THE NEWSJOURNAL OF CATHOLIC OPINION

CONSCIENCE

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Thorny Issues in the Abortion Debate

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"He who acts against his CONSCIENCE always sins."

— St. Thomas Aquinas

"CONSCIENCE is the most sacred of all property; other property depending in part on positive law, the exercise of that being a natural and unalienable right."

— James Madison

"A good CONSCIENCE is the palace of Christ."

— St. Augustine

"I shall drink—to the Pope, if you please—still to CONSCIENCE first and to the Pope afterwards."

— Blessed John Henry Newman

"But no man has a monopoly of CONSCIENCE."

— Mary A. Ward

CONSCIENCE

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Conscience is published by Catholics for Choice.

Catholics for Choice shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well-being and respect and affirm the capacity of women and men to make moral decisions about their lives.

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CATHOLICS FOR CHOICE

EDITOR'S NOTE

DESTIGMATIZING ABORTION IS VITALLY IMPORTANT for the health and well-being of women around the world. In some (too few) places, abortion care is considered to be part of the national healthcare framework, is relatively easy to access and does not impose undue financial burdens on the patient.

Sadly, in too many places, abortion is a thorny issue. It can be unavailable if not illegal, and stigmatized beyond all reason. At Catholics for Choice, we are especially concerned with the obstacles that disproportionately affect poorer women. Social justice demands that neither they—nor indeed any woman—face difficulties when accessing abortion care.

The first of the thorny issues we explore is the controversy in the United States over whether the state should fund abortion care. In "A Case We Can't Afford Not to Make," Andrea Miller argues in favor of public funding. Christian Fiala also investigates how various European countries deal with funding for abortion and contraception.

Willie Parker, an OB/GYN, describes why his outlook on abortions changed and why he now provides them. We also include "A Statement on Later Abortion" in which leading prochoice advocates state that "healthcare that does not include access to later abortions does not meet what women, and society, need."

We continue with statistical analysis from our colleagues at the Guttmacher Institute. Rachel Jones and Lawrence Finer answer the question, "So, Who Has Second-Trimester Abortions?" And, in "Between a Rock and a Hard Place," Jane Fisher, the director of Antenatal Results and Choice, discusses what happens when people receive a prenatal diagnosis of a fatal, life-limiting or disabling condition.

Finally, we move on to the political and advocacy worlds, and examine what we have learned from past battles and how we should gear up for future ones. Ann Furedi, the executive director of bpas, the British Pregnancy Advisory Service, explains why "choice" is an important part of our lexicon. Tracy Weitz then examines the political battles over access to abortion services. In "Lessons for the Prochoice Movement from the 'Partial Birth Abortion' Fight," she argues that we must not shy away from difficult issues, but rather embrace them as opportunities for educating both those who support us and those who do not.

A lot of thought and planning goes into every issue of *Conscience*. We would like to ensure that those who should be reading it get the opportunity to do so. If you know of somebody who should subscribe, or would like us to send them a sample copy, please let us know via e-mail at conscience@catholicsforchoice.org.

DAVID J. NOLAN
Editor

"What if we started to create new rules … where we proudly declare support for abortion coverage as a matter of fairness and justice?"

— ANDREA MILLER, *p12*

THE NEWSJOURNAL OF CATHOLIC OPINION

CONSCIENCE

DEPARTMENTS

FEATURES

Argentina Lacks Accountability for Women's Reproductive Health

Marta Alanis and Jacqueline Nolley Echegaray ("Fighting for Women's Lives in Argentina," Vol. xxxii No. 3), provide a hopeful overview of how the decriminalization of abortion has emerged as a human rights issue in Argentina. This is an important connection for the reproductive rights movement to make. A woman's access to safe and legal abortion is absolutely and inextricably linked to her most fundamental human rights. However, Human Rights Watch has found that changes in laws and policies alone are insufficient to protect these rights—there must also be accountability for putting them into practice.

Our research in Argentina demonstrates that the government's failure to carry out laws and policies on reproductive health can curtail women's rights to life, health, nondiscrimination, physical integrity, freedom of expression and religion, as well as the right to decide the number and spacing of children.

Systems exist in Argentina to ensure that public officials and medical providers comply with the law—but they are rarely used to safeguard access to reproductive health services. In our 2010 report, we documented how women pay the price—with their suffering or even with their death—for the failure to enforce the law. Ana María Acevedo, a young mother diagnosed with cancer, paid such a price. Doctors refused her radiation cancer treatment because she was pregnant. The hospital denied her petition for legal therapeutic abortion. She died five months later. A criminal court in Santa Fe province found that her doctors had failed to uphold their public duties, but though they were found culpable for her suffering in 2010, they have not been sentenced.

Argentina's laws may change, but for change to happen in the lives of women like Acevedo, Argentina's government should be accountable for carrying out policies that promote women's health, dignity and rights.

Amanda M. Klasing
Women's Rights Division
Human Rights Watch

Letters may be edited for clarity and length.

Catholic Healthcare Should Be Guided by Medical Standards, Not Church Politics

When Phoenix bishop Thomas Olmsted revoked the Catholic status of St. Joseph's Hospital and Medical Center for providing a life-saving abortion in 2010, he did the hospital a huge favor. He effectively took that hospital out of the line of fire in the "Nuns vs. Bishops" battle your recent issue so effectively described (Vol. xxxii No. 3).

Is it any wonder that the health system to which St. Joseph's Hospital belongs—Catholic Healthcare West—has just announced a decision to give up its official connection to the Catholic church and change its name to Dignity Health? Is it any surprise that communities don't want their nonsectarian hospitals to join Catholic health systems or merge with nearby Catholic hospitals because of well-grounded fears that bishops will interfere with patient care?

The bishops are only calling more attention to their heavy-handed approach in their latest campaign to insist that Catholic hospitals and social services agencies should be allowed to deny contraceptive coverage to their employees. They seem to have conveniently forgotten that these hospitals and agencies are not churches, but rather nonprofit entities that receive millions in tax dollars every year through Medicaid, Medicare and government grants.

The struggle over who has the final say on Catholic healthcare policies—the nuns who founded most Catholic hospitals or the bishops who outrank them in the church hierarchy—is a sad spectacle. A hospital license is a privilege, not a right, and brings with it a responsibility to serve the public—including people who are not Catholic or, if Catholic, do not agree with the bishops or nuns on such issues as contraception. Hospitals should be guided by medical standards of care, compassion for their patients and non-discriminatory labor practices, not by church politics.

Lois Uttley
Director
The MergerWatch Project

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Please e-mail letters to:

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The Church and Contraception

The Obama Administration Sides with Women, Against Bishops' Demands for Expansive Religious Exemption to Contraception Coverage

ON JANUARY 20 KATHLEEN Sebelius, Secretary of the Department of Health and Human Services (HHS), issued an interim final rule requiring that no-copay coverage for contraception must be made available in the majority of US employee health plans. "This decision was made after very careful consideration, including the important concerns some have raised about religious liberty," Sebelius said. "I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services."

A narrow group of religious employers, such as churches and other houses of worship, will be allowed to refuse to offer this coverage. The United States Conference of Catholic Bishops (USCCB) led an unsuccessful campaign demanding an expansive exemption that would have included religiously affiliated institutions such as Catholic healthcare facilities, charities and universities. This scenario would have forced millions of women to pay out of pocket for reproductive healthcare guaranteed to all other American employees.

Cardinal Timothy M. Dolan, president of the USCCB, reacted to the decision asserting, "In effect, the president is saying we have a year to figure out how to violate our consciences." Dolan has vowed to contest the HHS decision, saying that "the Catholic bishops are committed to working with our fellow Americans to reform the law and change this unjust regulation."

The administration is standing by the HHS policy. White House press secretary Jay Carney stated at a press briefing, "There's not a debate" over reversing the decision. "The decision has been made, and it was made after careful consideration," he said. Pointing out that "there are a lot of folks out there who support this policy," Carney indicated that in the coming year the White House will be focusing on helping organizations implement the rule.

Contraception a 'Clear Factor' in Declining Number of Catholics, According to Michigan Bishop

BISHOP ALEXANDER SAMPLE of Marquette, Mi., told *Catholic World Report* in November that Catholics' use of "artificial contraceptives to limit the size of their families" is to blame for smaller parishes and the closure of Catholic schools. "Not everyone wants to talk about it, but that is a clear factor in the decline of the Catholic community."

Bishop Sample also traced some of the church's current problems to "poor catechesis" after Vatican II, which he called a "time of great confusion": "While I certainly don't blame the [Second Vatican] Council, much upheaval occurred in the Church in its aftermath." Calling for a "renewal in catechesis," Sample specified that this meant reinforcing the hierarchy's rejection of reproductive rights.

In 2009, Sample withdrew an invitation to former auxiliary bishop of Detroit Thomas Gumbleton, asking him not to speak in the Marquette diocese because of Gumbleton's support for LGBT rights and women's ordination, though these topics were not going to be mentioned in the speech. Gumbleton told Catholic News Service that he and the bishop "worked it out" so he could have a private meeting with the peace group that invited him. Loreene Zeno Koskey, diocesan director of communications said, however, that "[Bishop Sample] still did not want [Gumbleton] to come."

The Church and Abortion

US Catholics Follow Their Consciences on Abortion and Sexuality, Survey Says

ON DECISIONS REGARDING sexuality and reproductive health, more than half of US

Catholics believe that individuals should have the final say, according to the most recent Catholics in America survey from the *National Catholic Reporter*.

The fifth installment of the series, released in October, reveals a shift in Catholic opinion towards valuing the individual conscience in moral decision making, and away from dependence on church leaders as moral arbiters on issues like abortion, contraception, sex outside of marriage and homosexuality, with each of these categories scoring anywhere from five to 11 points higher in terms of the individual's right to decide what is ethical. This is in comparison to the previous poll from 2005, which revealed very similar attitudes to the 1999 survey. Compared to the data from the first year, 1987, more US Catholics have moved away from the sole reliance on church leaders' moral direction, with the number of people following the hierarchy's leadership on abortion dropping from 29 percent in 1987 to 19 percent in 2011. Those who look only to church leaders for decisions about sex outside of marriage, homosexuality and abortion dropped 18 points, 16 points and 10 points, respectively, since 1987.

The findings reveal that Catholics who attend Mass regularly or who belong to the pre-Vatican II cohort are more likely to defer to the teachings of church leaders. The *Reporter* pointed out, however, that "half of the oldest generation of Catholics say individuals themselves are the proper locus of moral authority on abortion."

Overall, the survey concluded that only "one in five Catholics … says that church leaders such as the pope and bishops are the proper arbiters of right and wrong" on subjects like divorce and remarriage, homosexuality, sex outside of marriage, contraception and abortion.

US Bishops' Meeting Focused on Politics, Abortion, not Economy

THE ANNUAL BALTIMORE gathering of the United States Conference of Catholic Bishops (USCCB) reflected the hierarchy's priorities for the coming year, with USCCB president Cardinal Timothy M. Dolan emphasizing the church's political agenda on issues like abortion, religious liberty and same-sex marriage in his presidential address.

The November gathering took place against the backdrop of a bleak economic landscape and shortly after the indictment of Kansas City-St. Joseph Bishop Robert W. Finn on charges of failing to report suspected child abuse. The agenda, however, featured sessions on diocesan financial oversight and the political aims of the bishops, encapsulated in the creation of the USCCB's new Ad Hoc Committee on Religious Liberty.

Archbishop William E. Lori of Baltimore, who leads the committee, said at the November event that priests and laypeople would be enlisted in what the *New York Times* characterized as a "'religious liberty' drive." Lori discussed the hierarchy's recent battles to secure special rules for Catholic service providers receiving federal funding, using Catholic agencies that closed their doors rather than help same-sex couples adopt as an illustration of the threats faced by the church today.

"Church insiders say the hierarchy's internal political dynamics are driving the new, narrow focus," according to Religion News Service, which said that "opposition to same-sex marriage and abortion are simple, black-and-white issues that all bishops can get behind."

Uruguay Senate Passes Bill to Decriminalize Abortion

IN LATE DECEMBER Uruguay's Senate voted to decriminalize abortion in the first 12 weeks of pregnancy, passing the first hurdle towards liberalizing the country's abortion laws. The next step is for the legislation to pass the lower house, the Chamber of Deputies, controlled by allies of President Jose Mujica, who told the BBC he will sign the bill into law.

Currently, women who have an abortion or individuals who assist in abortions can be sentenced to prison. Only those women who are victims of rape or whose lives are in danger have a chance to access a legal abortion.

