*. Crawley, Western Australia: University of Western Australia Press.

McMichael, T. (Ed.). (1972). *Abortion, the unenforceable law: The reality of unwanted pregnancy and abortion in Australia*. North Carlton: ALRA.

McMichael, T. (1972a). Attitudes toward the foetus. In T. McMichael (Ed.), *Abortion, The unenforceable law: The reality of unwanted Pregnancy and abortion in Australia* (pp. 39–40). North Carlton: ALRA.

McMichael, T. (1972b). Forward. In T. McMichael (Ed.), *Abortion, The unenforceable law: The reality of unwanted Pregnancy and abortion in Australia*. ALRA: North Carlton.

McMichael, T. (1972c). Introduction. In T. McMichael (Ed.), *Abortion, The unenforceable law: The reality of unwanted Pregnancy and abortion in Australia*. ALRA: North Carlton.

Meade, A. (1994, April 14). Pressure to control fertility control aid. *Sydney Morning Herald*, p. 5.

Meade, T., & Walker, M. (Eds.). (1991). *Science, medicine, and cultural imperialism*. London: Macmillan.

Meckel, R. (1990). *'Save the Babies': American public health reform and the prevention of infant mortality, 1850–1929*. Baltimore: Johns Hopkins University Press.

Medical Officer of Health. (1931). Borough of Acton. Annual Report of the Medical Officer of Health. *London's Pulse: Medical Officer of Health reports 1848–1972*. Retrieved December 18, 2013, from http://wellcomelibrary.org/moh/

Medizinalreferat in Daressalam. (1914). Familien-Nachwuchsstatistik über die Eingeborenen von Deutsch-Ostafrika. *Deutsches Kolonialblatt. Amtsblatt für die Schutzgebiete in Afrika und in der Südsee, 25*(10), 440–457.

Mhlanga, E. (2003). Abortion: Developments and impact in South Africa. *British Medical Bulletin, 67*, 115–126.

Mignolo, W. (2000). *Local histories/global designs: Coloniality, subaltern knowledges, and border thinking*. Princeton: Princeton University Press.

Mill, J. S. (1865). *On liberty*. London: Longmans, Green & Co.

Millar, E. (2015). Choice-makers or failures: Providing a genealogy of abortion shame and shaming. *Law & History: The Journal of the Australian and New Zealand Law & History Society, 2*, 114–145.

Mills, C. (2014). *Decolonizing global mental health: The psychiatrization of the majority world*. London: Routledge.

Minh-ha, T. T. (1989). *Women, native, other: Writing, postcoloniality and feminism*. Bloomington: University of Indiana Press.

Minh-ha, T. T. (1995). Writing postcoloniality and feminism. In B. Ashcroft, G. Griffiths, & H. Griffin (Eds.), *The post-colonial studies reader* (pp. 264–269). New York: Routledge.

Ministerio de Hacienda y Estadística. (1950). National census.

Ministerio de Salud y Deportes. (2004). *Plan Nacional de Maternidad y Nacimiento Seguros (2004–2008)*. La Paz: Ministerio de Salud y Deportes, Pan American Health Organization (PAHO) and United Nations Population Fund UNFPA.

Ministerio de Salud y Deportes. (2006). *Dirección de Desarrollo de Servicios de Salud. Manual de normas, reglas, protocolos y procedimientos técnicos para el manejo de las hemorragias de la primera mitad del embarazo*. La Paz, Bolivia: IPAS.

Ministry of Health. (1939). *Report of the Inter-Departmental Committee on Abortion*. London: HMSO.

Ministry of Public Health. (1995). *Maternal and child health care and family planning services policy and standards*. Republic of Cameroon.

Mishtal, J. (2014). Reproductive governance in the New Europe: Competing visions of morality, sovereignty, and supranational policy. *Anthropological Journal of European Cultures, 23*(1), 59–76.

Mishtal, J. (2015). *The politics of morality: The church, the state and reproductive rights in postsocialist Poland*. Athens, OH: Ohio University Press.

Mochiwa, A. (1954). *Habari Za Wazigua*. London: Macmillan.

Moerman, D. E. (1998). *Native American ethnobotany*. Portland, OR: Timber Press.

Mohanty, A. R., & Torres, L. (Eds.). (1991). *Third world women and the politics of feminism*. Bloomington: Indiana University Press.

Mohr, J. C. (1979). *Abortion in America: The origins and evolution of national policy*. New York: Oxford University Press.

Montana Code, Annotated 45-5-203.

Moore, F. (2013). 'Go and see Nell; She'll put you right': The wisewoman and working-class health care in early Twentieth-century Lancashire. *Social History of Medicine, 26*(4), 695–714.

Moore, H. L., Sanders, T., & Kaare, B. (1999). *Those who play with fire: Gender, fertility and transformation in East and Southern Africa*. London and New Brunswick: The Athlone Press.

Moreton-Robinson, A. (2000). *Talkin' up to the white woman: Aboriginal women and feminism*. St Lucia, Qld.: University of Queensland Press.

Moreton-Robinson, A., & Roberts, E. F. S. (2012). Reproductive governance in Latin America. *Anthropology & Medicine, 19*(2), 241–254.

Morgen, S. (2002). *Into our own hands: The women's health movement in the United States, 1969–1990*. New Brunswick, NJ: Rutgers University Press.

Morgan, L. M., & Roberts, E. F. S. (2012). Reproductive governance in Latin America. *Anthropology & Medicine, 19*(2), 241–254.

Morton, R. (2012). Is this Australia's most controversial feminist? *Mamamia*.

Moscucci, O. (1990). *The Science of woman: Gynaecology and gender in England 1800–1929*. Cambridge: Cambridge University Press.

Moser, R. R. (1987). Transformation of Southern Tanzania marriages. In D. Parking & D. Nyamwaya (Eds.), *Transformations in African marriage* (pp. 323–329). Manchester, UK: Manchester University Press.

Mossuz-Lavau, J. (1991). *Les Lois de l'amour—Les politiques de la sexualité en France de 1950 à nos jours.* Paris: Privot.

Motoko, O. (1997). *Kinsei Nihon Mabiki Kanko Shiryo Shūsei* [Historical Materials on Mabiki in Early Modern Japan]. Tokyo: Tōsui Shobō.

Mukoda, T. (2006, June 9). Hinmin Kyūsai to Shōshi Taisaku. Bunka Bunsei-ki ni Miru [Relief of thePoor and Strategies for Declining Birth Rate from Bunka and Bunsei Periods]. *Iwate Nichinichi Newspaper.*

Murphy-Lawless, J. (2005). Bodies coming and going: Women and fertility in postmodern Ireland. In C. Douglass (Ed.), *Barren states: The population implosion in Europe* (pp. 229–248). New York: Berg Publishes.

Murphy, S. (2006). Mapping the literature of transcultural nursing. *The Journal of the Medical Library Association, 94*(2), E143–E151.

Nagar, R., & Swarr, A. L. (2010). Introduction. In*Theorizing feminist transnational praxis* (pp. 1–20). New York: SUNY Press.

Nash, M. (Ed.). (2014). *Reframing reproduction.* London: Palgrave Macmillan.

National Abortion Federation. (2011). *NAF violence and disruption statistics.* Retrieved June 15, 2013, from http://www.prochoice.org/about_abortion/violence/documents/Stats_Table2011.pdf

National Council of Public Morals. (1916). *The declining Birth-Rate: Its causes and effects.* London: Chapman and Hall Ltd.

National Organization for Women. (1978). Major National Organizations Opposed to Abortion. *The National Organization for Women Papers.* Schlesinger Library, Harvard University.

National Organization for Women. (2006). Reproductive justice is every woman's right. *National NOW Times.*

National Population Commission. (1993). *Declaration of the national population policy.* Yaounde: Ministry of the Plan and Regional Development.

