

An International Summit on Reproductive Choice

**LISBON
2014**

**Select Proceedings from
International Summit
on Reproductive Choice**

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Lisbon 2014:

An International Summit on Reproductive Choice

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Introduction.

In June 2014 more than 70 advocates, service providers and academics from across the globe gathered in Lisbon, Portugal, for a unique two-day summit to discuss how best to defend and advance women's reproductive choice of abortion.

The meeting was organized and funded by:

Catholics for Choice, a US-based non-profit that works internationally to promote Catholic social justice values committed to the right of women and doctors to follow their consciences when making moral decisions about their reproductive future, including about abortion.

British Pregnancy Advisory Service, a UK-based charity that provides abortion services each year to about 60,000 women in Britain and advocates internationally on issues related to reproductive choice.

Although CFC and bpas are very different, both share a core value: the belief that the proper person to make a decision whether to continue or to end a pregnancy is the woman who carries it. Both organizations share a concern that respect for the right and responsibility of women throughout the world to make their own reproductive choices is increasingly undermined. And both organizations have come under pressure to withdraw or modify their claim that support for women's reproductive choice extends to support when that choice defies the values promoted in modern liberal democracies.

CFC and bpas have insisted that it is essential to stand by the principle that support for a woman's right to choose involves support for a woman's reproductive health choice in pregnancy *whatever* her decision and *whatever* her reason. Personal choice regarding one's own pregnancy speaks to a woman's moral autonomy, her free conscience and her right to refuse to allow her own body to be used for others' purposes.

CFC and bpas have worked together to promote these values for many years. In 2012, we convened a working group in London that produced a declaration of what it means to be pro-choice (reprinted at p. 7). The Lisbon meeting, some two years later, aimed to extend that discussion beyond the initial core signatories, to re-evaluate the principles and to discuss, in a more detailed and inclusive way, some of the 'challenges to choice'. We were privileged to enjoy the collaboration of the Associação para o Planeamento da Família (APF), the main family planning organization in Portugal, and also the support of those contributors who so valued this conversation that they volunteered to contribute to their own costs of attending.

This pamphlet includes some of the introductions that speak most specifically to debates that have challenged those engaged with reproductive health concerns in both domestic and international settings.

Sex selection

In some countries sex selection has divided the feminist movement, causing some women's rights organizations to withdraw support for prenatal tests that might reveal fetal sex, or the disclosure of that information to patients, to prevent women from making an abortion choice based on the result – especially if the consequence is that more female than male fetuses are terminated. The governments in countries as widespread as India, Canada and the UK have been concerned enough to prohibit 'sex selection abortions', even where there is no evidence that a significant number of such abortions occur.

The result has been the creation of a policy climate that suggests that abortion is available 'too easily' and that women make fickle, irresponsible decisions that may undermine other advocacy initiatives to promote the rights of girl children. The question of whether it is possible to support freedom of choice, if some women's choice is boy-preference, has challenged some feminist commentators.

Fetal anomaly

Claims are increasingly made that the choice to end a previously wanted pregnancy following detection of fetal anomaly is an expression of an intolerance of 'imperfect' babies and parental consumerism that encourages couple to choose a 'type' of baby as they might choose a 'type' of car. As with sex selection, the discussion challenges a woman's right to make decisions about her pregnancy because of a supposed overriding concern about the impact of those decisions on others. In this case there is concern that a woman's decision to not give birth to an infant with Down's syndrome is an expression of discrimination and that it devalues those that are disadvantaged by the chromosomal condition.

Again, worries about a new 'eugenics' has led to calls for limited access to technology that provides the information on which decisions regarding disability may be based, and for the imposition of additional mandatory counseling for women considering abortion in these cases. Public opinion seems to vacillate on such abortions as claims are made about the trivial character of conditions for which women see abortion as a solution. Furthermore it is unsettling for supporters of reproductive choice who identify with social justice concerns to find themselves in an argument with the justice-based concerns of disability-rights activists.

Later abortions

Our increasing ability to deliver early abortion has reduced many people's tolerance for procedures at later gestations. There is a continuing assumption that the gestational age of abortions should be reduced in line with developments that may help to increase the life chances of infants born on the cusp of viability, and yet there seems to be little change in the reasons why women request abortions in more advanced pregnancies.

Later abortions, whatever the reason for the request, may be challenging. The potentially greater risks of more complex procedures and more demanding technical nature of surgery or induction may provide clinical reasons for the restriction of access. But the issues of fetal viability may raise moral challenging questions about the difference between ending a pregnancy and ending a pregnancy deliberately in a way that means that no living baby can result, since a medical induction late in pregnancy is simply the induction of birth unless the fetal life is ended first.

And then there is the matter of what the fetus experiences. For example, if the fetus experiences pain, does this constitute a harm? And do we see the fetus as an 'other' that we have a duty not to harm – even when we make the choice that serves us best?

The prevention of abortion

Much of the international movement for reproductive health and rights resonates with the claim that abortion should be safe and legal but rare, and it is often assumed that women have an obligation to prevent their need for abortion by preventing pregnancy. Policy-makers and donors like to draw a bright line between contraception, which is seen as responsible, necessary and 'good', and abortion, which is seen as a means of dealing with 'failure' – failure to provide contraception through adequate services, failure of women (and men) to use it effectively and sometimes failure of the technology itself. The acceptability of abortion for some people is built on an understanding that these failures make it a necessary back-up to birth control.

This ignores that for many women, across continents and throughout centuries, abortion is itself an acceptable form of birth control, as ending an occasional pregnancy is preferable to the continual attention required to prevent one.

Concern to reduce the number of women who have abortions 'repeatedly' is a feature of many reproductive health care services. The replacement of abortion by contraception may be presented as being for the good of women's health. But underneath the claims there usually lies an assumption that fewer abortions are better.

The authors will forgive us for saying that the following papers are unable to do the discussions justice. It is impossible to summarize the breadth of arguments from a range of disciplines in a short paper. The authors were asked to provide us all with a starting point for a further round of challenging discussions, debates and arguments.

These are difficult issues. They challenge us to think beyond the glibness of slogans and weigh up the consequences of what our argument for a woman's right to choose an abortion means – for her and for society.

Support for individual 'choice' in reproductive decision-making is something special and particular. It relates to the matter of 'who' can make a decision, which refers to the 'agency' and 'autonomy' of individuals.

The concept of reproductive choice is rooted in the liberal concept of autonomy: the idea that each individual should be free to follow their own life plan according to their beliefs, convictions and their conscience. When we talk about reproductive choices, we refer to the private matters that each of us must be able to resolve for ourselves. And when we say that we defend that for all women, it means we extend a trust and respect to all women to decide for themselves what is right for them. Of course, we understand that they may not always make the decision that we would make. They may not even make a 'good decision' for themselves. The point is that we believe the decision is theirs to make.

We understand that our reproductive choices, like other choices, are shaped by circumstances. There is much about our life circumstances that influences our decisions – but our circumstances do not *dictate* the choices we make. Our choices are also influenced by our values, beliefs and our conscience. Not all women in the same circumstances will want the same thing. Not everyone facing a problem pregnancy will believe that the same solution is right. The personal decisions we make express what we feel and who are.

When decisions about abortion are taken away from women, the status of competent, rational adults is taken away, too. In putting together this meeting and publication we were motivated by the belief that the defence of women's autonomy of moral decision must be put back at the centre of the abortion debate. If we can apply it to these more difficult issues, we can certainly apply it more broadly.

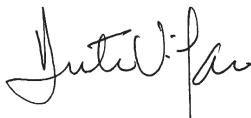
We urge every reader to take this booklet, and the London Declaration of Pro-Choice Principles, and use it as the basis for discussion about reproductive choice and autonomy. Consider what it means for women, for families, for doctors, for politicians and for ourselves.



Ann Furedi, Chief Executive, British Pregnancy Advisory Service



Jon O'Brien, President, Catholics for Choice



Duarte Vilar, Executive Director, APF

April 2015

London Declaration of Pro-Choice Principles.

In September 2012, Ann Furedi of bpas and Jon O'Brien of Catholics for Choice convened an international meeting of abortion providers, advocates and academics to discuss what it means to be pro-choice. The following statement from the meeting is being advanced through discussions in the pro-choice community around the world to foster reflection, discussion and our understanding of what it means to support choice.

We believe in a woman's autonomy and her right to choose whether to continue or end a pregnancy. Every woman should have the right to decide the future of her pregnancy according to her conscience, whatever her reasons or circumstances. A just society does not compel women to continue an undesired pregnancy.

We recognise that support for choice in itself is not enough. Access to abortion is an integral part of women's reproductive health care, and we believe in the right to receive this. Women need access to resources and services, including the counsel of the professionals, friends and family they choose to involve. Legal, political, social and economic changes are necessary to allow the exercise of reproductive choice, and a commitment to such changes is part of a commitment to choice.