According to a 2004 survey, approximately 54 percent of Uruguay's population is Catholic. A change in the country's culture may be indicated by the fact that it was the first Latin American nation to legalize civil unions for same-sex couples. Opinion polls reflect that the majority of people in Uruguay favor reducing legal obstacles to abortion.

A similar bill was vetoed by President Tabare Vasquez in 2008. The current measure was debated for over 10 hours in the Senate before finally passing in the face of some opposition, according to Reuters. The bill is on the docket to be debated in the Chamber of Deputies in March.

"We don't have the right to pass moral judgment by saying that the woman who continues her pregnancy and has her baby is in the right whereas the one who doesn't, for whatever reason, is in the wrong," said Senator Monica Xavier. "We're not moral censors, we're legislators."

The Church and State

Prochoice Catholic Governor Stands up to Cardinal on Abortion Issue

IN MID-DECEMBER, Chicago's governor, Pat Quinn, met with Illinois bishops, though the politician and the hierarchy differ as to the substance of the pastoral visit.

The two sides clashed in November over the award Quinn presented to a prochoice advocate, later revealed to be a rape victim. The most recent dispute was over the governor's characterization of the December meeting as mainly focusing on the poor: "A lot of the discussion was how we could work together to fight poverty," Quinn remarked to the *Chicago Sun-Times*.

In a statement, the bishops contested this summary, writing, "From our point of view … this was a meeting between pastors and a member of the church to discuss the principles of faith." The letter singled out the governor's justification of his sympathetic stance towards abortion rights and LGBT rights, saying that "the Catholic faith cannot be used to justify positions contrary to the faith itself."

By contrast, Gov. Quinn said that the conversation touched only "a little bit" on his prochoice stance and support of LGBT couples' right to adopt.

A spokesperson for the governor declined to comment on the bishops' letter. Quinn did emphasize that faith-based service providers, such as Catholic adoption agencies, are still required to follow civil laws, stating, "We can't allow anyone not complying with the law to continue to hold a contract."

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Illinois Governor Pat Quinn pictured in front of the White House in 2010.

Ireland Closes Embassy to Holy See

BY CLOSING ITS EMBASSY to the Holy See, Ireland stands to save 1.25 million euros a year, but it may prove more difficult for the Vatican to save face after this symbolic action.

The decision was made with "the greatest regret and reluctance" according to a statement from the Irish foreign ministry quoted by the BBC. Vatican spokesman Father Federico Lombardi said after the decision, "What is important are diplomatic relations between the Holy See and the States, and these are not at issue with regard to Ireland," according to a statement published by the Vatican Information Service. Despite the conciliatory language from both sides, the timing of the announcement is significant. The news broke in November, just six months after Prime Minister Enda Kenny blasted the Vatican's response to the sex abuse crisis and Archbishop Guiseppe Leanza, papal nuncio to Dublin, was recalled to Rome.

"This is really bad for the Vatican because Ireland is the first big Catholic country to do this and because of what Catholicism means in Irish history," said a Vatican diplomatic source who spoke to Reuters on the condition of anonymity.

The Church and Culture

Benetton Ad of Kissing Pope Pulled after Vatican Complaint

BENETTON, THE ITALIAN clothing company known for its provocative advertisements, pulled its ad depicting Pope Benedict XVI kissing a Muslim cleric in November after the Vatican announced its intention to take legal action. The digitally manipulated images of the pope and Sheikh Ahmed Mohamed El-Tayeb were part of the company's "UNHATE" campaign to promote tolerance, the latest in Benetton's attention-getting advertisements, which have featured death row inmates and a person dying from AIDS.

© REUTERS/STEFANO RELLANDINI

A man walks by the Benetton store in Rome, where the clothing retailer's latest ad campaign features the image of Pope Benedict XVI kissing an imam, later banned after Vatican complaints.

The Vatican's Secretariat of State released a statement condemning the ad in which "the Holy Father appears in a way considered to be harmful." Father Federico Lombardi of the Holy See Press Office expressed a "resolute protest at the entirely unacceptable use of a manipulated image of the Holy Father."

President Obama was also featured in a similar image with Venezuelan President Hugo Chavez. The White House has expressed its displeasure but has not yet taken legal action.

Hubert Tournès, Advocate and Friend, Remembered

A dear friend and colleague, Hubert Tournès, passed away last November. He was the cofounder and deputy chairman of the Association Droits et Libertés dans les Eglises/Rights and Freedoms in the Churches (1987) and cofounder of the European Network European Church on the Move/Réseau Européen Eglises et Libertés (EN/RE, 1981). He was a member of the coordination group and a member of the team for relationships with European institutions in charge of representing the EN/RE with the All Party Group on the Separation of Religion and Politics. He previously worked for the European Union in Brussels and in various public bodies, both in Algeria and in France. He also found time to be a member of the French Ligue des Droits de l'Homme, and was an elected lay member of a decision-making clergy/lay pastoral team in a Parisian parish during the 1980s. Hubert worked closely with Catholics for Choice on a number of projects in Europe and at the European Parliament. His commitment to progressive Catholicism, equality and human rights will be sorely missed.

The Church and Sexual Abuse

Report Details Sexual Abuse Cover-up in Dutch Catholic Institutions

THE DUTCH HIERARCHY failed to address widespread reports of sexual abuse in schools, seminaries and orphanages, according to an independent report released in December. As many as 10,000 to 20,000 minors were abused in Catholic institutions between 1945 and 1981, with "several thousand" cases of rape reported.

"The problem of sexual abuse was known in the orders and dioceses of the Dutch Catholic church," the commission that authored the report said to the AFP news agency, "but the appropriate actions were not undertaken."

The Dutch Catholic church has announced it will begin compensating victims. One sexual abuse survivor, Bert Smeets, told the Associated Press that the report and the official response were inadequate because "all sorts of things happened but nobody knows exactly what or by whom. This way, they avoid responsibility." Of the 11 cases the commission referred to prosecutors, only one had enough information to open an investigation, and none of the cases named the perpetrators.

Vatican Quietly Accepts Cardinal Law's Retirement

IN NOVEMBER CARDINAL Bernard Law left his position as archpriest of the prestigious St. Mary Major basilica at age 80, the official retirement age for the position, though it is common for cardinals to stay on past that age. That the cardinal was allowed to age out of office is significant, given that for many Law symbolizes the worst of the hierarchy's response—or lack of response—to the clergy abuse crisis.

Law held on to his position as archbishop of Boston for nearly a year after disclosures that he had allowed priests accused of abuse to remain active in parishes. He stepped down in 2002 after records revealed letters

that Law had written praising priests he knew to be pedophiles.

Less than two and a half years later, Cardinal Law led a memorial mass for Pope John Paul II in Rome amid some protests, according to the *New York Times*. Just a few days before the announcement, the *Boston Herald* reported on a "lavish" 80th birthday celebration in honor of the cardinal, attended by clergy in Vatican City. According to a guest, Cardinal Camillo Ruini, "[Law] threw the party himself."

Just three weeks later, in what amounted to an official slap in the face, the document communicating Law's replacement named his successor, Archbishop Santos Abril y Castelló, but did not mention Law's retirement.

Kansas City Bishop Agrees to Supervision to Avoid More Criminal Charges

AFTER BEING INDICTED IN Jackson County, Mo., for failing to report a priest accused of taking inappropriate photos of a minor, Bishop Robert W. Finn of the Diocese of Kansas City-St. Joseph agreed to monthly meetings with a prosecutor from neighboring Clay County to avoid additional criminal charges.

Finn will be required to report all possible episodes of abuse to Daniel White, prosecuting attorney of Clay County, or face prosecution for misdemeanor charges. White described the supervision requirement as more stringent than being prosecuted for a misdemeanor, which would have been "a slap on the wrist."

The *Kansas City Star* reported that dioceses in New Hampshire, Ohio and California have agreed to similar deals to avoid prosecution. Some victims' advocacy groups have criticized the arrangement, calling it a "free pass."

Poll Shows Irish Catholics' Unfavorable View of Church

TWENTY-EIGHT PERCENT of Irish Catholics have a "very unfavorable" view of the church, while 19 percent have a "mostly unfavorable" attitude, according to a poll of Irish Catholics conducted in late 2011 by the Iona Institute. Two of the negative factors identified by respondents were child abuse (cited by 56 percent) and the cover-up of abuse (18 percent). Individuals aged 45 to 54 had the most unfavorable views of the church, but 46 percent of Irish Catholics between 25 and 34 also had an unfavorable opinion of the church.

Endnotes

Bishop Resigns after Revelation that He Has Two Children

LOS ANGELES AUXILIARY Bishop Gabino Zavala resigned in early January after telling Los Angeles Archbishop José Gomez in December that he has two teenage children. Catholic News Service reported that the Vatican's announcement of Zavala's departure cited only the canon law that allows bishops to resign if they are ill or otherwise unfit for office.

"The archdiocese has reached out to the mother and children to provide spiritual care as well as funding to assist the children with college costs. The family's identity is not known to the public, and I wish to respect their right to privacy," Archbishop Gomez said in a written statement.

Father Alberto Cutié, a former Catholic priest who is now a married Episcopalian priest, commented on the situation in the *Huffington Post*. "When a priest fails to keep celibacy, that man-made rule that even the Roman Catholic Church admits is changeable, adaptable and dispensable, we should not be so easily scandalized," Cutié wrote. "Sexuality among consenting, single adults cannot continue to be considered 'a great scandal.'" ■

Pope Benedict XVI (R) greets Cardinal Bernard Law in Rome in 2005.

Be Catholic. Be Pro

The information contained in the publications below, and others available from Catholics for Choice, will enhance your faith and your principles and help you repudiate the arguments of those who oppose women's rights, reproductive rights, the separation of church and state and church reform.

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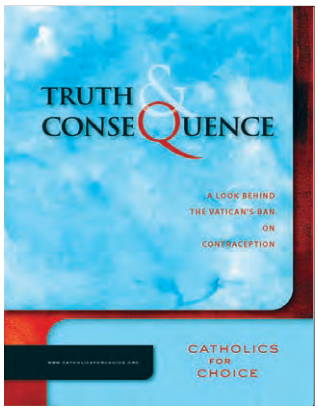

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On the eve of the pope's visit to the US in 2008, Catholics for Choice released a publication examining the impact of 40 years of *Humanae Vitae*, the Vatican document that cemented the ban on contraception. Widely acknowledged as a defining moment in modern church history, *Humanae Vitae* has become a source of great conflict and division in the church.

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RESTRICTIONS ON ABORTION FUNDING, SUCH AS THE HYDE AMENDMENT, MAKE IT MORE DIFFICULT FOR WOMEN, ESPECIALLY POOR WOMEN, TO ACCESS ABORTION CARE.

A Case We Can't Afford Not to Make

REGAINING LOST GROUND ON FUNDING ABORTION CARE

By Andrea Miller

Recently, I received a phone call that elicited equal parts pride and dread for a prochoice spokesperson like me. The call was from the editor of this magazine asking me to pen a piece about the Hyde Amendment and public funding for abortion, a topic that has become a "third rail" issue—something electrified that most people don't want to touch, both inside and outside our movement.

Why would this topic cause dread in someone with an unwavering personal and professional commitment to supporting public funding to help make the right to choose a reality, and who firmly believes that the prochoice community shares that view? When I think about public funding for abortion, two competing voices whisper in my ear: one reminds me that public funding is a political nonstarter because conventional wisdom says we have neither the votes nor the public on our side. This voice insists that focusing on public funding will hurt our prochoice allies and our movement by creating a storyline of loss. The other voice, though, tells me that this is gut-check time: we can't ignore our core value of justice for all women. This is especially true given that the lack of public funding renders the right to choose virtually meaningless for some of the most vulnerable women among us.

I am writing this because, ultimately, both whispers are true and should be respected. They tell a complex, but not competing, story which need not prevent us from moving ahead with an agenda that includes a passionate defense of public funding for abortion care, an agenda that lets our whispers about reproductive justice become roars. That's because I believe that our movement—and the public—are at a crossroads. More conversations than ever are taking place at every level of society about how abortions are paid for, the role of government in ensuring coverage for healthcare (including abortion), as well as the role of insurers in making care more or less accessible. Initially, this conversation opened the floodgates to new attacks on abortion coverage in the private marketplace, which our movement is working valiantly to hold back. And current political realities make it difficult—if not impossible—for us not to be tempted to pivot by stating that public funding is not the issue at hand. We feel backed into a corner, forced to tacitly accept

ANDREA MILLER *is president of NARAL Pro-Choice New York and the National Institute for Reproductive Health. She previously served as executive director of NARAL Pro-Choice Massachusetts, co-owned Public Interest Media Group, a national communications and PR firm, and helped to found the Center for Reproductive Rights.* *She wishes to thank her colleagues, Kelly Baden, Tara Sweeney and Angela Hooton, for their contributions to this article.*

the panoply of restrictions on public funding at the federal, state and local levels in hopes of mitigating further damage to women's access to abortion care.