NCAP Strategic Communication Plan. (2000). *The National Coalition of Abortion Providers Papers*, Box 3, Bingham Library, Duke University.

Nelson, E. (2009). *Birth rights: Bolivia's politics of race, region, and motherhood, 1964–2005.* PhD dissertation, University of Wisconsin-Madison.

Nelson, J. (2003). *Women of color and the reproductive rights movement.* New York: New York University Press.

Neocosmos, M. (2006). *From 'Foreign Natives' to 'Native Foreigners': Explaining xenophobia in Post-Apartheid South Africa: Citizenship, Nationalism, Identity and Politics.* Dakar: CODESRIA.

Nestel, S. (1998). (Ad)ministering dngels: Colonial nursing and the extension of empire in Africa. *Journal of Medical Humanities, 19*(4), 257–277.

Newman, K. (1996). *Fetal positions: Individualism, science, visuality.* California: Stanford University Press.

Newton, D. E. (2008). *DNA evidence and forensic science*. New York: Infobase Publishing.
Nile, Reverend the Hon. F. J. (1994, October 27). *RU486 Abortifacient Trials*. Hansard. NSW Legislative Council Debates. Web. 9 September 2014.
Nkhwashu, G. (2013, June 10). House of abortion horror. *Daily Sun*, pp. 1–2.
Nkwi, P. N., & Nyamnjoh, F. B. (Eds.). (1997). *Regional balance and national integration in Cameroon*. Leiden: African Studies Centre and Yaoundé: ICASSRT.
Nockles, P. B. (1994). *The Oxford movement in context: Anglican High churchmanship, 1760–1857*. Cambridge: Cambridge University Press.
North Carolina General Statue § 14-277.3A.
NY Consolidated Laws Service Penal § 120.45.
O'Carroll, J. P. (1991). Bishops, knights—and pawns? Traditional thought and the Irish abortion referendum debate of 1983. *Irish Political Studies, 6*, 53–71.
O'Donovan, M., & Stuparich, J. (Eds.). (1994). *The abortion debate. Pro-life essays*. Canberra: ACT Right to Life Association.
O'Leary, R. (2004). The relics of St. Thérèse. In M. Peillon & M. P. Corcoran (Eds.), *Place and non-place: The reconfiguration of Ireland*. Dublin: Institute of Public Administration.
O'Toole, F. (2012, November 17). When is an abortion not an abortion? *The Irish Times*, p. 4.
Oaks, L. (1999). Irishness, Eurocitizens, and defining abortion. In S. Franklin & H. Ragoné (Eds.), *Reproducing reproduction: Kinship, power, and technological innovation* (pp. 132–155). Philadelphia: University of Pennsylvania Press.
Oaisar, A. (2009). Pro-life and pro-choice debate: A journey from restriction to regulation—destination Pakistan. *Pakistan Law Journal*, 25–37.
Ochiai, E. (1994). Kinsei ni okeru Mabiki to Shussan: Ningen no Seisan o meguru Taisei Hendō [Mabiki and Birth in Early Modern Era: Institutional Changes in Human Reproduction]. In W. Haruko & S. B. Hanley (Eds.), *Jendā no Nihonshi Jō* [Gender and History of Japan] (Vol. 1, pp. 425–460). Tokyo: Tokyo Daigaku Shuppankai.
Office for Victims of Crime. Stalking. *Office of Justice Programs*. Retrieved June 15, 2013, from http://ovc.ncjrs.gov/topic.aspx?topicid=36
Office on the Status of Women. (2002). *South Africa's national policy framework for women's empowerment and gender equality*. Retrieved June 20, 2016, from http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=94056&p_country=ZAF&p_count=1051&p_classification=05&p_classcount=38
Official Code of Georgia, Annotated § 16-5-90.
Ogata, M. (1980). *Nihon Sankagakushi* [History of Obstetrics in Japan]. Tokyo: Kagaku Shoin.
Ohta, M. (1997). *Kyōdō Kenkyū no Kadai to Hōhō oyobi Tōtatsuten ni tsuite* [On the Mission, Methodology, and Results of the Collective Project]. In O. Motoko (Ed.), *Kinsei Nihon Mabiki Kankō Shiryō Shūsei* [Historical Materials on Mabiki in Early Modern Japan] (pp. 33–127). Tokyo: Tōsui Shobō.

Ohta, M. (2006). *Kogaeshi o Meguru Gensetsu: Kattō suru Shutai no Tanjō* [Discourses Surrounding Returning of the Child: The Birth of the Subject Who Contemplate]. In O. Motoko & M. Kenji (Eds.), *Inochi to Kazoku: Seishokugijutsu to Kazoku* [Life and Family: Reproductive Technologies and Family] (Vol. 1, pp. 107–139).Tokyo: Waseda University Press.

Ohta, M. (2007). *Kodakara to Kogaeshi* [Child as a Treasure, Returning of a Child]. Tokyo: Fujiwara Shoten.

Ohta, M. (2011). *Kinsei no Ie to Kazoku: Kosodate o meguru Shakaishi* [Household and Family in the Early Modern Period: Social History of Childrearing]. Tokyo: Kadokawa Sōsho.

Olusoga, D., & Erichsen, C. W. (2010). *Germany's forgotten genocide and the colonial roots of Nazism*. London: Faber and Faber.

Operation Save America. Meet the Director, Rev. Flip Benham. *Operation Rescue/ Operation Save America*. Retrieved June 15, 2013, from http://www.operationsaveamerica.org/about-us/rev-flip-benham-director/

Orelli, C. (1889). *The prophecies of Isaiah*. Edinburgh: T&T Clark.

Orner, P., de Bruyn, M., & Cooper, D. (2011). 'It hurts, but I don't have a choice, I'm not working and I'm sick': Decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa. *Culture, Health and Sexuality, 13*(7), 781–795.

Ostrach, B. (2014). Did policy change work? Oregon women continue to encounter delays in medicaid coverage for abortion. *Anthropology in Action, 21*(3), 20–30.

Ostrach, B., & Cheyney, M. (2014). Navigating social and institutional obstacles: Low-income women seeking abortion. *Qualitative Health Research, 24*(7), 1006–1017.

Oto, O. (1996). *Kinsei Nōmin to Ie, Mura, Kokka: Seikatsu-shi Shakai-shi no Shiza kara* [Family, Community, and Nation for Farmers in Tokugawa Japan: From a Perspective of the History of Lifestyle and Society]. Tokyo: Yoshikawa Kōbunkan.

Oyèwùmí, O. (2005). Colonizing bodies and minds. Gender and colonialism. In G. Desai & S. Nair (Eds.), *Postcolonialisms. An anthology of cultural theory and criticism* (pp. 339–361). New Brunswick: Rutgers University Press.

Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). *Teenage pregnancy in South Africa—with a specific focus on school-going learners*. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria: Department of Basic Education.

Parens, E. (2013). On good and bad forms of medicalization. *Bioethics, 27*(1), 28–35.

Parking, D., & Nyamwaya, D. (1987). *Transformations in African marriage*. Manchester: Manchester University Press.

Parliamentary Group on Population and Development. (2007). *Sexual and reproductive health and the Millennium Development Goals in the Australian aid*

program—the way forward. Canberra: Parliamentary Group on Population and Development.

Pavard, B. (2009). Genre et militantisme dans le Mouvement pour la liberté de l'avortement et de la contraception. Pratique des avortements (1973–1979). *Clio: Femmes, Genre, Histoire, 29*(68), 79–96.

Pavard, B. (2012). *Si je veux, quand je veux: Contraception et avortement dans la société française (1956–1979)*. Rennes: Presses Universitaires de Rennes.

Pavard, B., Florence, R., & Zancarini-Fournel, M. (2012). *Les lois Veils. Contraception 1974, IVG 1975*. Paris: Armand Colin.