We express solidarity with those who provide abortion care, and we recognise the moral value of their work. We recognise and respect that some health care personnel may choose not to provide abortions, but we believe it is ethically imperative for them to ensure that a woman receives a referral to a willing provider.

We believe there is a profound moral case for freedom of reproductive choice. We are committed to explaining why abortions are necessary and why women are competent to make decisions and act on them responsibly.

To be pro-choice is to be committed to the right of women to make their own reproductive decisions and to:

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- Strive to create the conditions in which reproductive choice may be exercised.
 - Support reproductive autonomy.
 - Advocate for legal frameworks that allow autonomous decision-making.
 - Educate the public and policymakers globally about the value of reproductive autonomy.
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Women are the only ones who can make the right decision for themselves. This is the very essence of what it means to be pro-choice.

Chandos House, London. September 2012.

Is One of These Things Not Just Like the Other? Why Abortion Can't Be Separated from Contraception.



Beverly Winikoff,
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This article also appeared in Conscience magazine Vol. XXXV, No. 3, 2014.

We have come to a pretty pass: advocates of family planning, who have long believed they could shelter their cause from unending fundamentalist attacks on reproductive health services if only they could only distance themselves from the subject of abortion, have received a rude shock. Family planning advocates who are opponents of mixing abortion with their contraception have suddenly awakened to the fact that the return tactic is merely to tar all contraception with the allegation that it, too, might be equivalent to abortion. In other words, making 'abortion' into an unequivocally stigmatized word (and action) has drawn attempts to attach 'abortion' to whatever aspect of reproductive care challengers wish to discredit.

How could we have been so confused in the first place? It has never been behaviorally, biologically or pragmatically sensible to try to promote contraception by segregating abortion. First, it may be helpful to review the history of how abortion was banished from the world of family planning and the misconstructions on which this tactic has been based.

The promotion of contraception

Early data on reproductive health and maternal mortality showed that limiting fertility to wanted children produced a great health benefit – both to women and to their families, including the children they did choose to bear. The safety of methods of fertility control and the public health impact of use of these methods was a subject of much research in the 1960s and 1970s.

One of the intellectual heroes of that movement, Dr Christopher Tietze of the Population Council, concluded that the safest strategy for a woman seeking to limit her childbearing would be to use a barrier method, with abortion as a backup in the case of failure. This integrated, strategic view of how a woman could achieve her fertility goals over her fertile years unfortunately became a minority vision when the family planning field changed to the more technocratic aim of optimizing the effectiveness of individual contraceptive methods.

The emphasis on individual methods also led to the kinds of policy compromises that have turned out to be costly in the long run. The official report of the UN International Conference on Population and Development in 1994 instructed that ‘in no case should abortion be promoted as a method of family planning.’ Over time, the sentence morphed from emphasis on avoiding the ‘promotion’ of abortion to the nonsensical but often-used phrase: ‘Abortion is not a method of family planning.’ The latter formulation effectively requires that everyone, including advocates for public health and women’s rights, subscribe to a fantasy – that women seek abortion for something other than to limit fertility.

The proposition that contraception and abortion are mutually exclusive contradicts women’s experiences by positing that women avoid all unwanted births *either* by preventing pregnancies *or* by terminating them. This false dichotomy sets up women who have abortions to be victims of friendly fire, abandoned by the very policies and people promising to help only with contraception.

Abortion exceptionalism

After all, contraceptives are not really available everywhere in the world, some have rather daunting price tags and none is 100 per cent effective: even sterilization has a failure rate. And a woman who is dedicated to limiting her fertility may feel profoundly deceived if she cannot get a reliable method or if her method fails. In such a circumstance, she may well decide to terminate her pregnancy as part of an overall strategy to limit births.

Indeed, we know that abortion rates do not necessarily decline immediately when contraceptive services are introduced. This situation occurs in part because the widespread adoption of contraception requires that many women begin to believe they can and should be able to control the number of children they have. At the same time, the availability of contraceptive methods and contraceptive services may not keep pace with demand – and many women may find themselves wanting to limit their fertility but not have access to affordable, effective contraceptive methods. In such cases, abortion is more frequently practiced.

It has never been behaviorally, biologically or pragmatically sensible to try to promote contraception by segregating abortion.

Yet, the language of family planning has specifically created an aura of exceptionalism around the practice of abortion. Many documents refer to ‘recourse to abortion’ or ‘need for abortion’ as though abortion were not a common practice, when in actuality, there are an estimated 44 million abortions every year, according to the latest figures in the *Lancet* (1). Women are portrayed as *needing* abortions only in exceptional circumstances (e.g., rape, incest or urgent medical problems). Abortion in other circumstances is basically viewed as a moral failure.

As we have often been cautioned about abortion stereotypes generally, there is not one type of woman that has abortions and another that has babies: these are the same

women who manage their lives in different ways at different moments, sometimes desiring a pregnancy and sometimes trying to avoid pregnancy and childbirth. Abortion has a relationship to all these goals: to avoid an unwanted birth, but also sometimes to deal with a very wanted birth when the trajectory of pregnancy has gone awry, for example, either endangering the woman's health or resulting in a fetus with terrible, sometimes lethal, physical problems.

The quest for bright line definitions

In order to avoid the stigma associated with abortion – a stigma reinforced when advocates for contraception turn their backs on the intimate relationship between abortion and family planning – there has been a seemingly endless quest for bright line definitions of what is and is not an abortion. In order to be sure something is not abortion, we need specific indicators of what *is* an abortion, raising questions therefore of when 'life' or 'human life' or 'a baby' is present. This perspective arises from a desire for clarity, such as one might find with legal definitions.

However, for biological phenomena, the task is much more difficult. Fertilization, implantation, embryogenesis, fetal growth, labor and delivery are part of a continuous, incremental biological whole where one process gradually leads into another. None of these processes takes place in an instant of time, and all are spread over hours, days, weeks or months. For each, there is a before, an after as well as a 'during,' which may create difficulty in deciding when one stage ends and another begins.

Indeed, the concept of 'viability' is also subject to this tug of war between precision and functional understanding. The US Supreme Court weighed in on this subject in the *Colautti v. Franklin* case, which was decided after *Roe v. Wade*, and suggests that the common understanding of viability as something achieved after a certain number of weeks of pregnancy is flawed. The court decided:

Viability is reached when, in the judgment of the attending physician... there is reasonable likelihood of the fetus' sustained survival outside the womb.... Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability – be it weeks of gestation or fetal weight or any other single factor – as the determinant....

Many of the processes in question when debating whether something is or is not abortion are both incremental and unobservable, so applying any definition to a particular situation may be impossible.

Of late, the US Supreme Court has taken another tack when confronted with biological uncertainty. In the Hobby Lobby case, corporation owners were exempted from covering certain contraceptive methods, such as IUDs and emergency contraception in employee health plans simply on the basis of a sincerely held belief that those methods were

abortifacients. This perspective confounds Daniel Patrick Moynihan's maxim that while you can have your own beliefs, you cannot have your own facts. By defining abortion as whatever each person decides it is – and ignoring the best current science – the decision essentially allows opponents to tag any reproductive health service with the stigma of abortion.

The result is that contraceptives are becoming abortifacients in a way that leaves family planning advocates wringing their hands in dismay. There is irony here as well, since the fertility-lowering effect of breastfeeding may function in ways similar to what is now considered 'abortion' by opponents of IUDs and emergency contraception. Are we now going to withhold funds from breastfeeding equipment and counseling on the grounds that we would be supporting abortions?

There are other ill effects of this metastasis of abortion stigma. We are mortgaging future contraceptive development as well, since segregating contraception from abortion has become a requirement for contraceptive advocacy without controversy – a dampening effect that extends to the technology, funding and marketing of contraception.

In this vision, contraceptive development is consigned to find additional ways to keep sperm and egg from meeting: anything else might be accused of being abortion. By acceding to this reality, we may very well be giving up the opportunity to create products that could exactly match what women say they want: something very effective, very safe, inexpensive and reversible, with minimal requirements to use.

There is not one type of woman that has abortions and another that has babies: these are the same women who manage their lives in different ways at different moments....

If we cannot get the conversation and the politics right, we may compromise advances in technology; restrict women's choices for planning their families; increase the stigma attached to all reproductive health options; fail to meet women where they are; and, generally, hinder the achievement of reproductive health and rights for large parts of the world, including the United States.

After all the noise we have heard in the political arena, professional forums and public spaces from those trying to impose an illogical and hurtful division between contraception and abortion, it would be easy to think that few in positions of power understand women's lives. But it's interesting that a US Secretary of State, Hillary Clinton, got it right: 'You cannot have maternal health without reproductive health, and reproductive health includes contraception and family planning and access to legal, safe abortions.'