Yet, tellingly, prochoicers are still losing ground—even in the area of public funding's presumably more popular sister, private insurance coverage for abortion. And the definition of public funding for abortion itself keeps changing. Our opposition keeps shifting the goalposts.

So let me ask you: Would you consider funding for medical training that includes education on abortion provision to be public funding for abortion? What about family planning funding for any entity that also provides abortion care, even though the dollars spent on abortion care are segregated from the family planning dollars? Or government subsidies to purchase health insurance if that insurance adheres to the industry standards for providing abortion coverage? Is it public funding for abortion if you spend funds in your personal health savings account for abortion care? Or if a charitable organization that provides or refers for abortion care gets a state tax credit? In 2011, antichoice lawmakers in Congress and state houses throughout the country classified all of the above, and more, as public funding for abortion.

So what exactly is public funding of abortion? I'd say that maybe the answer shouldn't matter to us. Today, when antichoice lawmakers talk about stopping public funding for abortion, they are not just talking about enshrining the Hyde Amendment, that decades-old restriction on using federal dollars to cover a woman's abortion care (except if her life is endangered or she was sexually assaulted) if she relies on Medicaid for her healthcare. Nor are they referring only to the Hyde Amendment and its many iterations affecting public employees, women in the military, women living in the District of Columbia, women who get care through Indian Health Services and more. They are also not simply seeking to expand that list by increasing the number of states that have adopted similar provisions.

Our opposition is looking far beyond what we in the prochoice movement have traditionally considered to be public funding for abortion. They have set their sights on making abortion as inaccessible and stigmatized as possible. And they hope that we tie ourselves up in knots, trying to parse out what is public funding and what is not.

I propose that instead, we should embrace the nuance and seize on the opportunity presented by a nascent blurring of the distinctions between public and private, thanks to the national dialogue on health reform. At the risk of sounding like a Pollyanna, I believe that we can use this moment to create a new conversation and forge a path—albeit a long one with some rockslides likely along the way—for support of abortion coverage, regardless of who foots the insurance bill.

In the summer of 2010, the National Institute for Reproductive Health (NIRH) conducted opinion research to better understand attitudes about private insurance coverage for abortion among prochoice supporters and those who could, hopefully, be persuaded to support our position. The timing was critical because, as I could already attest from my recent tenure as executive director of NARAL Pro-Choice Massachusetts, passage of a healthcare law—even one that maintains (if not expands) coverage for reproductive healthcare, including abortion—is not the end of the debate over the state's health policy. As the last year has shown, the vitriolic debate over abortion coverage in the Patient Protection and Affordable Care Act only signaled the beginning of the contention between policymakers and the public over how abortion is paid for and if it is covered by insurance. (While this was originally written in January 2012, these words ring even truer in light of the fight over whether the no-copays for preventive care will extend to contraceptives, regardless of where a woman works.)

The NIRH research findings caused a real "aha" moment for me. Something interesting surfaced in the focus groups conducted in Raleigh, NC; Minneapolis; Denver; Pittsburgh and Kansas City, Mo.; among prochoice women and men and those who agreed with some prochoice positions, described as "mixed choice." The healthcare debate—the Stupak amendment; the Nelson "compromise," a public option versus government subsidies for purchasing private insurance; the relationship between coverage and access to care; and the challenges so many face getting either or both—had trickled down in such a way that these pro- and mixed-choicers were seeing less of a distinction between private insurance coverage and public insurance coverage of abortion services.

This changing sensibility was echoed in the responses to the companion

The Hyde Amendment

In 1976 Congress passed the Hyde Amendment to ensure that abortion is not funded through Medicaid, except in limited cases. Named after Rep. Henry J. Hyde (R-IL), the amendment is a rider to the Labor/Health and Human Services/Education appropriations bill, which is renewed annually.

The exact wording of the exceptions to the Hyde Amendment has changed over time. Currently, the federal Medicaid plan does allow for abortion funding in cases of rape or incest, as well as when the pregnancy threatens a woman's life.

Since Medicaid coverage extends to people with lower incomes, the Hyde Amendment disproportionately affects poor women's reproductive choices. Other federal programs have instituted prohibitions on funding for abortion, including those for women who are Indian Health Service clients, Peace Corps volunteers and military personnel and their spouses.

national online poll, which surveyed 1,211 voters who believe: (a) abortion should be legal and generally available (group 1); (b) regulation of abortion may sometimes be necessary although it should remain legal in most circumstances (group 2); or (c) abortion should be legal in only the most extreme cases, i.e., life, rape and incest (group 3). To be clear, voters who believe all abortions should be illegal, who we typically assume comprise roughly 15 percent of the population, were excluded from the research because the goal was to assess what might motivate voters to support protecting private insurance coverage of abortion. (We don't ever expect to garner support from those who believe abortion should be completely illegal in all circumstances.) But among all of those polled, 62 percent agreed that *both* private health insurance and insurance paid for with government funding should cover abortion, including a majority of women who lean toward being antichoice. (For full disclosure, the question provided 4 options, the others being: private insurance [20 percent], health insurance should not cover [16 percent] and "health insurance paid for with government funding" [2 percent].)

I won't pretend that a national poll with the wording "taxpayer funding for abortion" would be likely to show widespread public support. But that's because this phrasing is the opposition's clarion call, not ours. What matters is that, when asked to choose between agreeing that "it's wrong to deny women coverage for a legal medical procedure like abortion just because some people do not approve of it" or agreeing that "taxpayer money should not be used to pay for health plans that cover abortion," 60 percent of ones, twos, and threes agreed with the statement that reflects our values.

I believe that the focus group participants and poll respondents were picking up on a phenomenon that will become much more pronounced in a post-Affordable Care Act world: people's health insurance status is not static. In the coming years, they will be moving back and forth even more often between utilizing employer-sponsored insurance; purchasing private insurance (in the future this may be on an exchange); receiving subsidies for insurance; and using public insurance. This will depend on myriad other factors in their lives: job status, marital and family status, income level, residence and more.

A Latina participating in the Denver focus group expressed her point of view thus:

> "Who has the right to tell people that they can't have insurance that covers abortions? Because they're low-income or because they're not getting insurance through a job like I am? I just don't think people have that right."

This sentiment may be indicative of a public that has become less invested in using demarcations of where a person's insurance comes from to determine what kinds of services are covered. This is probably because they are more aware now that, if they are on one side of that line today, they could be on the other side of it tomorrow. So, it becomes a matter of fairness: if abortion coverage is available to some, it should be available to all.

Women, historically, have been especially susceptible to what is known as insurance "churning," meaning that their insurance status is highly unstable as they move between types of coverage (employer vs. government) or between being covered and not. This is one of the many reasons that so many of us saw health reform as a woman's issue. We will see major changes in the insurance market trends in coverage over the next several years, along with the increased involvement and responsibility of consumers related to their insurance coverage. I believe this creates a new opportunity to begin building support for abortion coverage, including ultimately removing the restrictions on both public and private insurance.

How can the prochoice movement capitalize on this new landscape, where the public better understands the shifting source of one's insurance coverage? We can do so by consistently and forcefully maintaining that a woman deserves coverage for the care she needs, including abortion care, no matter where her insurance comes from. From this position, we can legitimately argue for abortion access for *all* women, with coverage for abortion care playing a vital role in making those services available. (If I may aim really high, this will also allow us to speak about abortion in a way that brings it back into the context of healthcare.)

You don't use polling and messaging to determine your values; you use them to figure out how to best convey your values to those you need to reach.

From here, I believe, we can begin to reclaim the ground lost on the Hyde Amendment and its many insidious incarnations in federal and state laws. This would steer us away from implying—even inadvertently—that public funding of abortion is a completely lost cause. We could argue against public funding bans as an unacceptable compromise in the abortion debate. After all, as we've been reminded so powerfully of late, if the antichoice lobby had their way in defining "public funding," any alleged "compromise" would create a slippery slope—and a whole new set of policies that undermine a woman's access to abortion care.

Advocates for abortion rights are working on the front lines every day to

stem the tide of antichoice legislation sweeping the nation. In a Congress that barely supports family planning funding, and in state houses that enacted 69 antichoice measures in 2011, prochoice organizations are battling mandatory delays, unnecessary ultrasound requirements, pre-viability abortion bans, attacks on family planning and onerous regulations on abortion providers. Bans on private insurance coverage for abortion have now joined the list. So how can we and our allies be asked to fight for public insurance coverage of abortion? The real question, though, is how can we not fight for it?

If the health reform fight and the losses we saw in 2011 can teach us something, it may be that sidelining public funding of abortion from other abortion-rights efforts has forced us to play by rules we did not create in a game we cannot win. What if we started to create new rules—a new discourse where women are not divided by their insurance coverage status, where we proudly declare support for abortion coverage as a matter of fairness and justice? I believe this is the way we can begin to change the conversation.

As much as we might want to sidestep discussions of abortion coverage in the hopes of avoiding a public fight, antichoice forces simply won't let us. As tempting as it might be to think that throwing them a "bone" (like the Hyde Amendment) could help us at least maintain the status quo, it will not satisfy them. The drumbeat to "stop taxpayer funding of abortion" (which the polling shows is a line that still resonates powerfully with the public) only grows stronger, more expansive and harder to fight. We can't ignore it. Nor can we rewind and erase the past. But we can move forward, together, with a renewed commitment to understanding how talking about abortion coverage without distinctions can better pave the way for future efforts to restore public funding for abortion.

I'm not going to claim that there is a single, silver bullet message that will protect our prochoice elected allies, persuade the mixed-choice public and reorient the debate over abortion in the United States. But I have learned two critical lessons over the years. First, you don't use polling and messaging to determine your values; you use them to figure out how to best convey your values to those you need to reach. Second, you need to know where people are in order to know how to get them to where you want them to be. We know what our values are, and the post-healthcare reform landscape has put the public in a place to be able to move toward us. Research has taught me that people can be prochoice and *also* believe that life begins at conception or that abortion ends it. Similarly, I believe that we need not get the public to embrace "taxpayer funded abortions" in order to get their support for abortion coverage writ large, private and public.

There is power—philosophical and political—in speaking consistently about the importance of abortion coverage for all women. We can capitalize on women's unwillingness to buy into the divisions that have been created for us—those with private insurance and those without—because we don't have to just talk about protecting what a woman can do with her own private money when purchasing insurance on an exchange. We can instead choose to talk about our underlying core values that all women deserve the same peace of mind that they can obtain the healthcare they need, regardless of where their insurance comes from.

Abortion has always been accessible for women of means. To truly be prochoice means fully embracing what has sadly become clear for so many more among us of late: you cannot underestimate the power of economic status and its relationship to access to healthcare. Surely, promoting a prochoice agenda that asks for the complete repeal of funding bans on abortion is an uphill battle. But we're no strangers to hills, and this one is critical. We must defend all kinds of coverage of abortion care in order to defend any kind of coverage for abortion care, and we must start now before we lose any more ground.

Those in the movement who count the votes know we don't have them right now. Those in the movement who talk to elected officials and candidates know that speaking out against the Hyde Amendment can hurt politicians. But I am hopeful that if we begin to operate within a new framework, we can begin to say "no" to the choice our opponents want to create for us, which is really no choice at all. We can find ways to better reconcile our short-term goals with our long-term vision of overturning the Hyde Amendment in all of its forms.

I know in my head and my heart that all of us in the prochoice movement want the same thing: we want a woman to be able to make personal, private decisions about her reproductive health *and* have access to the services she needs, including abortion care, no matter her income, insurance status, employment status, geography, citizenship status or race. Maligning coverage of abortion care in public plans has worked for the antichoice movement for decades. Now it's our time to use the public's sensitivity to issues related to healthcare access created by the health reform debate to advance our core values and support abortion coverage for all. ■

How can we and our allies be asked to fight for public insurance coverage of abortion? The real question, though, is how can we not fight for it?

A Perspective on Later Abortion... From Someone Who Does Them

By Willie Parker, MD

I AM INTRIGUED BY SOME REPRODUCTIVE rights advocates' increasing willingness to search for "common ground" with abortion opponents, evidenced by a recent conference convened with this purpose at a major university. Prior to the conference, one of its organizers, long-time reproductive rights supporter and former Catholics for Choice president Frances Kissling, expressed sentiments representative of this disturbingly conciliatory tone:

> "As long as women have an adequate amount of time to make a decision, and there are provisions for unusual circumstances that occur after that time, I would be satisfied [with early gestational age limits to abortion].... Women have an obligation to make this decision as soon as they possibly can."