Paxman, J. M., Rizo, A., Brown, L., & Benson, J. (1993). The clandestine epidemic: The practice of unsafe abortion in Latin America. *Studies in Family Planning, 24*(4), 205–226.

Peatling, S. (2012, August 30). Health group gets green light to import abortion drug into Australia. *Sydney Morning Herald*.

Peiper, O. (1910). Schwangerschaft, Geburt und Wochenbett bei den Suaheli von Kilwa. *Archiv für Schiffs- und Tropen-Hygiene, 14*(15), 461–469.

Peiper, O. (1912). Sozial-medizinische Bilder aus Deutsch-Ostafrika. *Zeitschrift für Säuglingsschutz*, 244–259.

Peiper, O. (1920a). Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee,—seine Ursachen und seine Bekämpfung. In Abteilung I des Ministeriums (Ed.), *Veröffentlichungen aus dem Gebiete der Medizinalverwaltung. Im Auftrage des Ministeriums für Volkswohlfahrt XI/7* (pp. 417–508). Berlin: Richard Schoetz.

Peiper, O. (1920b). Geburtenhäufigkeit, Säuglings—und Kinder-Sterblichkeit und Säuglingsernährung im früheren Deutsch-Ostafrika. In Abteilung I des Ministeriums (Ed.), *Veröffentlichungen aus dem Gebiete der Medizinalverwaltung. Im Auftrage des Ministeriums für Volkswohlfahrt XI/6* (pp. 371–412). Berlin: Richard Schoetz.

Perdue, T. (1997). *Cherokee women: Gender and culture change, 1700–1835*. Lincoln: University of Nebraska Press.

Perl, R. (1989, November 6). Foes put pressure on doctors to quit performing abortions. *Atlanta Journal Constitution*, p. A1.

Perrucci, A. (2012). *Decision assesment and counseling in abortion care*. New York: Rowman and Littlefield Publishers INC.

Petchesky, R. P. (1984). *Abortion and women's choice: The state, sexuality, and reproductive freedom*. New York: Longman Inc.

Petchesky, R. P. (1987). Fetal images: The power of visual culture in the politics of reproduction. *Feminist Studies, 13*(2), 263–292.

Petersen, K. (1993). *Abortion regimes*. Aldershot and Brookfield: Dartmouth Publishing Co. Ltd.

Peterson, D. R. (2006). Morality plays: Marriage, church courts, and colonial agency in Central Tanganyika, ca. 1876–1928. *The American Historical Review, 111*(4), 984–985.

Picq, F. (1993). *Libération des Femmes, Les Années-Mouvement*. Paris: Editions du Seuil.

Planned Parenthood of the Columbia/Willamette Inc. v. American Coalition of Life Activists. (2002). 290 F.3d 1058. Ninth Circuit Court of Appeals. Cert. denied. 539 U.S. 958.

Plant, R. J. (2010). *Mom: The transformation of motherhood in modern America*. Chicago: University of Chicago Press.

Plummer, M. L., et al. (2008). Aborting and suspending pregnancy in rural Tanzania: An ethnography of young people's beliefs and practices. *Studies in Family Planning, 39*(4), 281–292.

Poe, E. A. (1846). The philosophy of composition. *Graham's Magazine, 28*(4), 163–167.

Pollitt, K. (2014). *Pro: Reclaiming abortion rights*. New York: Picador.

Portelli, A. (1991). *The death of Luigi Trastulli, and other stories: Form and meaning in oral history*. Albany, NY: SUNY Press.

Potts, D., & Marks, S. (2001). Fertility in southern Africa: The quiet revolution. *Journal of Southern African Studies, 27*(2), 189–205.

Powell, S. (1996, August 20). Abortion—the great divider. *The Australian*, p. 11.

Pringle, H. (2007). Urban mythology: The question of abortion in parliament. *Australasian Parliamentary Review, 22*(2), 5–22.

"Progress Report from the Legal Sub-Committee of the Committee of Enquiry into Non-Therapeutic Abortion." The Wellcome Library, Archives and Manuscripts, SA/NBT/S.4/7.

Quijano, A. (2000). Coloniality of power, Eurocentrism, and Latin America. *Nepantla: Views from South, 1*(3), 533–580.

R.A.V. v. City of St. Paul. (1992). 505 U.S. 377. United States Supreme Court.

"R. v. Hollis." The National Archives, CRIM 1/102/9.

"R. v. White A." The National Archives, CRIM 1/54/9.

"R. v. White B." The National Archives, CRIM 1/42/3.

Rafter, N. (2009). *The origins of criminology*. New York: Routledge.

Rainer, B. (2003). *Der Diskurs der Überbevölkerung. Zu Metaphorik und Funktion Einer in Aussicht Gestellten Globalen Katastrophe*. PhD thesis, Freie Universität Berlin.

Ralstin-Lewis, D. (2005). The continuing struggle against genocide: Indigenous women's reproductive rights. *Wicazo Sa Review, 20*(1), 71–95.

Ram, K., & Jolly, M. (Eds.). (1998). *Maternities and modernities: Colonial and postcolonial experiences in Asia and the Pacific*. Cambridge: Cambridge University Press.

Rasch, V., & Lyaruu, M. (2005). Unsafe abortion in Tanzania and the need for involving men in post abortion counselling. *Studies in Family Planning, 36*(4), 301–310.

Raum, O. F. (1965). German East Africa: Changes in African tribal life under German administration 1892–1914. In V. Harlow & E. M. Chilver (Eds.), *History of East Africa* (pp. 163–207). Oxford: Oxford University Press.

Raymond, J. G. (1989). Reproductive technologies, radical feminism, and socialist liberalism. *Reproductive and Genetic Engineering, 2*(2), 133–142.

Reader, K., & Wadia, K. (1993). *The May 1968 events in France: Reproductions and interpretations.* New York: St. Martin's Press.

Reardon, D. C. (1996). *Making abortion rare: A healing strategy for a divided nation*. Randburg: Acorn Books.

Reagan, L. J. (1995). Linking midwives and abortion in the progressive era. *Bulletin of the History of Medicine, 69*(4), 569–598.

Reagan, L. J. (1997). *When abortion was a crime: Women, medicine, and law in the United States, 1867–1973.* Berkeley: University of California Press.

Reekie, G. (1997). History and the bodies of the illegitimately pregnant woman. *Australian Feminist Studies, 12*(25), 77–89.

Rees, H., et al. (1997). The epidemiology of incomplete abortion in South Africa. *South African Medical Journal, 87*(4), 432–437.

Reichs-Kolonialamt (Ed.). (1913). *Medizinal-Berichte über die Deutschen Schutzgebiete für das Jahr 1910/11.* Berlin: Ernst Siegfried Mittler und Sohn.

Reichs-Kolonialamt (Ed.). (1914). *Die Deutschen Schutzgebiete in Afrika und der Südsee 1912/13.* Berlin: Ernst Siegfried Mittler und Sohn.

Reid, A. (2012a). Birth attendants and midwifery practice in early twentieth-century Derbyshire. *The Social History of Medicine, 25*(2), 380–399.

Reid, A. (2012b). Mrs Killer and Dr Crook: Birth attendants and birth outcomes in early twentieth-century Derbyshire. *Medical History, 56*(4), 511–530.

Reid, L. (2011). *Midwifery in Scotland: A history.* Erskine: Scottish History Press.

Reineke, S. (2011). *Beauvoir and her sisters: The politics of women's bodies in France.* Urbana and Champaign: University of Illinois Press.

Reist, M. T. (2000). *Giving sorrow words: Women's stories of grief after abortion*. Sydney: Duffy & Snellgrove.

Reist, M. T. (2006). *Defiant birth: Women who resist medical eugenics.* Melbourne: Spinifex Press.