Reference

(1) Sedgh G, Singh S, Shah I, Åhman E, Henshaw SK, Bankole A. (2012). 'Induced abortion: Incidence and trends worldwide from 1995 to 2008.' *The Lancet* 379 (9816): 625–632.

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Later Abortion: What Makes It Difficult?



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In what ways and for whom is 'later abortion' difficult? The 'difficulty' that needs to be placed at the centre of discussion about abortion is that which is experienced by the relatively small proportion of women who find themselves terminating pregnancies at later stages of pregnancy. I discuss here some findings of a piece of research carried out in Britain about women's reasons for abortion in the second trimester of pregnancy and argue that abortion is needed not only as early as possible, but also as late as necessary, precisely because of that difficulty.

Many legal regimes make differentiations between earlier and later abortions. This has nothing to do with medical questions, such as the fact that abortions at different gestational stages are more or less complicated or challenging for providers. Rather, the idea that law should operate by making distinctions between 'earlier' and 'later' draws upon the conviction that the more advanced a pregnancy becomes, the terms on which women may access abortion should become more restrictive.

Since the 1970s, when women in Britain – and numerous other countries – have been able to access abortion legally, the focus for this conviction has found expression in debates about fetal viability. These debates continue, with advocates of lower time limits for abortion drawing on any advance in the care of pre-term babies born to women in maternity wards to argue that abortion access should be restricted. (1)

Developments in ultrasound technology have contributed to the way that medical technology has been mobilized to press the case for the legal protection of the fetus. For example, in Britain in 2004 the following was reported:

A new type of ultrasound scan has produced vivid pictures of a 12 week-old fetus 'walking' in the womb. The new images also show fetuses apparently yawning and rubbing their eyes. The scans, pioneered by Professor Stuart Campbell at London's Create Health Clinic, are much more detailed than conventional ultrasound. Professor Campbell has previously released images of unborn babies appearing to smile. (2)

Images from 3D and 4D ultrasonography are now absorbed into culture. They influence perceptions of pregnancy and the pregnant woman, and these shape ideas, policies and practices ostensibly unconnected to abortion. For example, such images are used widely in campaign materials produced by organizations that promote alcohol abstinence in pregnancy. (3)

The legal scholar Kristin Savell has argued, however, that their use in the abortion debate has opened a new frontier in the regulation of abortion; first bringing about a shift from 'viability to sentience as a criterion of legal significance' and second, on this basis, 'constructing abortion in terms of feticide as distinct from the termination of pregnancy'. (4)

There is little anyone can do about these realities of being a sexually active woman other than recognise the importance of abortion as part of fertility control.

This latter point draws attention to how the definition of abortion moves away from what it does to and for a woman (the ending of a pregnancy) to a growing focus on its effects for the fetus (the death of a feeling being).

As Stuart Derbyshire argues in this publication, 'sentience' is an uncertain concept (more so than even 'viability'). This uncertainty can bring with it claims about what 'matters' about a fetus, and what it can do or feel, that range from 12 weeks' gestation right through to birth. Claims about sentience in turn destabilize the arguments for legal limits for abortion based on viability.

Savell's point about the redefinition of abortion away from what it does to and for a woman (the ending of a pregnancy) to a growing focus on its effects for the fetus (the death of a feeling being), clearly also points to the basis on which claims for restrictions on abortion gain ground.

There is a range of possible responses to the opening of this new frontier in debates on abortion based in disciplines including ethics, psychology, history and sociology. The basis for the study discussed below was socio-legal, insofar as it took as its backdrop both the particular legal framework for abortion in Britain and its interpretation in practice since 1968.

Analysis of the law, and the practice of provision, indicates that a consistent proportion of around 12 per cent of abortions in Britain over the years have been performed in the second trimester, with diminishing proportions of this minority of abortions carried out as gestation increases.

In other words: despite better access to early abortion over the decades (5), a consistent demand for later abortion from British women is apparent. It was this which formed the study's explicit focus. Its aim was, by finding out more about why women have abortions later, to provide information that might play some part in re-grounding discussion of abortion as the ending of a woman's pregnancy, rather than the death of a fetus.

Women’s reasons for seeking later abortion

The study, which I conducted with colleagues from the University of Southampton and was published in 2007, drew on interviews with 883 women presenting for second trimester abortions at clinics around Britain. The details and interpretation of the study are reported elsewhere. (6) Here I want to emphasise the following points.

First, for some women later abortion is the necessary outcome of the pregnancy (that is, they could not have had an abortion earlier).

Second, later abortion emerged as not only the necessary outcome of pregnancy; for some women it was a better outcome than an earlier abortion. In other words, early abortion is not always better.

To discuss this further, I work though some points from what the study found, drawing particular attention to distinctions between what can be termed ‘service-related’ delays on the one hand, and ‘women-related’ delays on the other.

‘Service-related’ delays, and ‘women-related’ delays

We organized our questionnaire around the concept of ‘delay on the “pathway” to abortion’. The percentages overall with at least one reason for delay reported at each stage were as follows:

■ To suspecting pregnancy	71%
■ Between suspecting and taking test	64%
■ Between test result and decision	79%
■ Between decision and requesting abortion	28%
■ Between requesting abortion and procedure	60%

These findings suggest that majorities of women experience delays at all stages bar one. The one point in the pathway where there is relatively little delay is between decision and request; once a woman has first decided she wants to request an abortion this evidence confirms she will act on her decision. In the study sample, where delay at this stage was longer than 2 days, it was because of issues getting an appointment. We were told:

I had to wait more than 48 hours for an appointment at my/a doctor’s to request an abortion (27%).

I did not want to see my regular doctor and it took time for me to find another one (13%).

At the next stage, between request and procedure, it was clear that hold-ups in getting access to a procedure in a clinic were important for delaying abortion for many women. Forty-two per cent reporting delays at this stage waited over two weeks and 23 per cent waited over three weeks. Women told us:

I had to wait more than 5 days before I could get a consultation appointment to get the go-ahead for the abortion (32%).

The person I first asked for an abortion took a long time to sort out further appointments for me (30%).

I had to wait more than 7 days between the consultation and the appointment for the abortion (27%).

There were confusions about where I should go to have the abortion (24%).

These sorts of service delays are important ones for advocates of reproductive choice to address, as part of efforts to improve the abortion service. Less well recognized, however, is another part of the picture: 'women-related' reasons for delay.

Between request and procedure we were told by 16 per cent of women reporting delay at this point that: *'I was having second thoughts about having the abortion I had asked for, so I missed/cancelled some appointments and then re-booked them'*. This matter of 'second thoughts' (and variations of it) occurred at earlier stages too, in the following ways.

Three hundred and forty-nine women told us there were delays between taking a pregnancy test and deciding to request an abortion. These were the reasons they gave:

I was not sure about having the abortion, and it took me a while to make my mind up and ask for one (65%).

My relationship with my partner broke down (30%).

I thought the pregnancy was much less advanced than it was when I asked for the abortion (29%).

I was worried about what was involved in having an abortion so it took me a while to ask for one (27%).

I was hoping/waiting to see if my partner would support me in having a baby (20%).

My partner changed his mind about having a baby (11%).

[Reasons cited by >10% taking more than median time of 1 week]

The largest percentage thus reported being 'not sure'. Taking what we were told across all the stages, 'second thoughts' and 'not being sure' similarly emerged as commonplace in women's experience. Forty-one per cent of women across all stages told us, *'I was not sure about having the abortion, and it took me a while to make my mind up and ask for one'* and 32 per cent said that, *'I wasn't sure what I would do if I were pregnant'*.

These were not the only commonplace experiences. *'I didn't realise I was pregnant earlier because my periods are irregular'* was reported by 38 per cent of women; 36 per cent told us that, *'I thought the pregnancy was much less advanced than it was when I asked for the abortion'*; and 31 per cent that, *'I didn't realise I was pregnant earlier because I was using contraception'*.

These responses support the argument that contraception should not be seen as a 'solution' to abortion. They indicate that 'knowing' one is pregnant is not a straightforward matter. There is little anyone can do about these realities of being a sexually active woman other than recognise the importance of abortion as part of fertility control. The 'difficult' dimensions of deciding on abortion for some women go along with this too, however; taking time to make up one's mind is just as much part of the pathway to abortion as is failed contraception and breakthrough bleeding.

Later abortion emerged as not only the necessary outcome of pregnancy; for some women it was a better outcome than an earlier abortion.

Conclusions

This study, along with others like it, suggests that where arguments focus on 'the pregnancy' rather than 'the fetus', the case needs to be made equally strongly about what can be done and should be done to reduce delay, and what delay must and should be accepted. In Britain, at least, there is a lot to press for when it comes to improving services to reduce delays that are properly thought of as unhelpful and unnecessary. Some women who have second trimester abortions could and should have them earlier.