In short, the abortion debate has come to include abortion supporters and opponents bargaining about restricting second-trimester abortion as a means of seeking common ground. While I applaud efforts towards a more civil public discourse in principle, as a provider of second-trimester abortion services, I find this trend problematic and dangerous to the health interests of women. I am also troubled by the question—to whom, other than themselves, are women obligated "to make their decision as soon as they possibly can"?

Apparently recognizing that termination of pregnancy won't be outlawed any time soon, abortion opponents are willing to engage in dialogues that—while appearing to progress towards a more civil exchange with abortion supporters—unwittingly enlist the energies of abortion rights activists for the restriction of those rights. These conversations subtly endorse the parsing away of this fundamental human right, ironically beginning with women in their second trimester, who often have the most compelling need to have an abortion in the first place. As is common in discussions

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of abortion, absent from these dialogues are the voices of the women and families that are affected—the very women who are and will be denied access to what is oftentimes a health-related decision.

The lives of these women and their families are what compelled me to add abortion care to my practice, mid-career, when I was no longer able to weigh the life of a pre-viable or lethally-flawed, viable fetus equally with the life of the woman sitting before me. My intent here is to share why I provide abortions. The times in which we live call for a thoughtful, compassionate, evidence-based approach to women's healthcare that should empower healthcare providers to include abortion in their practice—second-trimester abortions included—because of the women who, in the absence of these services, would die unnecessarily.

I did not provide abortions for the first 12 years of my career as an obstetrician/gynecologist, even though my work allowed me to see first-hand the reproductive dilemmas and outcomes that women and families face. While recognizing that abortion was a need in my patients' lives, I grappled with the morality of providing them, as I came from a traditional religious background that considered abortion to be wrong. It is said that when you grapple with your conscience and lose—you actually win. I "lost" that 12-year battle about whether or not to provide abortions while listening to a sermon by Dr. Martin Luther King, Jr.

Dr. King related the story of the Good Samaritan to encourage compassionate action on behalf of others. The story tells of an injured traveler who was ignored by passersby until one person, the Samaritan, stopped to help. According to Dr. King, what made the Good Samaritan "good" was his refusal to place himself first, asking instead, "What will happen to this person if I don't stop to help him?" Similarly, I asked the simple question of myself, "What happens to women who seek abortion if I don't serve them?" This radicalized me, leaving me more concerned about the unnecessary peril to women when safe abortion services are not available than about what would happen to me if I helped women in this way. It was at that point—some eight years ago—that I began to perform abortions, compelled by women's situations and moved to action by their need, and by my respect for their moral agency to make such a decision.

The women I see in these situations are pregnant and they can't be or don't want to be. They are resolving dilemmas created by circumstances unique to their private lives, and certainly unknown to their critics who judge from afar.

The stories of the women who come to me are what move me to overlook the well-established danger of antiabortion violence to do this work. Approximately one in three women in the US will terminate a pregnancy in her lifetime. While the epidemiology of women who have abortions gives a general impression of who they are—40 percent of US pregnancies are unplanned, with about half of this number unwanted—it is the specific realities of women who seek abortion, especially in the second trimester, that best inform us. The stories of the following women and girls that I have cared for provide a small glimpse into their reality of unplanned, unwanted or wanted but lethally-flawed pregnancies:

An 11-year-old was discovered by her grandmother to be 19 weeks pregnant the day before she was to start sixth grade. A trip to an emergency room confirmed the pregnancy, leading the family to seek abortion services. While the young lady refused to name who impregnated her, our best judgment was that it did not indicate incest. In talking to her to determine "who" desired the termination, she did not want to be pregnant and was not being coerced, but the stark reality of just how young she was became explicit when she expressed her chief concern: she had missed three days of school and wanted to be with her friends. I safely terminated her pregnancy and restored her childhood by allowing her to have the only concerns an 11-year-old should have.

A 13-year-old girl was a victim of incest by her uncle who had lived with the family for six months. By the time the girl's mother discovered her pregnancy, she was 17 weeks along. Her quiet demeanor, interpreted by her mother as ideal behavior, unfortunately delayed the detection of her pregnancy. We performed her abortion, but the family was understandably deeply shocked by the circumstances of the abortion.

A 32-year-old attorney, senior staff for a prominent US senator, came in with a desired pregnancy at 20 weeks, complicated by a lethal fetal anomaly. By the time diagnosis was confirmed, she was 23 ½ weeks. She and her husband were distraught, as this was their first child, but resolute that this was the right decision for them. Compounding the horror of their situation were the delay and struggle they experienced when her federally-funded health insurance initially refused to cover her abortion. I performed her procedure without complication, for which they were effusively grateful.

The difficult circumstances described above are typical for second-trimester

abortions, with pregnancy detection and decision making often occurring late. The women I see in these situations are pregnant and they can't be or don't want to be. They are resolving dilemmas created by circumstances unique to their private lives, and certainly unknown to their critics who judge from afar. I define a dilemma as a situation in which one has to decide between nondesirable options without the luxury of foregoing the decision.

It is in this context that I understand the abortion care that I provide—in the first or second trimester. While their stories might differ, what all pregnant women have in common is the increasing difficulty in abortion access, especially for later abortions. Ironically, it is the lack of access to abortion care that oftentimes delays abortion to the second trimester. A pregnancy in this timeframe is troublesome to those who are in what a friend calls the "mushy middle"—people who approve of abortion access abstractly, but who become conflicted about its specifics, e.g., termination beyond the first trimester. Eighty-five percent of women in the US live in a county where there is no access to abortion and, if later gestational age is taken into account, that access is even more limited. That reality, along with my patients' compelling individual stories, compels me to provide the abortion care that I do, moved to help women in these crisis moments and to prevent the unnecessary health consequences that occur when safe abortion is not available.

The reality is that some women have pregnancies that they did not plan and have no desire to continue and, therefore, they seek abortion—legal or not, safe or not. I believe that it is their right to do so, in the second trimester or the first, that right being rooted in their moral agency as human beings. Thus, I advocate for reproductive justice (RJ).

The RJ movement, as distinct from "reproductive choice," places reproductive health and rights within a social justice and human rights framework. RJ supports the right of individuals to have the children they want, raise the children they have and plan their families through safe, legal access to abortion and contraception. In order to make these rights a reality, the movement recognizes that RJ will only be achieved when all people have the economic, social and political power to make healthy decisions about their bodies, sexuality and reproduction. To be certain, when reproductive justice is present, abortion is available as a choice, but in the RJ framework all reproductive decisions are valued equally. When RJ is a reality, women are empowered to maintain their dignity.

I endeavor to move our world to a place where women have the space and power to make these tough decisions without judgment, coercion or restriction thrust upon them, and are able to do so in a setting of safety and uniform access to all possible reproductive options. It is in this context that I gladly provide first- and second-trimester abortion access for women in support of their humanity, dignity and health. I challenge my peers to do the same. ■

A Statement on

In 2010, Catholics for Choice convened a meeting about later abortion with another organization, Advancing New Standards in Reproductive Health, to provide a chance to discuss a topic even seasoned advocates are not well informed about and to explore what, if anything, can and should be done for women who need later abortions.

We heard from experts about a range of issues in the current debate, including fetal survivability and viability, fetal pain, mental health and fetal abnormalities. We had a frank and thoughtful conversation about what this new information means for our organizations individually and for the movement as a whole, something that Catholics for Choice has carried forward in our work. From this work came the following statement—not intended or designed to be an all-encompassing or exhaustive statement but more a moral and ethical assertion as to how we feel about this issue, why we think this issue matters and why in good conscience we must address it.

As organizations, **we believe in bodily autonomy and a woman's right to choose** whether and when to have a child. We also believe in the right to receive safe medical care.

We stand with women who need abortions later in pregnancy, **and with the providers** who care for them.

We trust women. When we see a woman in need of a later abortion we know that she is worthy of our support and respect. She should be able to trust that she is in the hands of a provider who will help make her decision a reality. We believe that the right to choose is grounded in respect for her decision and the process and time it took her to make that decision.

As advocates for abortion rights, **we recognize the need for policies that address the full range of a woman's reproductive needs**, including maternity leave, subsidized childcare, quality prenatal care and expanded educational opportunities for pregnant teens. Support for free, accessible contraception has always been a cornerstone of this agenda. We have argued consistently for all these things. Access to abortion is an inextricable piece of women's reproductive health needs, and we believe that an ethical view that allows for later abortion is inseparable from one that respects any aspect of a woman's right to choose.

We believe that women are moral decision makers, and consider their options carefully when faced with an unintended pregnancy. It is more important that a woman make the right decision for her and her family than that she make an early one. Women deserve to have all the time they need in order to make the best pregnancy decision for themselves and for their families, even if this means needing a later abortion.

Later Abortion

Later abortion is something that many people find problematic—even those who support early abortion. This is often because they think it is unnecessary, preventable and requested too frequently. None of these things is true.

We believe that early and late abortions carry the same moral burden because we accept that all abortions end a potential human life. We further believe that the moral responsibility of decision making, whatever the gestation, should rest with women and their families, because only they can know their circumstances and the results of their actions.

We are committed to explaining why later abortions are necessary and why women and their doctors are competent to make moral decisions and to act on them responsibly. This is not a matter of "messaging" or staying true to an abstract prochoice principle. It is because healthcare that does not include access to later abortions does not meet what women, and society, need.

We believe that the provision of an abortion procedure requested by a woman in the second or third trimester **is preferable to its denial**, since the denial of abortion has consequences for a woman's life, for the lives that are touched by her life and for the life of the child that may be born.

We defend later abortions because we understand that women need them, just as they need early abortion—and, indeed, just as they need contraception.

We trust women to make responsible choices for themselves and their families. There is no reason to assume that any higher burden of justification is required than for earlier procedures.

Specifically, **we believe that we have a responsibility to stand with each and every woman** who seeks to make decisions about her own reproductive life, like abortion, using the counsel of the professionals, friends and family she chooses to involve. There is no debate about whether a woman is a person, a moral agent. Women must be allowed and encouraged to make the decision that is right for them whether that is to become pregnant or to remain pregnant. Truly, women are the only ones who can make the right decision for themselves. This is the very essence of what it means to be prochoice.

SIGNED:

Advancing New Standards in Reproductive Health (ANSiRH)
Association of Reproductive Health Professionals
Black Women's Health Imperative
Catholics for Choice
Medical Students for Choice
National Advocates for Pregnant Women
National Council of Jewish Women Washington
National Health Law Program (NHeLP)
National Latina Institute for Reproductive Health
National Network of Abortion Funds
National Organization for Women (NOW)

So, Who Has Second-Trimester Abortions?

By Rachel K. Jones and Lawrence B. Finer

Data from the Guttmacher Institute's 2008 Abortion Patient Survey revealed certain patterns to be found among women who had second-trimester abortions.

The overwhelming majority of abortions—88 percent in 2006—are first-trimester procedures, occurring in or before the 13th week of pregnancy. While research has established that women who have abortions have different traits compared to all women of reproductive age—they are poorer, younger and less likely to be white—little is known about the characteristics of the subset of patients who have abortions after the first trimester. Given that second-trimester abortions cost more than first-trimester procedures and are offered by fewer providers, it is likely that this group of women differs from the majority who has the procedure earlier. To investigate these differences, the Guttmacher Institute recently undertook the first national study of women in the United States who have second-trimester abortions, the results of which will be published in a forthcoming issue of *Contraception* (and are already available online at http://www.guttmacher.org/pubs/journals/j.contraception.2011.10.012.pdf).

To conduct our analyses, we relied on data from Guttmacher's 2008 Abortion Patient Survey, which gathered self-administered questionnaires from 9,493 abortion patients at 95 healthcare facilities across the United States. The study asked about age, race and how many weeks pregnant the woman was in addition to more sensitive topics such as exposure to domestic violence. The data are representative of all abortion patients in 2008.

What did we find? Of the 1.2 million abortions that occurred in 2008, 121,000, or 10 percent, were in the second trimester, defined as 13th to the 26th week of gestation. We found several groups of women to be overrepresented among those having abortions at 13 weeks or later, including African-American women, teens, women with a lower level of education, those using health insurance to pay for the procedure and those who had experienced multiple disruptive life events in the last year. For example, among black abortion patients, 13 percent terminated pregnancies at 13 weeks or later compared to 9 percent and 10 percent, respectively, for white and Latina women. Among abortion patients aged 19 and younger, 14 percent obtained abortions in the second trimester, a figure significantly higher than the proportion among women aged 20 and older (10 percent).