Religious Coalition for Reproductive Choice. (n.d.). A proud history as a voice of conscience.

Remeikis, G. V. (2001). A review of the psychoanalytic literature on abortion. *Journal of the American Academy of Psychoanalysis, 29*(2), 231–244.

Remez, L. C. (1995). Confronting the reality of abortion in Latin America. *International Family Planning Perspectives, 21*(1), 32–36.

Renne, E. (1996). The pregnancy that doesn't stay: The practice and perception of abortion by Ekiti Yoruba women. *Social Science & Medicine, 42*, 483–494.

Republic of South Africa, Ministry for Welfare and Population Development. (1995). *Population policy for South Africa: A green paper for public discussion.* Pretoria: Republic of South Africa.

Rhones, R. A. W. (Ed.). (2009). *The Australian study of politics.* Houndmills and New York: Palgrave Macmillan.

Richert, E. (1942). *Ta hand om Ulla! Ett ungt äktenskaps historia*. Stockholm: Medén.

Ricker, C. (2009). *Ratification of important women's rights document sparks controversy in Cameroon*. Retrieved September 2, 2015, from http://www.realitycheck.org/reader-diaries/2009/07/17/ratification-important-women

Right to Life Australia. (1980, July–August). *Right to Life News*.

Ripper, M. (2001). Abortion: The shift in stigmatization from those seeking abortion to those providing it. *Health Sociology Review, 10*(2), 65–77.

Ripper, M., Ryan, L., & Buttfield, B. M. (Eds.). (1994). *We women decide: Women's experience of seeking abortion in Queensland, South Australia and Tasmania, 1985–1992*. Bedford Park, SA: Women's Studies Unit, Flinders University.

Rivkin-Fish, M. (2005). *Women's health in post-Soviet Russia: The politics of intervention*. Bloomington: Indiana University Press.

Roberts, D. (1997). *Killing the black body: Race, reproduction and the meaning of liberty*. New York: Pantheon Books.

Rockel, S. J. (2000). Enterprising partners: Caravan women in nineteenth century Tanzania. *Canadian Journal of African Studies/Revue Canadienne des Études Africaines, 34*(3), 748–778.

Roberts, D. (2014). *Killing the black body: Race, reproduction, and the meaning of liberty*. Boston: Vintage.*Roe v. Wade*. (1973). 410 U.S. 113.

Rohlinger, D., & Meyer, D. S. (2005). Transnational framing of access to abortion in the United States, England, and Ireland. In L. A. Banaszak (Ed.), *The US women's movement in a global perspective* (pp. 197–214). New York: Rowan and Littlefield Publishers.

Romero Curtin, P. (1983). Laboratory of the oral history of slavery: The Island of Lamu on the Kenya Coast. *The American Historical Review, 88*(4), 858–882.

Ross, K. (2002). *May '68 and its afterlives*. Chicago: University of Chicago Press.

Ross, L. (2006). Understanding reproductive justice: Transforming the pro-choice movement. *Off Our Backs, 36*(4), 14.

Rossier, C. (2007). Abortion: An open secret? Abortion and social network involvement in Burkina Faso. *Reproductive Health Matters, 15*(30), 230–238.

Rossiter, A. (2009). *Ireland's hidden diaspora: The 'abortion trail' and the making of a London-Irish underground, 1980–2000*. London: IASC Publishing.

Rowland, R. (1985). Women who do and women who don't join the women's movement. *Women's Studies International Forum, 8*(4), 249–254.

Rundle, K., Leigh, C., McGee, H., & Layte, R. (2004). *Irish Contraception and Crisis Pregnancy [ICCP] study. A survey of the general population. Summary*. Dublin: Crisis Pregnancy Agency.

Russell, A., Sobo, E., & Thompson, M. (Eds.). (2000). *Contraception across cultures*. Oxford: Berg Publishers.

Russell, A., & Thompson, M. (2000). Introduction: Contraception across cultures. In A. Russell, E. Sobo, & M. Thompson (Eds.), *Contraception across cultures* (pp. 3–25). Oxford: Berg Publishers.

Ryan, C. (2011, March 15). Abortion by post. *The Irish Times.*

Ryan, S. (2009). Final report of the Commission to Inquire into Child Abuse dated 20th May 2009. *The Commission to Inquire into Child Abuse.*

Sachar, R. (2013, March 5). The tragic tale of Alice Bowlsby. *Forgotten Stories.*

Saletan, W. (2004). *Bearing right: How conservatives won the abortion war.* Berkeley: University of California Press.

Samandari, G., Wolf, M., Basnett, I., Hyman, A., & Andersen, K. (2012). Implementation of legal abortion in Nepal: A model for rapid scale-up of high-quality care. *Reproductive Health, 9*(7), 1–11.

Sander Esbensen, L. (2003). *'Thi Livet er starkare end Loven …' Danmarks moderne aborthistorie.* Köpenhamn: Syddansk Universitetsforlag.

Sanford, V. (2003). *Buried secrets: Truth and human rights in Guatemala.* New York: Palgrave Macmillan.

Saving Mothers: Republic of South Africa, Department of Health. (2014). Saving mothers 2011–2013: Sixth report on confidential enquiries into maternal deaths in South Africa. Retrieved from http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf

Savulescu, L. (2004). Abortion: Time to clarify Australia's confusing laws. *The Medical Journal of Australia, 181*(4), 201–203.

Sauerteig, L. D. H. (2001). 'The fatherland is in danger, save the fatherland!' Venereal disease, sexuality and gender in Imperial and Weimar Germany. In R. Davidson & L. A. Hall (Eds.), *Sex, sin and suffering. Venereal disease and European society since 1870* (pp. 76–92). New York: Routledge.

Sawayama, M. (1997). Sendaihan Ryōnai Akago Yōiku Shihō to Kanren Shiryō: Higashiyama Chiku o Chūshin ni [Historical Materials on Guideline for Childrearing in Sendai Domain: Focusing on Higashiyama District]. In O. Motoko (Ed.), *Kinsei Nihon Mabiki Kankō Shiryō Shūsei* [Historical Materials on Mabiki in Early Modern Japan] (pp. 33–127). Tokyo: Tosui Shobo.

Sawayama, M. (2004). *Umu Shintai no Isō: Kinseimatsu Mutsunokuni Ichinosekihan no Kaitai, Shussan Torishimarini Miru* [The Issues Surrounding Childbirth Regulations in the Ichinoseki Clan]. *Junsei Tanki Daigaku Kenkyū Kiyō, 33*, 87–109.

Sawayama, M. (2005). *Sei to Seishoku no Kinsei* [Sexuality and Reproduction in Early Modern Era]. Tokyo: Keisō Shobō.

Sawayama, M. (2006). *Ichinoseki-han no Ikuji Shihō kara mita Ninshin, Shussan, Kosodate: Bushi to Nōmin no Nichijō Sekai e no Sekkin* [A Study of the Childbirth Regulations in Ichinoseki Clan in the Early 19th Century: Focused on the Pregnancy, Childbirth and Childcare in Samurai and Peasant Families]. *Junsei Tanki Daigaku Kenkyū Kiyō, 35*, 25–46.

Sawayama, M. (2009). *Shussan to Iryō o Tōshite Mita Kinsei Kōki no Taiji, Akago to Haha no Inochi* [The Fetus and Infant and the Life of the Mother in Birth and Medicine in the Late Tokugawa Period]. *Bunka Kyoseigaku Kenkyu, 8*, 55–74.

Sawer, M. (1990). *Sisters in suits: Women and public policy in Australia*. Sydney: Allen and Unwin.

Sawer, M. (2003). *The ethical etate? Social liberalism in Australia*. Melbourne: Melbourne University Publishing.

Schapera, I. (1933). Premarital pregnancy and native opinion. A note on social change. *Africa, 6*(1), 59–89.