Then, however, there are delays that are either inevitable or, we would argue, necessary. Some women need later abortion because they need more time to decide and for these women earlier abortion may not be better—arguably worse a rushed earlier abortion, than a later one (or a baby).

We noted at the start of this article that the turn away from 'pregnancy' to 'the fetus' is a generally influential development. The sociologist Deborah Lupton has described what has happened this way:

Embryos and fetuses have gained increasing visibility in the public domain to the point that they have become fetishised cultural icons... Part of this process has been the infantilising of the unborn, which has reached into the earliest stage of embryonic development so that even new clusters of cells are now frequently referred to as 'babies'... Current discourses on pregnancy represent the pregnant woman as custodian of her precious and vulnerable 'baby' and frequently privilege the unborn's needs and rights over those of the woman. (7)

The study discussed here sought to make a contribution to what might be called the re-embodiment of pregnancy: that is to place the woman, her body, and experience of it, back in the frame and discuss what it means to focus on 'pregnancy' rather than 'the fetus'.

When pregnancy is embodied, we can see that women need abortion as late as necessary, not just as early as possible.

When pregnancy is embodied, we can see that women need abortion as late as necessary (not just as early as possible), and that for some women this will mean they 'delay'.

Lupton alerts us, however, to the fact that contesting the 'fetusization' of the abortion debate needs to be seen as one part of a much larger contest. The representation of the pregnant woman in general as the 'custodian of her...

baby' demands that those who know what is really 'difficult' about late abortion take on and battle around the wider 'difficulties' that our present constructions of pregnancy bring with them.

Notes

For those interested in research of this kind, the question 'Why "second trimester"?' might be asked. In our case, the main rationale was because we wanted to find out about differences between women presenting for abortion at different points across this band of 12-14 weeks. Otherwise, our thinking was largely conventional, based on the fact that discussion about abortion 'just does' use the concept 'trimester'. While this may be meaningful for medical research, its salience for social science research is, however, less obvious. More recently published studies have, we would suggest, been based on compelling rationales for sample selection. For example, Greene Foster and Kimport (2013) (8) use 'at or after 20 weeks' because of restrictions on abortion access in US states from this point, and Purcell *et al.* (2014) (9) use '16 or more weeks' because of limits on access to abortion in Scotland after this point. These are both excellent studies.

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Fetal Pain: What We Know, What We Believe, And What This Means For Abortion.



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In recent years, abortion has been posed as a conflict between the interests of the pregnant woman and the interests of the fetus growing inside her. According to this view, it becomes wrong to abort the fetus when the interests of the fetus exceed those of the pregnant woman.

Pain has consequently become of increasing interest to those who oppose abortion because it is generally agreed that all living organisms have a strong interest in avoiding pain. Several US states have enacted legislation to prevent abortion once the fetus reaches a developmental stage where pain is considered possible, typically around 20 weeks' gestation.

This article considers the evidence for fetal pain at various gestational ages. It concludes that whatever experience a fetus may have, this cannot be equivalent to the explicit pain experiences that emerge in early infancy. Further clarity regarding fetal pain, however, cannot be obtained. Fetal pain is necessarily vexed and, as such, is the wrong conceptual vehicle to guide legislation or clinical practice.

Before 8 weeks' gestation

Debate about fetal pain is dominated by approaches from neuroscience that ask when a minimally necessary neural circuitry for pain might be available. This approach has considerable merit.

People born without nerves that can detect noxious stimuli, including extreme heat, cold or pressure, have a condition called 'congenital insensitivity to pain' – they never experience pain. Consequently, such patients suffer extreme damage. They will, for example, take dishes out of the oven with their bare hands, bite off pieces of their own tongue when eating, break their bones to escape awkward positions, and so forth. Before such nerves develop in the fetus, therefore, it is reasonable to rule out any possibility of pain.

To the author's knowledge, all neuroscientists accept that for pain to be possible there has to be a connection of nerve fibers from the skin to the spinal cord and brain. This connection is formed between 8-12 weeks' gestation. Thus, there is total consensus that fetal pain is not possible before the eighth week of pregnancy.

Before 24 weeks' gestation

Most neuroscientists, however, believe that pain requires not just a connection from the skin to the spinal cord and lower centers of the brain but also to the cortex – the higher centers of the brain. Cortical connections are not formed before 24 weeks' gestation and so there is a general consensus that pain is not possible before the final trimester of pregnancy.

There is, however, considerable dissent from that general consensus. Those who oppose the consensus have argued that there is a structure underneath the cortex, called the subplate, which develops from 12 weeks' gestation. The subplate shares certain structural features with the cortex proper and, at least from around 18 weeks' gestation, neurons arriving in the subplate demonstrate evidence of functionality.

Also at 18 weeks' gestation, the fetus launches defensive reactions to surgery including behavioral withdrawal, redistribution of blood away from the arms and legs and towards vital internal organs, and the release of protective hormones. These observations imply that the cortex is not necessary for at least some types of defensive behaviors associated with pain.

**Fetal pain is necessarily vexed and...
is the wrong conceptual vehicle to
guide legislation or clinical practice.**

In addition, observations with anencephalic infants have also been used to undermine the necessity of the cortex for conscious sensation. In rare cases, the fetal brain fails properly to develop and the skull fills with fluid that prevents development of the cortex. Most such pregnancies spontaneously fail but, very occasionally, the infant is born and survives with only a brainstem. These infants have been demonstrated to laugh, cry and show other signs of emotion that have been interpreted as refuting the idea that a cortex is necessary for the experience of sensations and emotions.

Although the consensus position is that the cortex is necessary for pain, there remains no adequate explanation for how the cortex gives rise to pain. Consequently, it is difficult to dismiss the possibility that coherent activity within other parts of the brain might also give rise to pain. The argument is especially compelling because observation of the fetus and infants born without a cortex gives a direct impression of something being experienced; it just seems intuitively right that something akin to pain might be possible. Often a variation of Voltaire's 1764 challenge is issued:

Answer me, machinist, has nature arranged all the springs of sentiment in this animal that he should not feel?

After 12 weeks' gestation there is a nervous system capable of detecting noxious stimuli and after 18 weeks the fetus can be observed to withdraw and maybe also 'grimace' and show other emotional facial expressions. Intuition, if not hard science, points towards a pain experience.

The limits of intuition

The argument from intuition has some purchase, but there are important limitations to an argument that relies on what looks or feels right. The most important limitation is precisely that assumptions made based on intuition can be incorrect.

Cartoon characters can be observed to 'emote' and 'experience' but we know that the inference is incorrect and directly manipulated by the makers of the cartoon. Many people get attached to their prized possessions and imbue their cars, washing machines, plants and so forth with emotions. Application of a little logical pressure, however, leads most of us to give up the belief that our washing machine feels pain when it is overloaded.

Interestingly, health professionals who work with fetuses and neonates tend to distinguish between physical and mental states. Certainly, they will describe the fetus as being in pain but that description will often involve a distinction between pain as a direct response to injury and pain as a conscious experience. Injury and behavior can be directly observed but experience cannot be. Experience has to be inferred, and the process of inference is fraught with difficulty.

Going beyond neuroscience and intuition

A considerable problem with both the approach from neuroscience and the approach from intuition is the lack of any clear statement or investigation of the pain experience itself. The construct of pain is not examined and is, instead, presented as something already known and understood. Consequently, arguments can erupt because those involved are not talking about the same thing.

One possibly useful distinction might be between 'being in pain' and knowing that 'I am in pain'. Knowing will involve an explicit self-reflection on experience and an understanding of how events are unfolding, whereas being will just be without any wider comprehension of events or recognition of experience. Knowing might be more typical of the kinds of experiences we are used to when facing injury, medical intervention or spontaneous pains that come and go without any obvious reason.

Knowing is harder to map onto the fetus because it is not clear how the fetus could know, for example, that his or her leg were being pricked. 'Leg' is a concept that is linked to a broader understanding of bodies being separate entities with separable appendages. 'Pricked' is a concept that is linked to sharpness, distinct from dullness. Importing that much knowledge on behalf of the fetus quickly becomes implausible.

Being, however, just is, without any broader comprehension, understanding or reflection. A state of just being is much easier to map onto the fetus.

Thus, if the fetus does feel pain, then it is a kind of pain that lacks the fear and sensory identity that is typical of pain experiences known to mature human beings. Human beings experience pain partly *through* the unpleasantness and anxiety that comes from associating the outcome (a crushed limb) with concern for greater, more unpleasant outcomes (free movement, infection, death).

It is not clear, however, if a bounded, fleeting and immediate pain experience is possible. At any given moment, many thousands of receptors are firing as different sources of light, sound, smell, touch and so on bounce into your body. Consequently, any number of 'being'-type states might be generated. There is considerable difficulty in explaining how a non-conceptual mind might grab hold of any single sensation amongst the cacophony of other possible sensations.