While our study did not examine reasons why these women were having an abortion, we expect several conditions may contribute to this age pattern. It may take younger women longer to recognize that they are pregnant; they may have a difficult time approaching a parent or trusted adult to discuss the pregnancy; or they may have more dif-

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ficulties finding an abortion provider or coming up with the money to pay for the procedure (especially if they are trying to do so without involving an adult). Notably, while adolescents within the population of abortion patients were more likely to have a second-trimester procedure, these young women only accounted for 18 percent of all abortions and 24 percent of second-trimester procedures. Thus, the majority of abortions, including those in the second trimester, were for women aged 20 and older.

Adult women without a high school degree had the highest proportion of abortions at 13 weeks or later (13 percent), while women with college degrees had the lowest (6 percent). Again, we expect several dynamics may be at work. Less-educated patients may have less knowledge about reproduction and take longer to recognize they are pregnant. Similarly, they may have lower levels of health literacy and a harder time figuring out options, tracking down information about abortion or finding a provider.

Approximately one-third of abortion patients relied on either private health insurance or Medicaid to pay for the procedure, and these women were more likely than those who paid out of pocket to have an abortion at 13 weeks or later (14 percent vs. eight percent, respectively). Women who lack health insurance, or who have insurance that does not cover abortion, may be unable to afford a second-trimester procedure. Having and using insurance are two different things, however. Most women who have private health insurance do not use it to pay for abortion services, perhaps due to concerns about confidentiality and lack of knowledge about whether abortion services are covered. But because second-trimester abortions cost more than first-trimester procedures, women in these circumstances may be motivated to seek out information about coverage as well as decide that confidentiality is a secondary concern.

Women who experienced multiple disruptive events in the last year—such as being unemployed or falling behind on rent—were more likely to have an abortion in the second trimester. It is possible that these events lead to delays in recognizing the pregnancy as well as delays in accessing services. Alternately, some women who initially decide to carry a pregnancy to term may change their minds when confronted by an event such as losing a job or separating from a partner.

Because with each additional week of gestation abortions become more expensive and are offered by fewer providers, we wanted to see if there were differences among the population of women obtaining abortions at 16 weeks or later compared to those at 13–15 weeks. The only characteristic consistently and positively related to abortion at 16 weeks or later was using health insurance to pay for the procedure. In our more complex statistical analyses, once other factors were taken into account, we also found that women with the highest incomes actually had a relatively higher likelihood of having an abortion at 16+ weeks compared to poor women. Taken together, these two findings suggest that the higher cost and decreased availability of abortion services in later weeks make them less accessible to poor women and those paying out of pocket.

Prior research has found that the overwhelming majority of second-trimester patients would have preferred to have had their abortion earlier. Our findings suggest that certain groups of women—African-American women and those with less education—would most benefit from increased access to early abortion services. While expanded services could reduce the number of second-trimester abortions, the need for such procedures cannot be entirely eliminated. For one, diagnoses of fetal anomaly and maternal health complications often do not occur until the second trimester. Additionally, some women take longer to recognize they are pregnant and to decide that they are going to have an abortion, while the decisions of others are influenced by changes in their lives that occur after they find out they are pregnant.

For women needing second-trimester procedures, having health insurance or other financial resources to pay for abortion services is especially important. The average abortion patient pays $470 for a first-trimester procedure, but the cost can increase substantially with each additional week in the second trimester. Women who cannot afford to pay these increased costs out of pocket are then forced to carry an unwanted pregnancy to term. As of January 1, 2012, 16 states had laws that limit abortion coverage in health plans that will be offered in the upcoming health exchanges; eight of these states have limited abortion coverage more broadly in all private health plans they regulate. These restrictions, especially if adopted by more states, are likely to have a significant impact on women seeking second-trimester abortions. And yet, the irony here is that the growing number of restrictions on insurance coverage for abortion may paradoxically increase the need for second-trimester abortions by further delaying women's access to services early in pregnancy. ■

The higher cost and decreased availability of abortion services in later weeks make them less accessible to poor women and those paying out of pocket.

Why We Need to Choose 'Choice'

By Ann Furedi

When we talk about pregnancy termination, some might say that the language of "choice" is not helpful; abortion is not a choice but a necessity. Women do not choose to have abortions, the argument goes, they end their pregnancies when they have no other options. To say it's a "choice" makes it sound as though a woman is deciding between a pair of shoes and a handbag.

On face value, this sounds like a sensible argument—both sound "messaging" and an intelligent tactic. The term "choice" evokes consumerism and the marketplace, after all, which have nothing to do with abortion. We know that women opt for abortion, not because they positively *want* the procedure, but because they *don't want* to be pregnant. We also know that more people are sympathetic to abortion when they understand the real-life circumstances that bring a woman to the clinic. So, should we jettison the language of "choice"?

Some feminist writers have argued that we should. One of the louder voices making a reasoned case against the language of choice is Marlene Gerber Fried, a respected activist and philosophy professor who has argued for many years that framing abortion in terms of a woman's right to choose is problematic. She claims:

> "Because 'choice' appeals to those who have options, but is relatively meaningless to those who do not, it is politically divisive.... The fact that race and class inevitably circumscribe one's choice is ignored."

This view of choice informs many in the Reproductive Justice movement. But it is one we should resist. The concept of "reproductive choice" is as relevant as ever.

Traditionally, in our movement the term "prochoice" has been shorthand for respecting an individual woman's "right to decide" for herself. And the inescapable question at the center of *any* discussion about abortion, *when everything else is stripped away*, comes down to this: can a woman be trusted to make her own decisions about her own pregnancy?

This does not mean we ignore the very real issues of access to resources, services or the inequalities caused by socioeconomic conditions and the need for structural change. It does not mean that we ignore the impact of race or class.

That there *are* limits on how individual choice is *exercised* seems beyond debate. People do not live in a vacuum; no man—or woman—is an island. It's obvious to most of us that every personal decision (not just those concerning reproduction) takes place within our life-context; the exercise of choice is limited to what is possible. What is possible for me may not be possible for you. Sometimes we make choices that we do not want to make—but the decision falls to us nevertheless. Consider William Styron's novel, *Sophie's Choice*, in which a mother is forced to choose which of her children is killed.

The point is this: *life is full of decisions, and it is who makes them that matters.*

Making a choice is, *in itself*, a demonstration of a freedom of sorts—the freedom to influence and take responsibility for what happens next. Our lives are made richer if we can direct them according to our personal values and convictions—even if our lives are not made richer by the options available to us. A "rock" and a "hard place" can be equally uncomfortable even when you have chosen which to sit on.

Law professor Emily Jackson spells it out like this in her book *Regulating Reproduction: Law, Technology and Autonomy* (2001):

> "The decision to have an abortion ... is made because, for a variety of reasons, this particular woman does not want to carry a pregnancy to term. That she is not in control of these reasons should not lead us to ignore her deeply felt preference. Even if we recognize that social forces may shape and constrain our choices, our sense of being the author of our own actions, especially when they pertain to something as personal as reproduction, is profoundly valuable to us."

Making decisions is part of what it means to be human. We may have no control over what we "are," in the sense that our nationality and background may be set, but we do have some choice about what we "do." Socially constructed value systems do not predetermine all the decisions we make. People in similar situations make different choices. The abject poverty that drives one woman to have an abortion may drive another to place her children into social care. A diagnosis of Down syndrome may

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compel one woman to end her pregnancy, while another may decide to embrace the child as "special." The fact that a woman is poor, or alone, or stigmatized clearly will influence her decision—but it does not take away her capacity to decide, to make a choice.

On a fundamental level, if she has ***no*** capacity to make a choice in the matter it takes away her humanity, since our capacity to make decisions is part of what makes us human. If our lives are simply dictated by circumstances, then we are no more than base animals—driven by instinct and environment. There is no space for self-determination and no space for conscience because if we cannot choose what to do, then we cannot choose what is right and what is wrong. As Jackson says, "We cannot believe all our preferences are not ours without our sense of self effectively collapsing."

This is why the concept of "choice" is so important. When we argue for a woman's right to choose abortion, the argument is not just for the availability of a clinical option but also for the right to use her capacity to decide whether she will use it or not.

We may not be able to provide women with the social and economic resources to live their preferred lives. But we should not add to women's burdens by refusing to acknowledge the importance of what they do have—what some people call "agency" and others call "decision-making capacity."

To be prochoice is to say this: women, whatever their background and circumstances, are capable of making decisions. They do so every day. The decision to keep or end a pregnancy is one of these. Even though women's choices are shaped by the constraints of their circumstances, they are tailored by their beliefs and their consciences. We cannot put aside our claim for women's right to make reproductive choices any more than we can put aside our claim that women must be able to exercise the choice they have made.

Whatever we call it—it must, in essence, be a choice. ■

Lessons for the Prochoice Movement from the 'Partial Birth Abortion' Fight

By Tracy A. Weitz

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President George W. Bush signs the "Partial Birth Abortion Ban Act" on November 5, 2003. Also pictured (from left) Rep. Bart Stupak (D-MI), Rep. Henry Hyde (R-IL), Rep. Steve Chabot (R-OH), House Speaker Dennis Hastert (R-IL), Sen. Orrin Hatch (R-UT), Rep. James Sensenbrenner (R-WI), Sen. Rick Santorum (R-PA), Rep. James Oberstar (D-MN), Sen. Mike DeWine (R-OH) and House Majority Leader Tom DeLay (R-TX).

THE FIGHT OVER THE PROCEDURE that came to be known as "partial birth abortion" spanned 15 years, beginning in 1992 with a presentation made at a clinical meeting of the National Abortion Federation and ending in 2007 with the Supreme Court upholding the Federal Partial Birth Abortion Ban Act of 2003. During this time, the opposition destabilized the vision of abortion the prochoice movement had framed in terms of rights, shifting the nation's focus to abortions done later in pregnancy. Seeking to reclaim the agenda, the prochoice movement chose to focus on the women deemed worthy of needing an abortion while shying away from the opportunity to increase the public's understanding of abortion as a medical service. And buried in the ashes of this legendary battle are the stories of the real lives of the women who need abortions, as well as the potential to advance quality healthcare.

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DELINEATING WORTHY AND UNWORTHY WOMEN

In the talk that started it all, a physician from Ohio presenting at a national meeting of abortion providers described a procedure he called dilation and extraction (D&X), now most commonly called intact dilation and evacuation (D&E). During the procedure the woman's cervix is dilated over several days so that the fetus can be removed fully after the skull is collapsed. Believing the audience to be comprised of other physicians who perform abortions, his words were clinical and explicit in nature and clearly not meant for mass consumption. Unfortunately, the meeting was infiltrated by an antiabortion activist who was aghast at what was being discussed. Information about the described technique spread quickly among antichoice activists. After testing out several other names, the label "partial birth abortion" was eventually adopted as the public descriptor—conjuring up images of fully developed babies being killed in the process of being born.

In their responses to the attacks on "partial birth abortion," prochoice advocates appeared disorganized and uncertain about how to proceed. Some organizational spokespersons claimed that the described procedure was rarely performed, attempting to separate the abortion rights for which they advocated

from the maligned technique. Others pointed to the statistic that over 90 percent of abortions occur before the end of the first trimester. After a series of shifting strategies, most advocates decided to focus on women whose wanted pregnancies had gone horribly wrong and thus needed an intact abortion procedure as a lifesaving intervention. These women's stories were used to persuade President Clinton to veto a ban on "partial birth abortion" passed by Congress in 1996 and again in 1997. (The act was eventually signed into law by President George W. Bush in 2003.)

On the occasion of the first veto, President Clinton was flanked by women who aborted under the unusual circumstances described above (less than seven percent of all abortions are performed on women with wanted pregnancies). One woman was holding a framed photo of the hand- and footprints of her aborted child, demonstrating for the camera her sense of loss. In his veto message, President Clinton made a clear delineation between who should and should not have access to the banned procedure. "I cannot support use of that procedure on an elective basis, where the abortion is being performed for non-health-related reasons and there are equally safe medical procedures available.... There are, however, rare and tragic situations that can occur in a woman's pregnancy.... In these situations, in which a woman and her family must make an awful choice, the Constitution requires, as it should, that the ability to choose this procedure be protected."