Scheidler, J. (1985). *Closed: 99 ways to stop abortion*. San Francisco: Ignatius Press.

Schnookal, D. (1974). Excerpt from public meeting. WAAC, 'Open Letter, 28 November 1974', undated, box 46, Wainer Papers, MS134636, State Library of Victoria.

Schoen, J. (2015). *Abortion after Roe*. Chapel Hill: University of North Carolina Press.

Schulze-Engler, F., & Helff, S. (Eds.). (2009). *Transcultural English studies: Theories, fictions, realities* (Vol. 102). Amsterdam: Rodopi.

Schuster, S. (2004). *Der Schwangerschaftsabbruch im Grasland Kameruns: Medizin, Kultur und Praxis*. Frankfurt/Main: Peter Lang Publishers.

Schuster, S. (2005). Abortion in the moral world of the Cameroon grassfields. *Reproductive Health Matters, 13*(26), 130–138.

Schuster, S. (2010). Women's experiences of the abortion law in Cameroon: 'What really matters'. *Reproductive Health Matters, 18*(35), 137–144.

Scott, J. C. (1990). *Domination and the arts of resistance: Hidden transcripts*. New Haven and London: Yale University Press.

Sedgh, G., Bankole, A., Oye-Adeniran, B., Adewole, I. F., Singh, S., & Hussain, R. (2006). Unwanted pregnancy and associated factors among Nigerian women. *International Family Planning Perspectives, 32*(4), 175–184.

Seidler, E. (1993). Jahrhundert. Zur Vorgeschichte des Paragraphen 218. In R. Jütte (Ed.), *Geschichte der Abtreibung: Von der Antike bis zur Gegenwart* (pp. 120–139). München: C. H. Beck.

Sethna, C., & Doull, M. (2013, June). Spatial disparities and travel to freestanding abortion clinics in Canada. *Women's Studies International Forum, 38*, 52–62.

Shack, P. (1979). *CPD*, HR, 1104.

Shanahan, E. (1971, October 5). Doctor leads group's challenge to anti-abortion law. *New York Times*, p. 28.

Shashower, D. (2006). *The beautiful cigar girl: Mary Rogers, Edgar Allan Poe, and the invention of murder*. New York: The Berkley Publishing Group.

Sheldon, S. (1993). 'Who is the mother to make the judgement': The constructions of woman in English abortion law. *Feminist Legal Studies, 1*(1), 3–23.

Sheldon, S. (1997). *Beyond control: Medical power and abortion law*. London: Pluto Press.

Sherwin, S. (2008). Whither bioethics? How feminism can help reorient bioethics. *International Journal of Feminist Approaches to Bioethics, 1*(1), 7–27.
Shibata, J. (2013). *Nihon Yōji-shi* [History of Young Children in Japan]. Tokyo: Yoshikawa Kobunkan.
Shinmura, T. (1996). *Shussan to Seishokukan no Rekishi* [The History of Childbirth and Perspectives on Reproduction]. Tokyo: Hosei University Press.
Shoemaker, N. (1999). *American Indian population recovery in the twentieth century*. Albuquerque: University of New Mexico Press.
Shrestha, R. (2012). Maternal mortality in Nepal: Addressing the issue. *Student Pulse, 4*(10), 1–4.
Siegel, R. (2007). Sex equality arguments for reproductive rights: Their critical basis and evolving constitutional expression. *Emory Law Journal, 56*, 815–835.
Siegel, R. (2008). Dignity and the politics of protection: Abortion restrictions under Casey/Carhart. *Yale Law Journal, 117*, 1694–1800.
Siegel, R. (2014). Abortion and the woman question: Forty years of debate. *Indiana Law Journal, 89*, 1365–1380.
Silberschmid, M., & Rasch, V. (2001). Adolescent girls, illegal abortions and 'sugar daddies' in Dar es Salaam: Vulnerable victims and active social agents. *Social Science & Medicine, 52*, 1815–1826.
Silliman, J., & Bhattacharjee, A. (2002). *Policing the national body: Sex, race, and criminalization*. Boston: South End Press.
Silliman, J., et al. (2004). *Undivided rights: Women of color organize for reproductive rights*. Cambridge, MA: South End Press.
Silliman, J. M., et al. (2004). *Undivided rights: Women of color organize for reproductive justice*. Boston: South End Press.
Simon, L. (Ed.). (1953). *De legala aborterna*. Stockholm: Gebers.
Simon, P. (1979). *De la vie avant toute*. Paris: Editions Mazarine.
Simonds, W. (1996). *Abortion at work ideological and practice in a feminist clinic*. New Brunswick, NJ: Rutgers University Press.
Simper, E. (1980, March 17). Most favour abortion, poll shows. *The Australian*.
Simpson, K. (1947). *Forensic medicine*. London: Edward Arnold & Co.
Sitzman, K., & Eichelberger, L. (Eds.). (2011). *Understanding the work of nursing theorists: A creative beginning*. Boston: Jones and Bartlett Publishing.
Sjövall, A. (1949). Abortlagens begränsning. *Svenska läkartidningen, 46*, 1363.
Sjövall, E. (1946). *Barlast*. Stockholm: Bonnier.
Sjövall, E. (1951). *Fyra människor*. Stockholm: Bonnier.
Sjövall, E. (1952). Abortfrågan—ett mänskligt och socialt problem. *Populär tidskrift för psykologi och sexualkunskap, 3*(2), 99–109.
Sjövall, E. (1954). *Brev till Ragnar Liljedahl 13/4*. Ragnar Liljedahls arkiv. Linköpings stiftsbibliotek. Unpublished.
Sjövall, E. (1971). Särskilt yttrande. *Rätten till abort. 1965 års abortkommitté*. Stockholm: Statens offentliga utredningar, 58.

Sjövall, T. (1953). Legal abort och familjerådgivning. Psykiatriska synpunkter. *Populär tidskrift för psykologi och sexualkunskap, 4*(6), 252–258.
Smith, A. (1995). Women of colour and reproductive choice: Combating the population paradigm. *Journal of Feminist Studies in Religion, 11*(2), 39–66.
Smith, A. (2005a). Beyond pro-choice versus pro-life: Women of color and reproductive justice. *NWSA Journal, 17*(1), 119–140.
Smith, A. (2005b). *Conquest: Sexual violence and American Indian genocide*. Cambridge, MA: South End Press.
Smith, B. A. (1990). Homicide in a nineteenth-century rural community: The Talbott/Bell case of 1879. *Deviant Behavior, 11*(1), 17–43.
Smith, D. T. (1967). *Abortion and the law*. Cleveland: Western Reserve University.
Smith, F. J. (1920). *Taylor's principles and practice of medical jurisprudence*. London: J. & A. Churchill.
Smith, S. (1936). *Forensic medicine: A text-book for students and practitioners*. London: J. & A. Churchill.
Smith, W. D. (2005). *Abortion and nation: The politics of reproduction in contemporary Ireland*. Hants: Ashgate.
Smith, W. D. (2011). *The German colonial empire*. Chapel Hill: University of North Carolina Press.
Smyth, L. (2005). *Abortion and nation: The politics of reproduction in contemporary Ireland*. Aldershot: Ashgate.
Sneirson, A. M. (1995). No place to hide: Why state and federal enforcement of stalking laws may be the best way to protect abortion providers. *Washington University Law Review, 73*(2), 635–664.
Snell, A. H., & Matthews, B. (2000). *Grandmother's grandchild: My crow Indian life*. Lincoln: University of Nebraska Press.
Solinger, R. (Ed.). (1998). *Abortion wars: A half-century of struggles, 1950–2000*. Berkeley: University of California Press.
Solinger, R. (2001). *Beggars and choosers: How the politics of choice shapes adoption, abortion, and welfare in the United States*. New York: Hill and Wang.
Solinger, R., & Nakachi, M. (Eds.). (2016). *Reproductive states: Global perspectives on the invention and implementation of population policy*. New York: Oxford University Press.
Spence-Jones, H. D. M. (1890). *The pulpit commentary*. Grand Rapids, WI: Wm. B. Eerdmans Publishing.
Spillers, H. J. (1991). *Comparative American identities: Race, sex, and nationality in the modern text* (Vol. 1). New York: Routledge.
Spivak, G. C. (2003). Can the subaltern speak? *Die Philosophin. Forum für feministische Theorie und Philosophie, 14*(27), 42–58.
Spry, T. (2001). Performing autoethnography: An embodied methodological praxis. *Qualitative Inquiry, 7*(6), 706–732.
Srebnick, A. G. (1993). The death of Mary Rogers, the 'public prints,' and the violence of representation. *Legal Studies Forum, 17*(2), 147–169.