What this means for clinicians and health care users

On balance, it is reasonable to conclude that the fetus cannot experience pain, at least not in any equivalent way to how mature infants and adults experience pain. An immediate, fleeting experience, even if possible, will lack the precision and associated fear and dread of a more mature pain experience.

That conclusion may provide sufficient reassurance for many clinicians and women seeking fetal procedures that fetal pain is not something for concern. It is, however, not possible to use fetal pain to provide a definitive guide for clinical practice or legal policy regarding the fetus because the issue is too vexed; it is an unsuitable vehicle for deciding clinical practice or policy.

Therapeutic surgery for the fetus can only be guided by objective measures of outcomes decided in clinical trials. Policy towards termination can only be guided by democratic discussion of when society thinks it is acceptable for a woman to decide that she will not continue to be pregnant.

In contrast, fetal pain is an immensely provocative and thought-provoking non-issue that is not useful in deciding clinical practice or law.

In recent years, abortion has been posed as a conflict between the interests of the pregnant woman and the interests of the fetus growing inside her.

Conclusion

In summary, deciding whether the fetus can feel pain cannot be reduced to deciding when certain neural circuits are intact. Neural development is a process, not an event, and, in any case, there is no definitive understanding of how any neural circuit relates to any particular experience. Conclusions that derive from intuition also fail because, at root, intuition is a conclusion reached from assertion; e.g., it **looks** like pain, therefore it **must** be pain. Appearances, however, can be deceptive.

Logically, the fetus should be denied any conceptual, knowledge-based pain experience. The fetus could, however, still be allowed a non-conceptual, raw and immediate pain experience. That distinction, between conceptual and non-conceptual, feels like one that can work. Unfortunately, however, whether a non-conceptual experience is possible, what that kind of experience might feel like, or how the nervous system might deliver that experience, is entirely unknown.

[If] the fetus does feel pain, then it is a kind of pain that lacks the fear and sensory identity that is typical of pain experiences known to mature human beings.

Ultimately, fetal pain is a necessarily vexed issue because whatever states might be possible for the fetus, the fetus will be psychologically naive with an immature nervous system. There can be no regression from knowledge and maturity into a state of naivety; there is no return to innocence where non-conceptual feeling might be

experienced. Consequently, fetal pain cannot be usefully employed to provide any practical moral guidance for issues concerning good clinical practice or abortion legislation. Fetal pain is an issue that, for all practical purposes, should be ignored.

Dr Stuart Derbyshire is an Associate Professor in the Department of Psychology at NUS and A*STAR-NUS Clinical Imaging Research Centre. Dr Derbyshire has written extensively on a variety of topics related to health, society and politics, including fetal pain, fertility, economics and the brain and psychosomatic disorders. His major research interest is pain and the vexed relationship between the object of sensation and the content of sensory experience, what might be dubbed 'sensory cognitive neuroscience'. He is an associate editor of *Pain and Psychosomatic Medicine* and has received funding support from the Medical Research Council, the Wellcome Trust and the Economic and Social Research Council.

Selective Abortion For Fetal Anomaly: The Perspective Of A Support Organization.



Jane Fisher,
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Antenatal Results and Choices (ARC) is a UK charity that has been providing non-directive information and support to women and couples about prenatal testing and its consequences for more than 25 years. In that time we have had contact with thousands of expectant parents given a diagnosis of fetal anomaly and supported them through the difficult experience of ending what is most often a wanted pregnancy.

ARC has no agenda or investment in the decision women make after a prenatal diagnosis. We want to ensure that they are enabled to make the choice that is individually right for them: it is the women, and their partners, who have to live with the consequences. Our extensive contact with women and couples has given us insight into what they bring to their decision and the medical, cultural and political context that frames this complex experience. We can attest to the fact that in these complicated and often traumatic circumstances, women are capable of making the choices that are best for them and their families.

The legal context in the UK

In England, Scotland and Wales, abortion under 24 weeks' gestation is legal under Section 1 1(a) of the 1967 Abortion Act:

... when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith — (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family.

Terminations for fetal anomaly (TFA) are sanctioned (without gestational limit) through Section 1 (1) (d) of the Act, if:

... two registered medical practitioners are of the opinion, formed in good faith — (d) there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Neither 'substantial risk' nor 'seriously handicapped' is defined, which should enable doctors to consider the relevant factors in a particular case.

Although this legal ground extends beyond 24 weeks' gestation (the legal limit for most abortions), very few TFAs take place in the third trimester. There were fewer than 200 in 2013. ARC is aware that clinical practice in sanctioning post-24 week TFAs is variable. For example, some doctors will certify a third trimester termination after a late diagnosis of Down's syndrome and some will refuse.

The reality for a woman is that, after 24 weeks' gestation, it is her doctors' attitude to the potential outcome that holds sway. Before this point, under British law two doctors have to authorise the abortion, but the woman's views take precedent.

The medical context

All women in England, Scotland and Wales are offered screening tests in their pregnancy for Down's syndrome, sickle cell and thalassaemia, and structural fetal anomalies. Such

While there are no easy answers here, prenatal tests revealing uncertain information are not a new phenomenon.

testing is optional, and while the vast majority opt to have ultrasound scans, the uptake for Down's syndrome varies across the country, with an overall total of around 70 per cent of women opting in. Diagnosis of fetal anomaly continues to rise due to an increase in maternal age and the application of more sensitive testing technologies.

A recent major development in prenatal testing is the introduction of non-invasive prenatal testing for Down's syndrome (NIPT). This involves a maternal blood test from which circulating cell free fetal DNA is extracted for analysis. Without putting her pregnancy at risk a woman can get a 99 per cent accurate assessment of the chance of her baby having Down's syndrome. This is 10-15 per cent more accurate than standard screening tests.

NIPT is widely available in the private sector from 10 weeks' gestation and an evaluation study is underway to see how it might be implemented within the National Health Service (NHS). At the same time a new technique for detecting chromosomal anomalies is being introduced into practice. Known as array comparative genomic hybridization (arrayCGH),

this method is a hundred times more sensitive than conventional chromosome analysis. While this can improve the detection rate of genetic conditions, it will also pick up genetic copy number variants (CNVs) of unknown significance.

Concerns in the clinical community about relaying information of uncertain consequence are illustrated by this extract from a major UK research study into the prenatal application of arrayCGH:

The main risk is that arrayCGH will detect a significant number of CNVs with unknown or variable significance and that, in communicating these results to parents, we will increase the anxiety associated with prenatal testing. In some cases the inability to cope with the uncertainty of a CNV's significance could lead parents to choose to terminate a fetus potentially at low risk of adverse outcome. (1)

There is currently a debate within the genetics community as to whether arrayCGH should be narrowly targeted to avoid presenting what some ethicists have dubbed 'toxic' information to expectant parents. Others believe this restriction impinges on the woman's autonomy and her right to know as much as possible about any potential genetic anomalies affecting her fetus. The debate is likely to continue as scientists are on the cusp of being able to sequence the whole fetal genome within pregnancy.

While there are no easy answers here, prenatal tests revealing uncertain information are not a new phenomenon. Ultrasound scanning has been around for decades and can detect an ever-increasing number of unusual features in the developing fetus. However, doctors' ability to apply accurate prognosis has not kept pace.

All too often, fetal medicine specialists find themselves pointing out anomalous scan findings that may indicate potential disability but are unable to give the woman a clear picture of what it will mean for her child. Some women decide to end the pregnancy in this circumstance as they feel unable to manage the uncertainty ahead and the possibility of an adverse outcome. While we support such an autonomous decision, we also recognize the ethical load this places upon clinicians in the field.

With the very limited number of in utero treatments for fetal anomaly at their disposal, many fetal medicine specialists spend much of their clinical time giving expectant parents difficult news without being able to intervene medically to 'make things better'. At ARC we have maintained a close collaborative relationship with clinicians to help them to address both their own needs, and the needs of women in their care.