Focusing on women with wanted pregnancies who end up needing abortions has become the subsequent go-to strategy for prochoice advocates fighting limits on later abortion. Evidence of this shift can be found in the records of state legislative hearings in Nebraska, Ohio and Idaho in 2009, 2010 and 2011. Lost during these state debates, as in the nationwide fight over "partial birth abortion," is any focus on the majority of women who need later abortions (after 20 weeks of pregnancy).

At the University of California, San Francisco, my colleague Diana Greene Foster, PhD, is conducting a nationwide study of women seeking abortion in the US. She recently completed an analysis of the participants who were seeking abortions after 20 weeks of pregnancy. (The results were presented at the American Public Health Association annual meeting in November 2011.) She found that almost three-quarters of the women fit one of six profiles: women with babies under age one; women who report difficulty deciding to have an abortion and also experience logistic or financial troubles accessing abortion; young women who have never been pregnant before; women with a history of substance abuse and/or depression; women who report domestic violence and conflict with their partner over whether to have an abortion; and women with a chronic health condition and income below the poverty line. The prochoice movement lost the opportunity to build support for these women's lives and social circumstances and instead focused on the few women whose abortions are deemed more acceptable. The women in the above categories have complicated lives whose stories take longer to tell and require greater empathy on the part of the listener.

Today's prochoice messaging clearly delineates between worthy and unworthy women in the same way that Clinton's veto message did. And national advocacy groups seem to have no stomach for telling the truth, which is that women need abortions throughout their pregnancies for reasons that reflect the complexity of women's lives. While public opinion polls continue to show limited support for later abortions, prochoice advocates seem ill-equipped to control the cultural conversation and build, rather than simply defend, support for abortion rights in the United States. Prochoicers find it even harder to talk about abortion as a medical service rather than in legal terms.

SHYING AWAY FROM EXPLAINING ABORTION

Abortion is indeed a medical procedure, but one that involves private and intimate parts of the female anatomy and blood, mucus and other bodily secretions. The fetus is usually removed in pieces using instruments and/or suction. None of these characteristics makes for pleasant dinner conversation. For years, prochoice advocates could avoid any discussion of the unpleasant side of abortion techniques, pivoting instead to the horrific and graphic stories of illegal abortion. Consequently, when confronted with the "partial birth abortion" fight abortion rights activists were unprepared for talking about the medical realities of abortion. And when they did try to use medical arguments, the descriptions were often guarded, defensive and disjointed. Court transcripts from the early litigation against state "partial birth abortion" legislation are filled with awkward silences when lawyers and witnesses searched for the appropriate words and phrases. The discomfort evidenced in the transcripts stands in direct contrast to the clarity with which the issues were discussed in 2003 by the legal team and the witnesses assembled to fight the Partial Birth Abortion Act. By

National advocacy groups seem to have no stomach for telling the truth, which is that women need abortions throughout their pregnancies for reasons that reflect the complexity of women's lives.

that time, the medical community had explored the value of the intact D&E technique and determined it to have several clinical advantages over disarticulation D&E, which was not banned under the Supreme Court decision. Lawyers found value in defending, not simply the rights of doctors to practice according to what they determine to be medically necessary for the patient, but in specifically rescuing the legal legitimacy of the banned technique. The American Medical Association, which had initially supported a ban on "partial birth abortion," subsequently reversed its position and opposed setting limits on abortion techniques. The American College of Obstetricians and Gynecologists issued strong statements about the potential harms the ban could cause to women's health.

Unfortunately, abortion rights advocates outside of the medical and legal fields still lacked the skills with which to discuss abortion. After the "partial birth abortion" debate, the take-home lesson for these advocates was that talking about the details of abortion was a losing strategy. The consequence of this avoidance is that the actual effects of the ban are hidden from view.

My colleague Lori Freedman, PhD, is studying the experiences of OB/GYNs who deliver reproductive healthcare in hospital settings. Some physicians whom she interviewed do not routinely provide abortions and don't consider themselves "abortion providers," but nonetheless they have been affected by the very existence of the "partial birth abortion" ban. At a recent San Francisco General Hospital Abortion Discussion Group held on January 17 of this year, Dr. Freedman presented the story of one doctor trying to care for a patient who was losing a 22-week pregnancy due to ruptured membranes. In writing this article, I contemplated how much to edit the doctor's story and decided on modeling the approach I want advocates to take: allowing the real stories of women and providers to reach the general public.

> Dr. B: *"[The patient] was kind of in the process of delivering but it wasn't coming fast enough and she's trying to hemorrhage to death.... So I took her to the OR to basically do a D&E ... so I could get her to quit hemorrhaging. Well, you know the whole thing about the partial birth abortion. I mean, [it's] being born breach, it's still kicking, it still has a heartbeat, its head is stuck in her cervix. What would make sense would be to punch a hole in the back of its skull, collapse its brain, get it out of there and save the patient. But you've got all these people in the OR that don't know what the background situation [is].... And it's just like that would've made perfect sense to do that but I didn't primarily because I was worried that all these, you know, the techs and circulating nurses in the OR are going to think, 'Oh, Dr. B. is a baby killer,' you know, 'And she just did a partial birth abortion and doesn't everybody know that's illegal?'"*

According the law, the intervention the physician described would probably not meet the standard for criminal prosecution since the provider did not "intend" to do an intact procedure, but no case law has yet been written on the subject. And regardless of the letter of the law, the effect of the law has been to create a surveillance system in which doctors feel watched, whether or not they actually are. French philosopher Michel Foucault called this phenomenon the "Panopticon." With this kind of surveillance, physicians make decisions in the operating room based on their fears about who might be watching, worried that onlookers will misinterpret the situation. In this case, the physician was able to complete the disarticulation D&E and the patient recovered, but these kinds of scenarios weigh heavily on the minds of physicians who have the surgical skills to implement lifesaving interventions. Their stories, however, are not told. These physicians are not monsters—rather they are focused on the health of the pregnant woman.

A RENEWED NEED FOR AN HONEST CONVERSATION

The prochoice movement was unprepared for the fight over "partial birth abortion," in part because it was hindered by its own members' hesitation about advocating for a healthcare intervention they weren't comfortable explaining. However, in failing to learn how to talk openly about what abortions look like and why physicians might need to perform them, prochoicers left the issue to be framed by antichoicers. Prochoice advocates then countered by focusing not on the care women need but on the worthiness of the woman obtaining the care. This limited the movement's ability to develop support for the majority of women who will need abortions later in pregnancy, women whose lives don't fit neatly into the one box allowed for later abortions.

The House of Representatives is currently debating legislation that would allow hospitals to opt out of providing emergency abortion care (whether the healthcare professionals in those hospitals want to or not). In order to successfully engage in this and subsequent debates, the prochoice movement will need to move away from attention to the worthiness of the patient in need of care. Instead, advocates need to focus on the rights of all patients to obtain the most appropriate healthcare. The attention should be on healthcare professionals being able to use all of their abilities and professional resources and their right not to be limited by either informal surveillance systems or formal institutional policies rooted in politics, not medicine. To oppose laws that determine what kind of care a healthcare professional can offer or that would allow institutions to decide not to take care of patients, advocates need to be able to share medical stories in ways that enhance rather than obscure the realities of medical care.

Abortions are socially complicated and medically unpleasant to describe, as the story in this article demonstrates, but advocates for abortion rights are best served by acknowledging rather than trying to ignore this dimension. The lesson from the "partial birth abortion" debate is not to move away from the conversation but to lean into it, bringing multiple arguments to bear on all women's worthiness of the right to have a safe abortion. ■

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Between a Rock and a Hard Place

DECIDING ABOUT A PREGNANCY AFTER A PRENATAL DIAGNOSIS OF FETAL ANOMALY

By Jane Fisher

IMAGE: WIKIMEDIA COMMONS: GEORGE GASTIN

A picture of chromosomes taken at London's Science Museum.

"This was our baby that we had waited a long time for and the decision was not made lightly. We had to think of our life too and that of our families. What would happen after we died? Nobody could love our child like we could. We had to let go, try to be unselfish. Perhaps many would say that this decision was not right, but we made it for what we considered the right reasons."

— "Jill" 2007

JANE FISHER *is director of the UK charity ARC (Antenatal Results and Choices). The organization provides non-directive information and support to women and their partners through prenatal testing and its consequences.*

Since Antenatal Results and Choices (ARC) was founded in the UK in 1988, we have had contact with thousands of women like "Jill." In our lifetime, we have seen a rapid development in and implementation of genetic testing technologies. What has definitely not changed is the emotional impact on a parent who is told their baby has a fatal, life-limiting or disabling condition. After receiving the news that their baby is not developing as expected, parents then face the difficult decision about continuing or ending the pregnancy. I use the words "parent" and "baby" because this is the way women

like Jill who come to us most often refer to themselves and the fetus.

I have spent 10 years with ARC speaking almost daily to women and their partners before and after their decision to end a pregnancy upon receiving a prenatal diagnosis. This includes many for whom the unexpected news comes late in the pregnancy. It is undoubtedly a traumatic life event and the psychological repercussions can be significant. But my experience has reinforced my belief that in the face of a fetal anomaly, parents must be empowered to make the decision that is right for themselves and their families. The vast majority of parents ARC supports regret that they found themselves in such distressing circumstances, but do not regret that they had the choice to end the pregnancy.

Rather than offer a polemic on the ethical justification for abortion in cases of fetal anomaly, I want to use our experience at ARC to let women who have had such abortions provide insight.

THE POLITICAL CONTEXT SURROUNDING ABORTION FOR FETAL ANOMALY IN THE UK

> *"I even envied women who had miscarried—something I'd experienced myself, with great sadness, three years previously. But at least those babies hadn't died at their mother's hands, and their experiences evoked straightforward sympathy, never vitriol."*
>
> *"Sara" 2011*

It is worth pausing to consider the political context in which women now make decisions after prenatal diagnosis. In recent years we have seen laudable gains made by the disability rights movement. There have been legislative changes to combat discrimination against those living with disabilities and inroads made in constructing a more inclusive and accepting society. At the same time, antichoice campaigners have seized the opportunity to attack the clause in the UK Abortion Act of 1967 that allows for abortion if "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" and called it "eugenic." Antichoice advocates have attempted to enlist disability campaigners to their cause. The Society for the Protection of the Unborn Child (a small but vociferous UK antichoice organization) uses its website to accuse ARC of being "actively complicit in the fatal discrimination of disabled people enabled by legal abortion."

It is a clever move by the antichoice lobby, as they are aware that many who would class themselves as "prochoice" worry that ending a pregnancy on the grounds of disability may devalue the lives of those living with some sort of impairment. Furthermore, when antichoicers decry that those women who have terminations for fetal anomaly are pursuing perfection or taking the "easy way out," they know that it is rare for a woman who made this choice to speak out publicly against such vilification. In such a deeply private and personal experience, most women understandably do not want their circumstances put under public scrutiny.

The antichoice movement also readily exploits public squeamishness about late abortions in the hope of restricting access. There are regular media flurries around late abortions, in particular those performed past the legal limit of 24 weeks for non-medical abortions in the UK. The fact is that these post-24 week abortions are few in number (according to government statistics there are fewer than 200 post-24 week abortions per annum in England and Wales—0.1 percent of the total) and the majority are carried out due to indications of serious fetal abnormalities that do not manifest until late in the pregnancy.

This charged context can add an extra layer of difficulty for women and couples dealing with a diagnosis of fetal anomaly. They struggle with complex and often conflicted feelings over ending the pregnancy while being fearful of the judgment of those around them and in the wider world. I hope that by exploring the perspective of parents who come to ARC, it will be clear that they are not denigrating those living with a disability, but making responsible decisions informed by their individual values and personal circumstances.

The vast majority of parents ARC supports regret that they found themselves in such distressing circumstances, but do not regret that they had the choice to end the pregnancy.

WHY WOMEN NEED ACCESS TO ABORTION BEYOND 20 WEEKS OF PREGNANCY

Most developed countries now offer prenatal screening and diagnosis for major chromosomal disorders before the first 14 weeks of pregnancy. This has been facilitated by improvements in scanning technologies and testing techniques that now deliver an accurate early screening result. This in turn enables women to opt for chorionic villus sampling (CVS), an invasive diagnostic procedure that can be carried out from 11 weeks in order to check for chromosomal conditions such as Down syndrome. Early scans now produce images that are instantly recognizable as a developing baby, even to the untrained eye. Today most prenatal diagnoses of Down syndrome in England are

made earlier in pregnancy as a result of these technological breakthroughs. But it is important to understand that there is a limit to the diagnoses available at this stage of fetal development.