Srebnick, A. G. (1995). *The mysterious death of Mary Rogers: Sex and culture in nineteenth-century New York*. New York: Oxford University Press.

St. Denis, V. (2007). Feminism is for everybody: Aboriginal women, feminism, and diversity. In J. Green (Ed.), *Making space for indigenous feminism* (pp. 33–52). Halifax: Fernwood Publishing.

Stambach, A. (2003). Kutoa mimba: Debates about schoolgirl abortions in Machame, Tanzania. In A. M. Basu (Ed.), *The sociocultural and political aspects of abortion: Global perspectives* (pp. 79–102). Westport, CT: Praeger Publishers.

Stannus, H. S. (1910). Notes on some tribes of British Central Africa. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 40*, 285–335.

State of Florida. Statute §784.048.

State of Montana v. Ross. (1995). 269 Mont. 347. Supreme Court of Montana.

State of North Carolina v. Phillip Benham. (2012). 731 S.E. 2d 275. North Carolina Court of Appeals.

Statistics South Africa. (2008). *Estimation of fertility from the 2007 Community Survey of South Africa*. Pretoria: Statistics South Africa.

Staub, S. C. (2005). *Nature's cruel stepdames: Murderous women in the street literature of seventeenth century England*. Pittsburgh, PA: Duquesne University Press.

Stephens, R. (2007). *A history of motherhood, food procurement, and politics in East-Central Uganda to the nineteenth century*. PhD dissertation, Northwestern University.

Stoecker, H. (1991). *Drang nach Afrika. Die deutsche koloniale Expansionspolitik und Herrschaft in Afrika von den Anfängen bis zum Verlust der Kolonien*. Berlin: Akademie.

Stoler, A. L. (2010). Archival dis-ease: Thinking through colonial ontologies. *Communication and Critical/Cultural Studies, 7*(2), 215–219.

Stote, K. (2015). *An act of genocide: Colonialism and the sterilization of aboriginal women*. Black Point: Fernwood Publishing.

Stremlau, R. (2011). *Sustaining the Cherokee family: Kinship and the allotment of an indigenous nation*. Chapel Hill: University of North Carolina Press.

Stringer, R. (2006). Fact, fiction and the foetus: Violence against pregnant women and the politics of abortion. *Australian Feminist Law Journal, 25*(1), 99–117.

Strobel, M. (1975). *Muslim women in Mombasa, Kenya, 1890–1973*. New Haven: Yale University Press.

Strobel, M. (1991). *Wanawake Watatu Wa Kiswahili: Hadithi Za Maisha Kutoka Mombasa, Kenya*. Bloomington: Indiana University Press.

Sugitatsu, Y. (2002). *Osan no Rekishi* [History of Childbirth]. Tokyo: Shueisha Shinsho.

Sunseri, T. (2002). *Vilimani. Labor migration and rural change in early colonial Tanzania*. Portsmouth, Oxford and Cape Town: James Currey.

Superintendents' Annual Narrative and Statistical Reports, Record Group 75, Bureau of Indian Affairs, National Archives and Records Administration, Labriola National American Indian Data Center, Arizona State University.

Swantz, L. (1956). *The Zaramo of Tanzania: An ethnographic study*. New York: Syracuse University.

Swärd, S. (1984). *Varför Sverige fick fri abort. Ett stadium av en policyprocess*. Stockholm: Stockholm Studies in Politics.

Swarr, A. L. (Ed.). (2010). *Critical transnational feminist praxis*. Albany: State University of New York.

Sweet, G. G. (Ed.). (1985). *Pro-life feminism: Different voices*. Toronto: Life Cycle Books.

Sweetman, K. (1996, September 16). Nats push Telstra trade-off. *Daily Telegraph*.

Takagi, M. (1996). *19 seiki Tohoku Nihon no 'Shibō Kiki' to Shusseiryoku* ['Mortality Crises' and Fertility in Nineteenth Century Northeastern Japan]. *Shakai Keizaishigaku, 61*(5), 567–598.

Takahashi, B. (1936). *Datai Mabiki no Kenkyū* [Study on Abortion and Infanticide]. Tokyo: Dai Ichi Shobo.

Takamura, E. (2002). *Mitohanryō ni okeru Shussan to 'Kindai'* [Childbirth and 'Modernization' in Mito Domain]. *Joseishigaku, 2*, 17–33.

"Taking a 'dying declaration' from a witness." The National Archives, MEPO 3/407.

Tankard, M. (1987, September 3). The baby behind abortion's jargon. *The Daily Forty Niner*.

Tankard, M. (1989, April 12). Feminists who say no to abortion. *The Age*.

Tankard, M. (1990, April 11). Peace with raised fists. *The Herald*, p. 8.

Tankard Reist, M. (1994a). Abortion and the Feminist Sell-Out. In M. O'Donovan & J. Stuparich (Eds.), *The abortion debate. Pro-Life essays* (pp. 56–87). Canberra: ACT Right to Life Association.

Tankard Reist, M. (1994b). Whose consensus is it? The feminist challenge to Cairo. In M. Cook (Ed.), *The New imperialism, world population and the Cairo conference* (pp. 89–106). Sydney: Little Hills Press.

Tankard Reist, M. (1997, May 24). An (Un)informed choice. *Canberra Times*.

Taylor, L. (1995). *Occasions of faith: An anthropology of Irish Catholics*. Philadelphia: University of Pennsylvania Press.

Tengroth, B. (1948). *Törst*. Stockholm: Wahlström & Widstrand.

Texas Abortion Physicians Providing Abortions v. Lakey. (2012). 667 F.3d 570. Fifth Circuit Court of Appeals

The Fair Housing Act. 42 U.S.C. § 3631.

Thomas, L. (2003). *Politics of the womb: Women, reproduction, and the state in Kenya*. Berkeley: University of California Press.

Thomas, L. (2006). Schoolgirl pregnancies, letter-writing, and "Modern" persons in late colonial East Africa. In K. Barber (Ed.), *Africa's hidden histories: Everyday literacy and making the self* (pp. 180–207). Bloomington: Indiana University Press.

Thompson, D. (2001). *Radical feminism today*. London: Sage.

Thomsen, C. (2008). *The rhetorics of U.S. abortion narratives: Thematic continuities, shifting applications and political strategies, 1969-present*. MA thesis, University of Arizona.

Thorne, S. (1999). *Congregational missions and the making of an imperial culture in nineteenth-century England*. Stanford: Stanford University Press.

Thorsson, I. (1954). Abortfrågan. *Svenska läkartidningen, 51*, 2953–2963.

Torday, E., & Joyce, T. A. (1906). Notes on the ethnography of the Ba-Huana. *The Journal of the Royal Anthropological Institute of Great Britain and Ireland, 36*, 272–301.

Torpy, S. (2000). Native American women and coerced sterilization: On the trail of tears in the 1970s. *American Indian Culture and Research Journal, 24*(2), 1–22.