The cultural context: the spectre of eugenics

Prenatal diagnosis and subsequent abortion decisions have long been the subject of debate within the disability rights community. While many commentators identify as pro-choice, they worry that the provision of prenatal screening in order to facilitate reproductive decision-making promotes a negative attitude to those living with disability. To quote disability studies academic Adrienne Asch:

The focus of my concern here is not on the decision made by the pregnant woman or the woman and her partner. I focus on the view of life with disability that is communicated by society's efforts to develop prenatal testing and urge it on every pregnant woman. (2)

In the UK there has been focus on the abortion law as it applies to fetal anomaly, and some have suggested that the difference in time limit for the abortion of a 'healthy' fetus as opposed to one with potential disability is discriminatory. A group of anti-choice Members of Parliament (MPs) went so far as to instigate an enquiry that concluded:

Parliament should consider at the very least the two main options for removing those elements which a majority of witnesses believe are discriminatory – that is either reducing the upper time limit for abortions on the grounds of disability from birth to make it equal to the upper limit for able bodied babies or repealing Section 1(1)(d) altogether. (3)

These 'expressivist' arguments often resonate with pro-choice advocates. In this regard, it is worth quoting the well-known British disability rights campaigner and academic Dr Tom Shakespeare, who has achondroplasia (a form of dwarfism):

I conclude that prenatal diagnosis is not straightforwardly eugenic or discriminatory. We should be on hand to offer counselling, good quality information and support, but we should not venture to dictate where the duties of prospective parents may lie. Nor should we interpret a decision or termination of pregnancy as expressing disrespect or discrimination towards disabled people. Choices in pregnancy are painful and may be experienced as burdensome but they are not incompatible with disability rights. (4)

It is reassuring that in the UK, the introduction of national prenatal screening programs in the past 20 years has coincided with improvements in conditions for those living with disability with the introduction of legislation to promote inclusion and reduce discrimination. Thus the provision of prenatal diagnosis and the fact that most women confronted with serious fetal anomaly decide on termination is compatible with an empathetic and inclusive attitude to those living with impairment.

The political context of abortion: 'You are the person responsible for the loss; abortion suggests the baby is unwanted' (5)

Many women facing a diagnosis of fetal anomaly find that their stance on abortion in the abstract changes in the complex reality of what it means for their prospective child and their own future. We speak regularly to women on our helpline who define themselves as anti-abortion and are anxious to differentiate themselves from those who end pregnancies for non-medical reasons.

The fact that 'termination' is the term consistently used in this context illustrates the emphasis on the medical grounds and perhaps an attempt to avoid the stigma associated with 'abortion'.

Psychologically many women struggle to reconcile their concept of themselves as a mother carrying a desired baby with the decision to terminate:

I really thought after bonding with my baby and thinking the week before we found out the results that I would never dream of ending the pregnancy whatever the outcome. I researched the condition, and we just wouldn't know how poorly she would be until she grew up (if she lived that long). (6)

Such conflicted feelings can lead to what has been termed 'disenfranchised grief', where women do not feel they deserve sympathy from others or have the right to mourn their loss because it was self-inflicted.

The complicated grieving process in the aftermath of TFA can be exploited by those who wish to prove that abortion harms women. ARC is aware of 'crisis pregnancy centers' in the UK that are all too ready to exploit women's ambivalent feelings, by providing them with 'post abortion recovery programs' that aim to highlight the 'wrongness' of their decision and suggest that only through absolution will they find peace.

Final thoughts: Supporting women who terminate a pregnancy for fetal anomaly

In the midst of the context outlined above is an individual woman reeling from the intense shock inherent in the news of fetal anomaly. Suddenly her world is shattered as she is no longer expecting the healthy baby around whom she had built her hopes and expectations. In a state of emotional turmoil she has to negotiate a way forward that she knows will be life-changing.

[I]n the UK, the introduction of national prenatal screening programs in the past 20 years has coincided with improvements in conditions for those living with disability.

Some women take longer than others to come to a decision. It will always be painful; it will often feel almost impossible to envisage two apparently equally onerous potential outcomes. Our work at ARC and published evidence tells us, even in these extreme circumstances, that women are able to make the choices that are right for them and to live with these choices:

This was the most dreadful thing we have ever been through in our lives. The grief, the emotional pain and the shock were overpowering. But even through this truly terrible time we felt a sense of gratitude that we had the choice to end the pregnancy. We felt and still feel that we made the right decision for us, but also, importantly, for her. (7)

Expectant parents are best placed to decide what they can cope with and what they want their child to cope with, and should be able to depend on our unequivocal support and compassion for their choices.

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Jane Fisher joined Antenatal Results and Choices (ARC) in 2001 as Support Coordinator and became Director in 2004. ARC is a UK charity with a remit to provide non-directive information and support to parents throughout prenatal testing and when fetal anomaly is diagnosed. Help is offered for as long as is needed whatever decision is made about the future of the pregnancy. ARC also runs a well-established training program for health care professionals. As well as managing the charity, Ms Fisher is also involved in directly supporting anxious expectant and bereaved parents, training health care professionals, research, policy and media work. She represents service users on the UK National Screening Committee, Fetal Maternal and Child Health Group of the UK NSC and a number of its subgroups.

Sex Selection: The Uneasy Choice.



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Sex selection is the response to the desire to have children of a particular sex. In Asia, the desire is most commonly for male children. Although we identify this process with pre-conception, pre-implantation, and antenatal methods, it is important to recognize that there are postnatal interventions also. These postnatal interventions include female infanticide or the starvation, neglect and abandonment of the girl child.

The desire to be able to select and control the sex of one's child has been present from ancient times. The Chinese Gender Charts have been popular for thousands of years. A range of methods is promoted in many other countries as being able to help choose the sex of the child. These include a 'gender selection diet', assessing the pH of vaginal secretions at the time of intercourse, and many others that claim high success rates but not much scientific evidence.

Recently an 'astrologer' in South India was found to be making predictions for the next three to four pregnancies, based on which women would terminate two to three consecutive pregnancies until the son was conceived. (1)

Why does sex selection happen?

Although sex selection could be understood as selecting either sex, the issue that is currently a concern in some Asian countries and their diaspora is the tendency to select in preference for the male child. This is a reflection of son preference as well as daughter unwantedness. (2)

Son preference is an indicator of the status of women in a patriarchal system. It is also impacted by the politics of population control by the state, or even by the choice to have a small family, in cases where couples want only one or two children but desire that at least one of them should be a boy.

A sex ratio at birth that lies between 934 and 952 females per 1,000 male births is considered to be within the normal range, based on observation over several decades for many countries. (3) More male children die in the early neonatal period, hence the ratio almost balances out in the next few years.

Although sex selection has been practiced through home remedies and female infanticide for hundreds of years, the use of ultrasound followed by an abortion, mostly in the early second trimester, led to campaigns against the sex selective abortion procedure in the 1980s in India. While this campaign brought much-needed awareness about this practice, unfortunately it also moved attention away from the underlying gender discrimination and social, cultural and patriarchal norms, putting the spotlight on the pregnancy terminations that followed.

The consequence of this was that some of the rhetoric of the campaign against sex-selection became anti-abortion, although that was never the intention of the campaign. In recent years, anti-abortion groups have also discovered a love for the girl child. The unsaid message in their communication materials and images is that abortion itself is unethical and immoral.

A law called the Pre-Conception, Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act) was passed in India in 1994 and amended in 2002. (4) However, the 2011 census data in India showed that sex ratios had not improved and were, in fact, continuing to decline, as they have been since the first census was conducted in 1900. (5) The government agencies in many states then stepped up the implementation of the PCPNDT Act. The resultant harassment of doctors in private practice has now discouraged them from providing any second trimester abortions at all, and they are turning women away. (6)

Once again, the stigmatization of abortion has increased and women are being forced to find unsafe or exploitatively expensive means to terminate a pregnancy.

The important question to ask here is: Why do we want more women to be born? An article from Kazakhstan puts the question in context:

The role of almost all Eastern women, whether they are dependent or independent, is to make a home and do housework for the family. Therefore, Kazakh women need someone who will help the former fulfil their roles. In this culture, their daughters are their best assistants because it is the social standard for them to act in this manner. In return for their help, mothers teach their daughters how to cook, clean, wash clothes and perform other tasks required to maintain an efficient Kazakh household. Each of these skills will be helpful to the daughters in their future lives. What is most beneficial about this cultural practice, because of the sustained interactions, is that mothers and daughters bond with each other in a powerful, caring relationship. (7)

The campaigns to defend the girl child in India have spoken to similar themes, arguing that girls are needed in order to marry men, have children, and generally fulfil their obligations in perpetuating a patriarchal system. There are projections of violence against women, rape, polyandry – as though there is no exploitation and abuse in societies with a ‘good’ sex ratio! The underlying argument is also a bit of a threat – ‘If you don’t have more girl children, don’t blame us for what happens next. We warned you’.

The pro-choice dilemma

Advocates for women's right to safe abortion and the right to choose are now facing a serious dilemma. What does it mean to be pro-choice under these conditions? What should one be able to choose: When to be pregnant? How often to be pregnant? At what intervals to be pregnant? How many children to have? These choices were recognized by the International Conference on Population and Development in 1994, where governments endorsed the need to move away from target-based approaches to rights-based ones.

But when it comes to what kind of child to have, there is hesitation and the old worries of eugenics come to the fore.

Is there ever really a true choice? There are always personal reasons, family reasons, social norms and pressures, economic reasons (jobs for women, equal pay, maternity benefits, cost of education), country policies (one-child or two-child family norm, military recruitment). 'Choice' is not really exercised in a vacuum and the state can (and does) interfere with the reproductive freedom of individuals.