Having been reassured by first trimester screening, many parents approach their mid-pregnancy anomaly scan (usually performed at around 20 weeks) as an opportunity to "see" their baby, perhaps learn the sex and gain further reassurance that all is progressing as expected. While they may be aware that anomalies could be detected, this will not normally be at the forefront of their thinking. Some will invite other children and family members to be present in the scan room to share the excitement.

Within seconds, all their hopes and dreams around the baby that they had envisaged are destroyed and many then confront the prospect of possibly ending their pregnancy.

"The 20-week scan brought the shocking diagnosis. We only spoke to the sonographer who faxed a referral to a fetal medicine department. I then had to wait from Thursday until the Tuesday to speak to someone. It was the worst few days of my life not knowing what was going to happen—all I knew was that it was spina bifida and malformed brain. That 20-week scan has changed my life forever."

"Amanda" 2010

parents have to make what they know are life-changing decisions based on an emerging, but still incomplete, picture of the fetus.

DECIDING TO END THE PREGNANCY

"But how, as … a human being you make those sorts of decisions, you know, 'Do I stick a needle in my baby's heart and kill him now? Do I give birth to him and then sort of hope that he doesn't die, have a heart attack and drop dead at the age of five, you know? Or, if he survives it all, which is the best you hope for, how will he live with the burden of this knowledge of this terrible incurable thing.… ?'

"And I remember sort of going round in circles in my head between these things, and thinking, what am I going to choose, you know? Which of these three just awful, very different scenarios is the one that I feel I could live with, or that I could choose him to have to live with?"

"Melanie" 2008

I have lost count of the number of women who have told me that they had always been antiabortion but suddenly found their position first challenged, and then ultimately shifting.

"So on the Friday morning we went to the hospital for the anomaly scan, and my expectation of that was to be told that everything was fine, and find out the sex of my baby. And that was, that was all I thought was going to happen, because there couldn't have been anything wrong because everything so far had told me that everything was okay. And even though I read the leaflet that said, you know, this condition and that condition and—none of it really sunk in."

"Val" 2011

When parents receive the news that all is not well, they feel as though their expectations are shattered.

"'Everything is all right isn't it?' I said in my innocence. It was then that he stopped the machine; put his hand on my arm and stony faced said, 'No, I'm afraid it's not. I think we need to have a chat.'

"That moment and those words will remain with me until the day I die—my blood actually ran cold."

"Jo" 2010

After the initial information, there are usually further specialist scans and tests to confirm the diagnosis. Some parents will be encouraged to wait to see how the condition develops. All this can mean that they can find themselves close to, or occasionally beyond, 24 weeks before being able to make a final decision to have a termination.

There are some structural conditions, particularly those affecting the fetal brain, which do not become apparent until the third trimester. Thankfully, these conditions are rare and can be picked up by chance when a scan has been scheduled for other reasons, such as checking placental position. Again, there will be the need for further testing and sometimes careful monitoring to give as much prognostic information as possible. Sadly, while medical technology has made great advances, clinicians' ability to give accurate or conclusive information about the expected outcome is still limited, particularly early in the pregnancy. Thus,

"Melanie" powerfully expresses the intense distress often inherent in the decision-making process. It can feel like an impossible dilemma and many will try, like Melanie, to work out what the least worst option is for them. We will never have definitive information on exactly how women make these decisions, but over the years at ARC we have gained knowledge of the factors that parents weigh in the process.

"There was no way I could go through the pregnancy and give birth only to hold my baby and watch it pass away. We also had to think of our daughter, the effect on her. She already knew there was a baby in Mummy's tummy and loved putting her hand on the 'little bump' and talking to the baby. It would have

been awful to go through the whole experience and then have to explain to her that the baby wasn't coming home."

"Chrissie" 2011

When the diagnosis is a lethal or life-limiting condition, for some women a termination hastens the inevitable and prevents more suffering for themselves, their baby and other family members. When the condition is disabling rather than life threatening, parents consider how this will affect their child's quality of life, the long-term impact on their relationship, on their own individual lives and that of their families.

"I tried to shake away the image I conjured in my head of a little boy, lonely and friendless, robbed of the most basic human functions. The prospect of watching a child I'd love just as much as his sisters suffer in this way made me howl. I hugged my stomach, as if I could in some way shield him from the misery that lay ahead."

"Sara" 2011

"We had our other children to think of and who would look after our child when we were no longer here. Also we are not very well off financially."

"Petra" 2009

"Petra" was concerned about the financial implications of bringing up a child with disabilities. It may feel uncomfortable to consider economic factors but there is no denying the reality that a child with a significant disability will need extra care, frequently requiring one or both parents to reduce their working hours. In these times of fiscal austerity in the UK, social care cutbacks have resulted in reduced access to services for those who cannot afford to pay for them.

There are other considerations for some women and couples, such as the attitudes of close family and friends along with their own values and beliefs around abortion, sometimes informed by their faith. I have lost count of the number of women who have told me that they had always been antiabortion but suddenly found their position first challenged, and then ultimately shifting. Those people of faith who choose to terminate can reconcile their decision with their religion. They often conceive of a benign God who has given them the opportunity to prevent their child's suffering. They take comfort from imagining the baby at peace in heaven.

Some parents will make a decision quite quickly; others will struggle and vacillate before ultimately deciding to terminate the pregnancy. None will end a wanted pregnancy easily; all know that the consequences of their decision will stay with them. But those who do so have said that for them the consequences will ultimately be less onerous than watching their child die or suffer after birth.

The women whose words appear here articulate the often painful nature of the decision to end a pregnancy due to fetal anomaly. For many there will always be a part of them that rails against being involved in their wanted unborn baby's death. As we support women and their partners in the aftermath of the procedure, we see them contemplate the extraordinarily demanding circumstances that were thrown at them. We see them make peace with having made a decision that was emotionally painful, but right in their own individual context. We see them integrate the experience into their lives and move forward. It is particularly moving to hear from women from Northern Ireland and the Republic of Ireland who have had to travel to England to have a termination because it is not legal at home. Some of them want to express their gratitude to us for having helped them access services and offered support so they could prevent the birth of a child with severe disabilities or who would not survive.

"The lady that scanned me first of all was very thorough. And if it hadn't have been for her, we would have never ever have known. And I would like to thank her and I can't remember her name but I would like to thank her very much, because if she hadn't pointed these things out in the first place, we'd have never have got to the specialist hospital. We'd never have had the amniocentesis, and we would have never have known until the day he was born."

"Debra" 2010

The legal situation in Britain regarding abortion is not perfect, but on the whole, when a significant fetal anomaly is diagnosed, women are given the *option* of abortion. We have heard testimony from enough women at ARC to tell us that this is as it should be and we will do our utmost to ensure that this is how it stays.

The quotes in the article are all from ARC members and are taken from *ARC News*, our quarterly newsletter, with two exceptions.

The story from "Sara" appeared in the *Daily Mail* on May 15, 2010. The quote from "Melanie" comes from HealthTalk Online.org's web page "Making the decision to end the pregnancy." ■

Who Pays the Piper?

FUNDING FOR CONTRACEPTION AND ABORTION

By Christian Fiala, MD, PhD

As human beings we are far from perfect. This means that accidents happen. Since accidents are unpleasant experiences, we try to avoid them. For example, to prevent traffic accidents, we make driving licenses obligatory, impose speed limits, limit alcohol use by drivers and make sure people respect these and other rules through regular enforcement. These are all helpful strategies to reduce accidents. But some accidents will still happen, so we need medical backup, everything from first aid, emergency call centers and ambulances, to specialized trauma units in hospitals. Our modern societies have established these prevention and medical backup services for all the contingencies of life. The approach of prevention and care has become standard—an important cultural achievement.

But there is one exception: accidents as a result of sexual activity. If an unintended pregnancy occurs and the woman decides to have an abortion, she is suddenly left alone. "It's her own fault," was a common reaction some decades ago. But we still act that way even though most people don't dare say it out loud nowadays. Because of the implicit social expectation that women should carry their pregnancies to term and the ongoing stigma against abortion, women are still forced to explain themselves and accept insensitive or insulting behavior from others around them, including unprofessional treatment from some healthcare professionals.

We have made considerable progress over the last century, during which time women have gained much more autonomy over their bodies, including their reproductive health. This shift from paternalism to self-determination was a significant factor in the unprecedented improvement in women's health and quality of life. But society as a whole has also profited from increased women's autonomy: the high standard of living that so many of us enjoy today is the result of the female population's ability to actively participate in society without their lives and health being threatened by illegal and unsafe procedures, or repeated unwanted childbearing.

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Abortion coverage and legality in Europe

- Abortion is illegal and done only exceptionally for medical reasons or not at all (Ireland, Poland, Malta)
- Abortion is paid for by social security at least for some women (almost all Western Europe)
- Abortion is not covered by social security although it is legal and being done (Austria and some Central European countries)
- No data

IMAGE: CHRISTIAN FIALA

Coverage of costs for contraception and abortion in various European countries

Country	Contraception	Abortion costs
France	most	most
Albania, Belgium, Germany, Italy, Netherlands, Spain, Sweden, Turkey, Uzbekistan	some	most
UK	some	some
Finland, Switzerland	none	most
Bosnia and Herzegovina	most	none
Austria, Cyprus, Czech Rep., Hungary, Israel, Latvia, Russian Federation, Slovakia	none	none

However, the ancient double standard prevails in reproductive health. Women are still burdened with all the consequences if they go against societal expectations and decide they don't want to get pregnant or stay pregnant. For example, women often have to pay out of pocket for basic preventive measures and for the medical treatment of unwanted pregnancy.

We seem to have forgotten why the so-called developed countries got to where they are today. One of the main reasons is our social consensus that it is in the interest of the whole of society to help individuals prevent accidents and to care for them if an accident does occur, regardless of the reason or the person's social status or income. This concept of helping individuals instead of letting them fend for themselves is well-established in many countries. Most European countries have extended this social compassion to reproductive health and coverage for the costs of contraception and abortion with social security, at least in part (see table).

However, this is not the case in a number of countries. Even in those places where reproductive health is covered, abortion coverage is under constant threat.

The reluctance to apply evidence-based medicine to reproductive health reflects a preference for traditional or religious beliefs over historical experience and facts, because it's difficult to understand from a rational point of view. The health and social benefits of covering contraception and abortion are clear—it saves women's lives, improves their health and that of their families and allows them more chances to fully participate in society.

Unfortunately, the debate over abortion coverage does not take place in the realm of evidence-based medicine. Instead, the conflict is part of the centuries-old fight between those in power and individual citizens who want to decide for themselves. Political leaders have sometimes sought to increase their population for military or nationalistic purposes, especially in wartime and during dictatorships. To reach this goal, some imposed and continue to impose restrictions on contraception and abortion.

The debate about covering costs for contraception and abortion has little to do with facts or reducing the number of abortions. It is about personal beliefs and forcing others to conform to one's own belief system. It is a remnant of the ancient struggle between those holding power and the individual's desire for self-determination. It is a struggle between two competing social ideas: the militaristic concept of power and the new democratic view based on individual responsibility and autonomy. To establish the latter, we need to extend our social consensus on free healthcare for all to include easy access to free contraception and abortion services. These are not luxuries or elective services—they are the very basis for achieving a high standard both for women's health and for society's well-being. ■

Acknowledgement: The author thanks Joyce Arthur for contributing to this report.

Abortion Cost and Coverage: A Cross-European Comparison

By Christian Fiala, MD, PhD

Despite the great attention society pays to abortion practices, little is known about the economic aspects of abortion. The medical, psychological, political and legal facets of abortion are frequently and thoroughly examined within an international context, but there remains a lack of comparative data on the actual costs of abortions. To arrive at an understanding of abortion costs in Europe, a 2005 study conducted by Christian Fiala, Sophie Hengl and Chantal Birman collected reproductive health coverage and national health plan refund policies across the continent.

This information was gathered through questionnaires sent to abortion providers, gynecologists, hospitals, family planning centers and healthcare organizations, asking about contraception and abortion coverage through public assistance; the out-of-pocket cost for women; and access to different methods of abortion. The cost of abortions in each country was interpreted relative to the per capita indicator of the Gross Domestic Product (GDP)—that is, to the country's economy overall.

The data revealed that abortion costs vary considerably throughout Europe, ranging from free to €517. The line between reimbursement strategies can be drawn roughly between East and West. Most countries in Western Europe provide a full or almost-full refund to the majority of women who have an abortion. In contrast, most women in Eastern Europe, as well as in Austria, bear the cost of abortion alone. And there are still a few countries where, due to pressure from the Catholic hierarchy, legal abortion is either nonexistent or impossible to access: Ireland, Malta and Poland.