Towler, J., & Bramall, J. (1986). *Midwives in history and society*. London: Croom Helm.

Treaster, J. B. (1983, June 16). Civil liberties union hales ruling on women's rights victory. *New York Times*, p. B8.

Trennert, R. (1998). *White man's medicine: Government doctors and the Navajo, 1863–1855*. Albuquerque: University of New Mexico Press.

Trouillot, M. (2002). North Atlantic universals: Analytical fictions, 1492–1945. *The South Atlantic Quarterly, 101*(4), 839–858.

Tsukamoto, M. (1983). *Shōrui wo Meguru Fōkuroa* [Politics Surrounding Living Beings: Folklore in Genroku Period]. Tokyo: Heibonsha.

Turenne, S. (2007). *Le Juge Face à la Désobéissance Civile en Droits Américain et Français Comparés*. Paris: Librairie Générale de Jurisprudence.

Turner, H. (1973, May 10). *CPD*, HR, 1987.

Turner, L. (2009). Anthropological and sociological critiques of bioethics. *Bioethical Inquiry, 6*, 83–98.

Turner, V. (1970). *The forest of symbols: Aspects of Ndembu ritual*. Ithaca: Cornell University Press.

Turyomumazima, B. (n.d.). *No place for abortion in African traditional life—some refelctions*. Retrieved May 25, 2011, from http://www.consciencelaws.org/background/procedures/abortion019.aspx

UBINIG. (1996). Declaration of People's Perspectives on 'Population' Symposium. In D. Bell & R. Klein (Eds.), *Radically Speaking: Feminism Reclaimed* (pp. 519–524) . Melbourne: Spinifex.Print

Ulrich, R. (2010). *American Indian nations from termination to restoration, 1953–2006*. Lincoln: University of Nebraska Press.

United Nations. (2007). *World abortion policies 2007*. Retrieved March 27, 2010, from http://www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007_WallChart.pdf

United Nations. (2011). *World abortion policies 2011*. Retrieved September 2, 2015, from http://www.un.org/esa/population/publications/2011abortion/2011wallchart.pdf

United States v. Cox. (1992). 957 F.2d 264. Sixth Circuit Court of Appeals.

United States v. Gilbert. (1989). 884 F.2d 454. Ninth Circuit Court of Appeals.

United States v. Hart. (2000). 212 F.3d 1067. Eighth Circuit Court of Appeals.

United States v. Hoffman. (1986). 806 F.2d 703. Seventh Circuit Court of Appeals.

United States v. Kelner. (1976). 534 F.2d 1020. Second Circuit Court of Appeals.

United States v. White. (2012). 670 F.3d 498. Fourth Circuit Court of Appeals.

United States v. Dinwiddie. (1996). 76 F.3d 913. Eighth Circuit Court of Appeals.

Upadhyay, U., Cockrill, K., & Freedman, L. (2010). Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Education and Counseling, 81*(3), 415–421.

Uren, T. (1979, March 21). *CPD*, HR, 978.

Usborne, C. (2007). *Cultures of abortion in Weimar Germany*. Oxford: Berghahn.

Uwechue, R. (Ed.). (1996). *Africa today*. London: Africa Books.

Vaca, M. (2010, September 29). Bolivia: Mortalidad maternal en ascenso. *BBC Mundo – Noticias*.

Valabrègue, C. (1970). *La condition etudiante*. Paris: Petite Bibliothèque Payot.

Valente, T., Watkins, S. C., Jato, M. N., van der Straten, A., & Tsitsol, L. (1997). Social network associations with contraceptive use among Cameroonian women in voluntary associations. *Social Science & Medicine, 45*(5), 677–687.

Valenti, C. (2010). *Bobigny: Le procès de l'avortement*. Paris: Editions Larousse.

Van Bogaert, L. (2003). 'Failed' contraception in a rural South African population. *South African Medical Journal, 93*(11), 858–861.

Van der Burgt, J. M. M. (1913). Zur Entvölkerungsfrage Unjamwesis und Ussumbwas. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 12*, 705–728.

Van der Burgt, J. M. M. (1914). Zur Bevölkerungsfrage Unjamwesis und Ussumbwas. *Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner, 1*, 24–27.

van der Sijpt, E., & Notermans, C. (2010). Perils to pregnancies: On social sorrows and strategies surrounding pregnancy loss in Cameroon. *Medical Anthropology Quarterly, 24*(3), 381–398.

van Gennep, A. (1960). *The rites of passage*. Chicago: University of Chicago Press.

van Laak, D. (2004). Der deutsche Kolonialismus und seine Nachwirkungen. *APuZ - Aus Politik und Zeitgeschichte, 4*, 3–11.

Van Wardt, L. (2006). Untitled letter to the editor. *South African Medical Journal, 96*(11), 1140–1142.
Vashti Collective. (1973, March). Vashti's voice: A newsletter of the women's liberation movement 3.
Vaughan, M. (1991). *Curing their ills: Colonial power and African illness*. Stanford: Stanford University Press.
Verhagen, S. (2011). *Rights of women bulletin: Rebecca Gomperts, Women on Waves*. Retrieved November 25, 2011, from http://www.sophieverhagen.com/writing.htm
Vicinus, M., & Nargaard, B. (1989). *Ever yours, Florence Nightingale: Selected letters*. London: Virago.
Virginia v. Black. (2002). 358 U.S. 343. United States Supreme Court.
WAAC. (1973). Right to Choose! 1 (1973).
WAAC. (1974a). Right to Choose! 2 (early 1974).
WAAC. (1974b, December). Right to Choose! 5.
WAAC. (1975a). *A woman's guide to abortion: Why, how, where*. Glebe, NSW: D. Whelan.
WAAC. (1975b, February–March). Right to choose! 6.
WAAC. (1975c). Right to choose! 7 (mid 1975).
WAAC. (1975d, September-October). Right to choose! 8.
WAAC. (1976, May). Right to choose! 11.
WAAC. (1977). Right to choose! 14 (Autumn 1977).
WAAC. (1978a). Right to choose! 15 (Summer 1978).
WAAC. (1978b). Right to choose! 16 (Winter 1978).
WAAC. (1978c). Right to choose! (Extra, July 1978).
WAAC. (1978d). Right to choose! 17 (Spring 1978).
WAAC. (1979, February–March). Right to choose! 18.
WAAC. (n.d.). "Answers to common right to life arguments about abortion," Box 46, Wainer Papers, MS134636, State Library of Victoria.
WAAC. (n.d.). "Open letter, 28 November 1974," Box 46, Wainer Papers, MS134636, State Library of Victoria.
WAAC. (1973–1984). *Right to choose!*
WAAC. (1973, July). Submission to the Federal Government for funds for a conference to mark the International Women's Year of 1975. *Vashti's Voice 4*.
Wagoner, P. L. (2007, January 17). *An experiment in democracy: The politics of impeachment on the Pine Ridge Indian Reservation*. Bookend Series Lecture, Juniata College Press.
Wainer, B. (1969, September 12). To the editor. *The Age*.
Wainer, B. (1969). To the Editor. *The Age*, September 12.
Wainwright, J. (2008). *Decolonizing development. Colonial power and the Maya*. Oxford: Blackwell.

Wakam, J. (1994). *De la Pertinence de Théories 'Economistes' de Fecondité dans le Contexte Socio-Culturel Camerounais et Négro-Africain*. Yaoundé: IFORD.

Walgenbach, K. (2005). *'Die Weiße Frau als Trägerin Deutscher Kultur'. Koloniale Diskurse über Geschlecht, 'Rasse' und Klasse im Kaiserreich*. Frankfurt/Main: Campus.

Walter, B. (1992). *Von Gottes Treue getragen. Die Missions-Benediktinerinnen von Tutzing. Band 2: Gottes Treue verkünden. Wegbereitung für die Kirche in Ostafrika*. Erzabtei St. Ottilien: EOS.