If we want to ensure that women and couples do not choose to terminate a female fetus, we need to start addressing the reasons why the girl child is so unwanted. We need to talk about dowry, child marriages, violence against women, access to education, employment, paid maternity leave, equal inheritance of property, political representation, gender sensitive programming, and budgeting – among other issues of empowerment.

Laws for social change can work, as they seem to have in South Korea: but they need to be part of a multi-pronged approach which recognizes that women's empowerment and equal status is the foundation on which we can build an equal society. Until we work on all these elements, just focusing on the termination of a female fetus pregnancy as being unwanted is really missing the wood for the trees.

Women's rights groups need to deliberate on this question. Can one advocate for a right to choose and then place limitations on that choice? 'Sex selection' as a term also includes the pregnancy termination and stigmatizes it, rather than just saying 'sex determination'. Now we have so many new ways of describing it: sex selective abortion, gender selective abortion, female gendercide, female feticide, gender genocide.

But there must be as many women and couples who find out the sex of the fetus and because it is male, they simply go home and have the baby – and we never know about them. They are also actively undertaking sex determination but no one talks about them.

So then this issue is really about the abortion, isn't it?

**What should one be able to choose:
When to be pregnant? How often
to be pregnant? At what intervals to
be pregnant?**

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Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States.



Miriam Yeung,
Executive Director,
National Asian Pacific American Women's Forum, US

From as early as the late 1990s, we have documentation of anti-abortion activists proposing that sex-selective abortion bans be a new basis for challenging the legal status of abortion in the United States. Since then, eight states have enacted laws prohibiting sex-selective abortion. Twenty-one other states and the federal government have considered laws banning sex-selective abortion in recent years.

Sex-selective abortion bans have also proven to be a useful organizing tool for the anti-abortion movement, and they do so while exposing and picking on three enduring deficits in our reproductive rights, health and justice movements.

One of these deficits is that our movement lacks strong and unifying values messages. Meanwhile, our opponents have learned from social justice and human rights and are stealing pages directly out of our playbooks. So while these sex-selective abortion bans take away women's rights, anti-abortion activists do so under the banner of feminism. Model bill language for these sex-selective abortion bans almost always begins with a coopting of human rights and feminist framing about sexism and women's equality.

A second of these deficits is that the US reproductive rights, health and justice movement is singularly focused on issues within our own borders and we are not well synced or aligned with partners working on similar issues in other countries. The converse is also true. Sex-selective practices, including sex-selective abortions, as a result of son preference is actually cause for great alarm around the world.

Our opponents have learned from social justice and human rights and are stealing pages directly out of our playbooks.

Activists in India and China are leading incredible campaigns to raise the value of women and girls. Unfortunately, some of the strong feminist language our Asian sisters developed, when placed in our US context, is being used against abortion rights. At the same time, our US-based organizations have not adequately confronted the realities of what it means to mix rampant son preference and the legal subjugation of women with greater availability of reproductive health technologies. Abortions are being used to deselect for girls in some parts of the world and this has dire consequences, not just for abortion rights.

Lastly, our reproductive rights and health movements have not adequately addressed legacies of racism and xenophobia. Women of color and immigrant women have a long and sometimes tortured relationship with the reproductive rights and health movements. While women of color depend on reproductive health access as a means for our own economic empowerment, we have also been oppressed by those same establishments – forced sterilizations and medical experimentation being two of many examples of ways women of color had their bodily autonomy stripped away.

Sex-selective abortion bans take advantage of tensions around race and immigration status.

Sex-selective abortion bans are a wedge issue that takes advantage of tensions around race and immigration status and particularly strikes at our country's hostilities toward Asian American immigrants.

Recently, the National Asian Pacific American Women's Forum (NAPAWF), along with the

International Human Rights Clinic, University of Chicago Law School, and ANSIRH, a program of the Bixby Center for Global Reproductive Health at the University of California, San Francisco, published a report entitled *Replacing Myths with Facts*, which identifies six myths in statements made by legislators, testimony submitted to legislatures, and reports issued by legislative committees that have considered or adopted laws banning sex-selective abortion. (1)

While this report does not proclaim to make up for all the deficits described above, the authors did attempt to provide our movement with a systematic legal and social science analysis that takes into account both the US and international context. The following is a very short summary of those myths, an example of how they are used by anti-abortion activists, and the facts that we reveal from our analysis.

MYTH #1: Male-biased sex ratios at birth are proof that sex-selective abortions are occurring.

'What is causing the skewed ratio: abortion. If the male number in the sex ratio is above 106, it means that couples are having abortions when they find out the mother is carrying a girl.' – Quoted in a submission from United States Representative Trent Franks (R-AZ) to a hearing before the Subcommittee on the Constitution of the Committee on the Judiciary.

FACT #1: Male-biased sex ratios at birth do not provide proof that sex-selective abortions are occurring because sex selection can be achieved by artificially inseminating only sperm with the X or the Y chromosome or by implanting embryos of the desired sex into the uterus.

MYTH #2: India and China are the only countries where male-biased sex ratios exist.

'Countries with long-standing experience with sex-selection abortion, such as the Republic of India... and the People's Republic of China...' – Prenatal Nondiscrimination Act (PRENDA) of 2013.

FACT #2: Male-biased sex ratios at birth can be found in many countries throughout the world, including those with predominantly white populations. The countries with the highest male-biased sex ratios in the world are Liechtenstein and Armenia and both countries have higher sex ratios than India and China. Nonetheless, only immigrants from India and China are targeted in legislative hearings and discussions.

MYTH #3: The United States is one of the few countries in the world that does not ban sex-selective abortion.

'We are the only advanced country left in the world that still doesn't restrict sex-selection abortion in any way.' – Press release from United States Representative Trent Franks (R-AZ)

FACT #3: Only four countries explicitly prohibit sex-selective abortion: China, Kosovo, Nepal and Vietnam. Countries that are concerned about sex selection regulate the practice by prohibiting sex selection through pre-conception and pre-implantation techniques.

MYTH #4: Laws banning sex-selective abortion are an effective way to prevent sex selection and adjust male-biased sex ratios at birth.

'[T]here are regulations in here, not just to restrict abortions but to protect the victims. There is a prohibition against sex selection.... So we are saying that sex selection is not necessary.' – Statement of Pennsylvania State Representative Stephen Freind (R-PA) during a hearing of the Pennsylvania House of Representatives.

FACT #4: Our empirical analysis of sex ratios at birth five years before and after sex-selective abortion bans were enacted in Illinois and Pennsylvania indicates that the bans instituted in those states were not associated with changes in sex ratios at birth.

MYTH #5: Empirical studies of sex ratios at birth of foreign-born Chinese, Indians and Koreans prove that sex-selective abortions based on son preference are occurring in the United States.

'While it is difficult to say with any exactitude how many sex-selection abortions take place in the U.S. each year, the number is not trivial.... [W]e are talking about communities consisting of 3.9 million Chinese Americans, 2.8 million... Asian Indians, [and] 1.6 million Korean Americans[.] [T]he highly skewed sex ratios found in census surveys suggest among these groups alone, that tens of thousands of unborn girls have been eliminated, for no other reason than they are considered by some to be the wrong sex.'
– Testimony of Steven W. Mosher, President of the Population Research Institute, at a hearing before the Subcommittee on the Constitution of the Committee on the Judiciary.

FACT #5: By analyzing census data from 2007 to 2011 using statistical weights and accounting for all births we found that foreign-born Chinese, Indians and Koreans had approximately 2,772 more girls than white people from 2007 to 2011 and Asians American as a group had 3,080 more girls than white people. Moreover, when taking into account all births of Asian American families their sex ratios at birth are within the standard range.

MYTH #6: The primary motivation for laws banning sex-selective abortion in the United States is to prevent gender-based discrimination.

'The reason for opposing sex-selection is uniform: the desire to combat discrimination.' – Submission of United States Representative Lamar Smith (R-TX) to the Committee of the Whole House on the State of the Union.

FACT #6: Restricting access to abortion is the primary motivation for sex-selective abortion bans. All the bans have been proposed and supported by people who oppose abortion generally. None of the bans prohibit non-abortion methods of sex selection. Our analysis found that over 90 per cent of Republican representatives in the six states that enacted bans in the last four years voted for the laws. In contrast, only 20 per cent of Democrats voted for the bans in four of the six states. In the two states where sex-selective abortion bans achieved meaningful support from Democrats – Oklahoma and South Dakota – laws that restrict access to abortion consistently receive bipartisan support.

As one can see from the logical progression of the myths we lay out in the report, anti-abortion advocates in the United States are exploiting xenophobic stereotypes of Asian American women to pass racist anti-abortion legislation. At the same time, they are coopting feminist values and language to try to organize a base of supporters from amongst communities of color. NAPAWF is working to combat sex-selective abortion bans by organizing resistance amongst those most affected and targeted by these laws – Asian American women – and by connecting these efforts to the larger set of social justice and human rights values that informs our work.

A woman's bodily autonomy is no less connected to her experience of race, class, immigration, ability, sexuality or any other aspect of her life.

A woman's bodily autonomy is no less connected to her experience of race, class, immigration, ability, sexuality or any other aspect of her life. In order to dismantle threats to women's reproductive choice, we believe we must organize our communities to dismantle all systems of oppression.

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Miriam W. Yeung MPA is the Executive Director of the National Asian Pacific American Women's Forum (NAPAWF), the only organization dedicated to building a movement for human rights for Asian American and Pacific Islander women in the US. With chapters in 15 cities and offices in New York and DC, NAPAWF is a multi-issue organization most recently focused on rights for immigrant women, expanding public benefits, countering sex-selective abortion ban legislative efforts in the US, and other reproductive justice campaigns.

Not Only Abortion: Wider Reproductive Choice Issues.



Marlene Gerber Fried,
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I am grateful to the organizers of the 2014 International Summit on Reproductive Choice for including me in this important conversation. In order to effectively counter the opponents of abortion rights, we need more 'inside the family' talk about the issues they frequently use as 'moral defenses' for curtailing abortion access.

At the Summit, we looked at abortion for reasons of sex selection or fetal anomaly and later abortion. The need for these internal conversations is driven not just by the opposition, but also because these issues remain unresolved and divisive among advocates of abortion rights.

The London Declaration of Pro-Choice Principles (1), a starting point for the convening, articulates a strong commitment to women's autonomy in the context of abortion:

Every woman should have the right to decide the future of her pregnancy according to her conscience, whatever her reasons or circumstances.

Seeking resolution among abortion advocates about the 'hard' issues set out above is a priority because of a commitment to preserving the principle of reproductive autonomy as a basic tenet of the choice movement. Further, it is at the core of gender equity and justice.

However, there has not been the same impetus to resolve disagreements over the other side of the reproductive coin, the right to have children. In fact, the choice movement has, from its beginning, included those who supported policies denying that right to specific groups of women. Women from marginalized and disempowered communities have been considered unfit for motherhood and subjected to coercive practices by both state and private actors, aimed at preventing them from having children.

Women of color and their allies in the reproductive justice movement have exposed and led the resistance against these practices. They have argued that the right of all women to have and to parent children is as integral to reproductive autonomy as the right not to.

Mainstream abortion rights organizations have been largely absent from the resistance efforts. Even worse, at times they have supported curtailing the childbearing rights of women on the margins. This has been a fault-line between the choice and reproductive justice movements.

I believe that we can and must address this divide. Doing so requires that the choice movement affirm, with the same passion and commitment it accords to abortion rights, the right of an individual woman to make her own decision to have a child, regardless of her resources or circumstances.

The following examples all offer the opportunity for examining and, where necessary, challenging, our underlying attitudes about who should have children and under what circumstances: (1) coercive sterilization of women in prison; (2) coercive sterilization of women living with HIV/AIDS; and (3) Project Prevention, formerly known as C.R.A.C.K.

The same distrust of women's ability to make decisions about their health and reproduction underlies both restrictive policies on abortion and childbearing. I hope discussion of these examples will raise awareness about the importance of expanding the political agenda of the choice movement so that it embraces an understanding of reproductive autonomy which is grounded in the experiences of all women.

I believe that we can and must address this divide by affirming, with the same passion and commitment it accords to abortion rights, the right of an individual woman to make her own decision to have a child, regardless of her resources or circumstances.

Coercive sterilization of women in prison (2)

In 2013, Justice Now, an organization which advocates for both the rights of people who are incarcerated and for prison abolition, exposed the ongoing coercive sterilizations of women incarcerated in California prisons. Between 2006 and 2010, approximately 148 tubal ligations were performed without proper authority and in violation of prison rules, and perhaps 100 more dating from the late 1990s. (3)

Women testified to feeling pressured by doctors and prison officials. In some cases, they reported being given incorrect diagnoses and subjected to unnecessary hysterectomies when other less invasive procedures were possible. Those affected were poor and disproportionately women of color. Former inmates and prisoner advocates maintain that prison medical staff targeted those deemed likely to return to prison in the future. (4)

Current sterilizations come in the context of a history of eugenicist practices. Under compulsory sterilization laws in California and 31 other states, minority groups, the poor, the disabled, the mentally ill and criminals were singled out as inferior and sterilized to prevent them from spreading their genes.

In that same tradition, a physician employed by a California prison justified the sterilization of incarcerated women in economic terms. He told a reporter that the amount of money the state prison system spent on sterilizations was small 'compared to what you save in welfare paying for these unwanted children – as they procreated more.' (5)

In the 1970s, women of color brought attention to sterilization abuse in their communities. Their advocacy secured policies aimed at preventing future abuse. Yet mainstream choice groups did not join these efforts, and in some cases even opposed them. Unfortunately, today the choice movement continues to sit on the sidelines of this issue.

Coercive sterilization of HIV-positive women

The International Committee of Women Living With HIV/AIDS (WLHA) has documented coerced sterilization in Namibia, South Africa, Thailand, Chile, Uganda, Zambia, Jamaica, and Mexico. Women with HIV/AIDS who have been sterilized face a double burden of stigma – not being able to have children and being HIV positive.

The same distrust of women's ability to make decisions about their health and reproduction underlies both restrictive policies on abortion and childbearing.

While having children is crucial to women's status, if you are HIV positive, childbearing and even getting pregnant is considered irresponsible. The belief persists that a woman infected with HIV/AIDS will inevitably transmit this to her child despite the fact that this is not true. (6) Sterilization has been promoted as the best way to prevent mother to child transmission.

At the same time, abortion is often not an option for women living with HIV/AIDS, who face discrimination and a lack of services. While there is broad support among advocates and public health professionals for integrating HIV treatment with reproductive health services, abortion, even where legal, is not included. Further, within the medical community there is inadequate knowledge about HIV and abortion. For example, more research is needed about how health providers treat women living with HIV/AIDS and about whether surgical or medical is preferable and safer even though, in many settings, there are no options.

Often charges of coercive sterilization have been ignored because of inadequate documentation. HIV/AIDS advocacy organizations have stepped into this void. Lawsuits were filed in Namibia in 2010. A complaint on behalf of Chilean women was brought to the Inter-American Commission for Human Rights by Vivo Positivo, a Chilean HIV/AIDS service organization, and the Center for Reproductive Rights. (7) Here too, the mainstream 'choice' movement has been largely silent, and resistance has come primarily from HIV/AIDS organizations.

C.R.A.C.K. = Project Prevention

In 1997, C.R.A.C.K. (Children Requiring A Caring Kommunity, now called Project Prevention), a US-based non-profit organization, began advertising in low-income communities and communities of color, offering to pay women who use illegal drugs \$200 to be sterilized or to accept long-term contraception. Since that time, the organization claims to have paid 3,600 women in the US.

Project Prevention has also expanded outside the US. In the United Kingdom, it is allowed to pay addicts and alcoholics to use long-term birth control, but cannot pay for sterilization. In Kenya, the organization offers women living with HIV/AIDS \$40 to have an intrauterine birth control device (IUD) implanted. In its fundraising materials, Project Prevention makes the false claim that this is the only way to reduce the number of babies born with HIV.

Women of color and their allies opposed this program, linking it to eugenics. They argue that the approach is not the way to solve problems associated with drug use and pregnancy. Instead, it pushes a population control agenda, and disseminates medical misinformation and political propaganda.

Advocates for reproductive justice have pointed to the need for expanded drug treatment and general health services and education. However, the choice movement has not been part of these efforts.

Conclusion

It is past time for the large, mainstream choice organizations to ally themselves with the struggles of all women to have children. Silence from the pro-choice community perpetuates these violations of human rights and stigma. On my agenda for future discussions of divisive issues I propose that we ask: how we can counter societal prescriptions about who should be a mother? How can we advocate for people whose reproduction is stigmatized and feared? What are the fears about taking on these battles? What are the political costs of doing so? What are the costs of not taking them up?

It is my hope that engaging these questions will enable the choice movement to join with the reproductive justice movement in supporting reproductive autonomy for all women.

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(1) For the full text of the statement, see page 7.

(2) For more on this see Ross, Loretta (2014) 'Eugenicists Never Retreat, they Just Re Group: Sterilization and Reproductive Oppression in Prisons,' *RH Reality Check*, 12 June. Accessed 14 September 2014. Available at: <http://rhrealitycheck.org/article/2014/06/12/eugenicists-never-retreat-just-regroup-sterilization-reproductive-oppression-prisons/>.

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