Ward v. Rock against Racism. (1989). 491 U.S. 781. United States Supreme Court.

Ward, H. (1996, April 20). *Conscientious objection to participating in or performing abortions in the light of proposed legislation tabled before parliament for the current year 1996: Considerations and recommendations*. Retrieved January 29, 2013, from http://www.consciencelaws.org/background/procedures/abortion014-002.aspx

Ward, H. (1996, October 2). *Major problems with proposed New Abortion law*. Written submission to the Portfolio Committee on Health, National Assembly. Retrieved May 26, 2011, from http://www.consciencelaws.org/issues-background/abortion/abortion14.html

Warhurst, J. (2008). Conscience voting in the Australian federal parlaiment. *Australian Journal of Politics and History, 54*(4), 579–596.

Warhurst, J., & Merill, V. (1982). The abortion issue in Australia: Pressure and policy. *The Australian Quarterly, 54*(2), 119–135.

Watkins, S. C., Behrman, J., & Kohler, H. (2002). Social networks and changes in contraceptive use over time: Evidence from a longitudinal study in rural Kenya. *Demography, 39*(4), 713–737.

Watkins, S. C., & Rutenberg, N. (1997). The buzz outside the clinics: Conversation and contraception in Nyanza Province, Kenya. *Studies in Family Planning, 28*(4), 290–307.

Watts v. United States. (1969). 394 U.S. 705. United States Supreme Court.

Weill-Halle, M. L. (1959). *Le planning familial*. Paris: Librairie Maloine.

Weill-Halle, M. L. (1962). *Contraception orale ou locale: Experience française sur 2011 femmes, (1958–1961)*. Paris: Librairie Maloine.

Weill-Halle, M. L. (1967). *La contraception orale ou locale: Expérience française sur 7600 couples, (1956–1960)*. Paris: Librairie Maloine.

Weingarten, K. (2014). *Abortion in the American imagination: Before life and choice, 1880–1940*. New Brunswick: Rutgers University Press.

Weinreb, A. (1997). *Post-abortion family planning: A practical guide for programme managers*. Geneva: Division of Reproductive Health.

Weinreb, A. (2001). First politics, then culture: Accounting for ethnic differences in demographic behaviour in Kenya. *Population and Development Review, 27*(3), 437–467.

Weinreb, A. (2011). *Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008.* Geneva: World Health Organization.

Welsch, W. (2009). On the acquisition and possession of commonalities. Transcultural English studies: Theories, fictions, realities. In F. Schulze-Engler & S. Helff (Eds.), *Transcultural English studies: Theories, fictions, realities* (Vol. 102, pp. 3–36). Amsterdam: Rodopi.

Whaley, L. (2011). *Women and the practice of medical care in early modern Europe, 1400–1800.* Basingstoke: Palgrave Macmillan.

White, L. (2000). *Speaking with vampires: Rumor and history in colonial Africa.* Berkeley: University of California Press.

Whittaker, A., Manderson, L., & Cartwright, E. (2010). Patients without borders: Understanding medical travel. *Medical Anthropology, 29*(4), 336–343.

Widmer, A. (2008). The effects of elusive knowledge: Census, heal laws, and inconsistently modern subjects in early colonial Vanuatu. *Journal of Legal Anthropology, 1*(1), 92–116.

Wilhelm, R. (2011a, August 6). The great trunk mystery. *Murder by Gaslight.*

Wilhelm, R. (2011b). The mysteries of Pearl Bryan. *Kentucky Explorer, 26*(6).

Williams, C. R. A. (1834). *Fall river: An authentic narrative.* Boston: Lilly, Wait & Co. (second printing).

Williams, D. (2010). *God's own party: The making of the Christian right.* New York: Oxford University Press.

Williams, S. (1997). *Women & childbirth in the twentieth century.* Stroud: Sutton Publishing.

Wilson, T. M., & Donnon, H. (2006). *The anthropology of Ireland.* Oxford: Berg Publishing.

Winikoff, B., & Sheldon, W. (2012). Use of medicines changing the face of abortion. *International Perspectives on Sexual and Reproductive Health, 38*(3), 164–166.

Wishner, J. (Ed.). (1993). *Abortion and the states political change and future regulation section of urban, state, and local government law.* Chicago: American Bar Association, Section of Urban, State and Local Government Law.

Wolf, E. (1982). *Europe and the people without history.* Berkeley: University of California Press.

Wolf, N. (1995, October 16). Our bodies, our souls. *New Republic*, pp. 26–35.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research, 8*(4), 387–409.

Women on Waves. (2012). Campaigns. Retrieved November 11, 2012, from http://www.womenonwaves.nl/

Women's Forum Australia. (2006). *Submission to the Senate Community Affairs Committee Inquiry into the Therapeutic Goods Amendment* (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005. Web. 9 September 2014.

Women's National Abortion Action Coalition. (1971). More than 1000 women launch Women's National Abortion Action Coalition. *The Human Rights for Women Papers*. Schlesinger Library, Harvard University.

Wood, K., & Jewkes, R. (2006). Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters, 14*(27), 109–118.

Woolcott, R. (1995). The United Nations Population and Development Conference: Its Message for Australia. In Bureau of Immigration, Multicultural and Population Research (Ed.), *Third National Immigration and Population Outlook Conference*. Carlton: Bureau of Immigration, Multicultural and Population Research.

World Health Organization. (1994). *Abortion: A tabulation of available data on the frequency and mortality of unsafe abortion*. Geneva: Division of Family Health.

World Health Organization. (1997). *Post-abortion family planning: A practical guide for programme managers*. Geneva: Division of Reproductive Health.

World Health Organization. (1998). *Unsafe abortion: Global and regional estimates of the incidence of and mortality due to unsafe abortion with a listing of available country data*. Maternal and Newborn Health/Safe Motherhood Unit. Geneva: Division of Reproductive Health.

World Health Organization. (2004). *Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*. Geneva: World Health Organization.

World Health Organization. (2011). *Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Geneva: World Health Organization.

Wynn, L. K., Hafez, H. M. A., & Ragab, A. (2014). Social class and sexual stigma: Local interpretations of emergency contraception in Egypt. *Critical Issues in Reproductive Health, 33*, 85–102.

Yanagita, K. (1966). *Teihon Yanagita Kunio shū* [Writings by Yanagita Kunio] (Vol. 15). Tokyo: Chikuma Shobo.

Yee, J. (2011). Reproductive justice—for real, for me, for you, for now. *SisterSong: Women of Color Reproductive Justice Collective Anthology* (forthcoming). Yee's full essay can be found online at http://jolocas.blogspot.ca/2011/11/reproductive-justice.html. Retrieved January 20, 2013.

Young, R. (2001). *Postcolonialism: An historical introduction*. Oxford: Blackwell.

Zantop, S. (1997). *Colonial fantasies. Conquest, family and nation in precolonial Germany, 1770–1870*. Durham and London: Duke University Press.

Zerubavel, E. (1991). *The fine line: Making distinctions in everyday life*. Chicago: University of Chicago Press.

Ziegler, M. (2013). Roe's race: The Supreme Court, population control and reproductive justice. *Yale Journal of Law & Feminism, 25*, 1–50.

Zimmerer, J., & Zeller, J. (Eds.). (2008). *Genocide in German South-West Africa: The colonial war of 1904–1908 and its aftermath*. Monmouth: Merlin Press.

Zulawski, A. (2007). *Unequal cures: Public health and political change in Bolivia, 1900–1950*. Durham: Duke University Press.

Index

Note: Page numbers followed by 'n' refer to foot notes.

S. Stettner et al. (eds.), *Transcending Borders*,
DOI 10.1007/978-3-319-48399-3