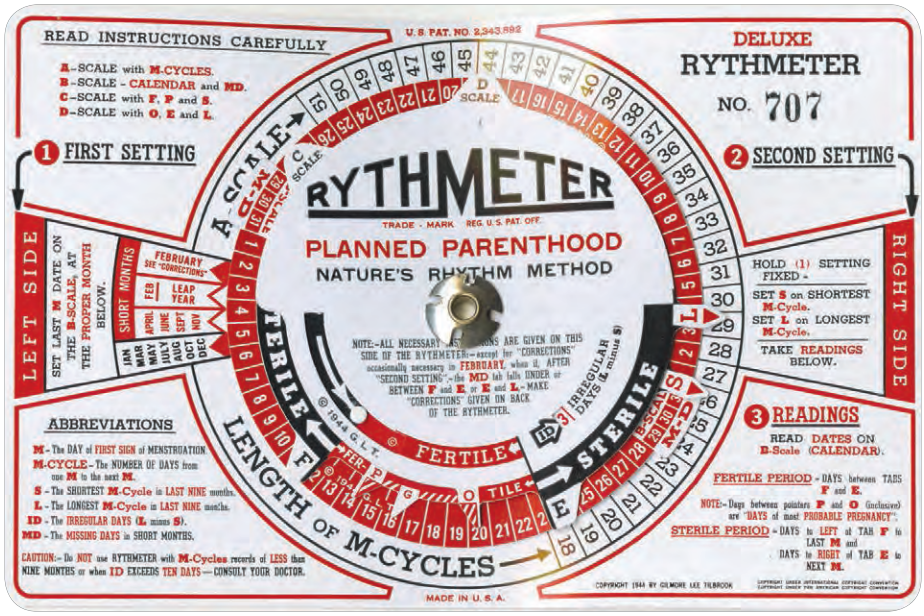
Though abortion is legal in most countries across Europe, the affordability and accessibility of the procedure vary sharply from place to place. The varying economic conditions related to abortion seem to reflect an "evidence-free zone," meaning that policy and practice are often decided by ideological considerations rather than a concern about women's well-being. Engagement on two fronts is needed if we really care about the health of women: the application of evidence-based medicine in abortion care, as well as joint international efforts to further improve the healthcare systems that deliver such care. A commitment to women's reproductive health across the board would level out many of the differences we currently see in abortion policies across Europe.

Contraception: My Health, My Conscience, Our Freedom

By Jennifer Becker-Landsberger

One could say I have always wanted to be Catholic. I was raised in a non-practicing Methodist household. At least twice a month, though, I would sneak off to the Catholic church—during off hours—and sit in the silence and admire the beauty. The intricate carvings, the candles burning steadily and the smell of incense all combined to form a sense of holiness and *presence* that I still love.

When I became engaged to a Catholic gentleman, I began the process of converting to Catholicism. We were married in the Catholic church by an extremely nice priest who didn't berate us for living together prior to the wedding. As a happily married Catholic couple, we had to immediately deal with the fact I was on six different medications for my bipolar disorder. My doctors have made it clear that, for the health of any future child or children, I would have to be on different medication or none at all for at least six months before trying to get pregnant. I would also need family members to stay with me during the pregnancy. These considerations mean that, realistically, pregnancy is not an option for me.



Engineer Gilmore Tilbrook patented his "Rhythmeter for determining sterility and fertility" in 1944.

IMAGE COURTESY OF FRANCIS A. COUNTWAY LIBRARY OF MEDICINE, HARVARD MEDICAL SCHOOL

My husband is on active duty with the Navy, and after our marriage we were transferred to South Carolina, where we immediately found a new church. I scheduled an appointment with the priest and he assured me that natural family planning (NFP) was the way for us to go. He said that there was no need to violate the ban on contraception and we could still act responsibly in regards to my medical situation. My husband and I met with a lady, whom I'll call Nancy, who had gone through the required NFP classes and certifications and was highly recommended by our priest.

The two initial NFP classes taught me more about the female reproductive system than I ever learned in school. For the first two months we were abstinent, as required for the initial charting. It seemed like a small sacrifice in our marriage for the state of our religious well-

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being, which was important to us both. During the two-month period, we went to two additional appointments with Nancy, learning more about the natural family planning method. Despite the fact we're fairly intelligent (my husband is a chemist and an engineering laboratory technician; I'm also a former chemist and current Mensa member), we fell for Nancy's claims that NFP is 99 percent effective without doing any double-checking. After all, a lady in the employ of any church wouldn't lie. Then I attended appointment number five. Nancy told me that the birth control pill, which I had used for five years, had probably caused me to have multiple abortions without me realizing it.

while some women may believe the misinformation out there, many are dismissing it. A recent report from the Guttmacher Institute showed that only two percent of sexually active Catholic women, even regular church attendees, rely on natural family planning. The other 98 percent have used birth control methods banned by the Vatican at some point in their lives, with 70 percent currently using the pill, sterilization or an IUD. This is not a surprise, since the World Health Organization states that natural family planning is only 75 percent effective, not 99 percent as we were told.

A year later, we're using birth control pills again, since our three options according to the Catholic hierarchy are:

IUDs—can induce abortion. Hormonal contraceptives help prevent pregnancy by three means: preventing ovulation, thickening cervical mucus to make it harder for sperm to reach the egg and by thinning the lining of the uterus. But the fringe of the antichoice movement argues that pregnancy starts the moment sperm meets egg, forming a zygote. By this logic, if any woman with a fertilized egg is pregnant, then a contraceptive that prevents pregnancy after the point of fertilization is actually causing an abortion. However, the American College of Obstetricians and Gynecologists (ACOG) holds that a pregnancy is not established until a fertilized egg is implanted in the lining of a woman's uterus.

Our priest's insistence that natural family planning was the only moral decision caused me to fear his possible reaction—particularly in light of the fact that I was not planning on "repenting" of my sin.

I sat there speechless. I believed her for about 10 seconds, and then the part of my brain that uses reason spoke up. It said plainly—and thankfully, silently—a skeptical word that a nice, religious young lady shouldn't say. I smiled sweetly, sat through the rest of the appointment, and left. Upon reaching the house, I got on the computer and started researching. My initial web search brought up a variety of sites agreeing with Nancy that I had unintentionally killed multiple babies, but I was still skeptical.

Then I adjusted the search parameters to pull up scholarly articles, published news articles and results from educational sites. To my relief, I found out that taking hormonal birth control does not cause abortions. But my curiosity was aroused. I wondered how many other women were being told this. I also wondered how many did a general web search, believed the results of the first five sites that a search engine pulled up, and stopped their research there. Luckily,

1) use natural family planning and run a serious risk of getting pregnant and causing harm to the fetus; 2) abstain from sex all together and run a serious risk of ruining our marriage; or 3) violate the rules laid down by the Vatican and use "real" birth control. Also a year later, I've become aware of a movement, disguising itself under the banner of morality, attempting to take away the option to use many forms of birth control. This movement is trying to force us back to the era when women faced with choices about contraception, pregnancy and necessary—even lifesaving—medications had fewer options than they do today.

CONTRACEPTIVES DO NOT CAUSE ABORTIONS

What was told to me in a church-sanctioned class can be heard elsewhere: that any woman using a hormonal method of birth control—including oral contraceptives, Depo-Provera and Lunelle shots, NuvaRings, Ortho Evra patches and

This question is not just nitpicking over definitions. The argument that certain contraceptives cause abortions has been used by some pharmacists to refuse to fill prescriptions for birth control, thereby denying women prescriptions that are not only legal, but prescribed by their doctors. It is fundamental to the question of contraceptives and women's right to use them.

Those who object to birth control either for religious reasons or based on faulty science are actively working on the political front to change laws and regulations so that women no longer have the option of choosing some forms of birth control. Several states have attempted to pass sweeping pieces of legislation claiming to protect "personhood," which is defined as beginning at the moment of fertilization. This move is being promoted most heavily by an organization going by the name of Personhood USA, though many other groups are aiding the battle. The Mississippi version of the amendment

was defeated during the November 2011 election, but the similar movements in other states are causes for concern. Well-known politicians, including both parties' nominees for governor of Mississippi, supported the measure. The major media networks, including CNN, consistently referred to the amendment as an "abortion ban," completely ignoring the various other fields the amendment would affect. This oversimplification misleads many who would vote against it if they were privy to the full story, which is that this amendment would also outlaw many forms of birth control as well as in vitro fertilization.

DISSENTING OPINIONS

The misconception that using a contraceptive is the same as having an abortion may be distressingly common at church, in politics and online, but there is hope. Men and women, once informed about the full scope of this issue, often express a dissenting point of view. They spread good information to those they know. They vote. And they let their church leaders know that they, the laity, are considering the moral implications of these questions. But are church leaders listening? And are all of the laity brave enough to share their opinion?

I must admit with sadness that, thus far, I have not been one of the brave ones. Once back on regular birth control and more informed about its effects, I avoided going to confession. Our priest's insistence that natural family planning was the only moral decision caused me to fear his possible reaction—particularly in light of the fact that I was not planning on "repenting" of my sin. Having not gone to confession, I felt guilty about taking part in the Eucharistic celebration, specifically the actual taking of Communion. Our church attendance became less frequent.

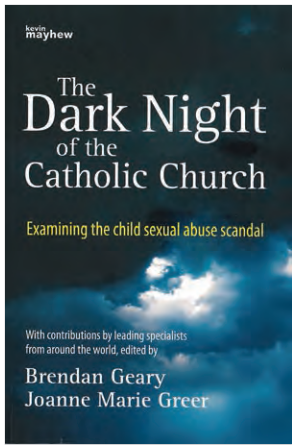
We've recently moved again—as I said, my husband is active duty military. Three months in our new home and we still haven't visited our local church. I cannot speak for my husband's reasons; I can only share his actions. My conscience has been bothering me, and writing this essay has helped clarify my feelings. At this point I am gathering my courage: I love my church and shouldn't avoid it out of fear. I plan on going to confession and hearing the priest out. And unless he flatly forbids it, I also plan on taking Communion. Because I am morally sure, in my heart, that for me, this is the proper decision. ■

In Spite of the Hierarchy: Understanding Clergy Sexual Abuse

By Thomas P. Doyle, JCD, CADC

The Dark Night of the Catholic Church
Brendan Geary and Joanne Marie Greer (Editors)
(Kevin Mayhew, Ltd., 2011, 620 pp.)
978-1848673854, £34.99

This book is one of the very few written about the clergy abuse issue that provides scholarly articles about the key aspects of this complex and highly controversial subject. One of its more valuable aspects is the objectivity of the contributions. This objectivity is remarkable because, out of 25 chapters, including an introduction and conclusions, by 18 authors, nine of the authors are clerics or members of Catholic religious communities. All contributors are professionals with impressive credentials and experience. *The Dark Night of the Catholic Church* is not presented as an apology for the institutional church's efforts to confront the pandemic of abuse worldwide, nor is it a polemic against the responses of the Vatican and the bishops. It succeeds fairly well at its aim to be a source of information about clergy abuse.



The book is made up of 25 chapters divided into four parts: "Understanding," "Listening," "Responding" and "Educating and Preventing." The first section attempts to present answers to basic questions about why clerics molest children, the effects on the victims and, most importantly, the contribution of the institutional church and secular society to the sexual abuse phenomenon.

The dimension of the abuse scandal that has captured the greatest share of attention and emotion has been the question of causality—not "why do clerics sexually abuse minors?" but "why did the church allow it to happen?" This latter question is directed not at the wider church, but at the leadership, namely the popes throughout the ages and the bishops. The first chapter provides a concise historical overview of the church's official responses beginning with the *Didache* of the first century and culminating with a very brief summary of the 20th century. The chapter concludes with the thoughtful statement that, with few exceptions, "the church does not understand the damage that abuse does to children." Other chapters in this section explore how society in general and the Catholic hierarchical system in particular have contributed to child abuse. The chapter on the contributions of the hierarchy is especially well done. It dives into the clerical culture and provides examples of arrogant clericalism on the part of complicit hierarchs. The section on what is best termed "lay clericalism" dovetails well with the preceding chapter on societal endorsement of abusive behavior towards children. One of the primary causes underlying the widespread abuse has been the reprehensible tendency of secular society and many Catholic laity to react with either denial or minimization.

The chapter titled "Religious and Educational Cognitive Distortions Used by Clerical Child Sex Abusers" is a fascinating contribution and one that is long overdue. The author provides lucid explanations as to why abusers often appear to justify their behavior, sometimes using theological concepts. This section goes into some of the cognitive distortions and toxic belief statements of those who oversaw clerics. The chapter proves the necessity of further study of the cognitive distortions of the hierarchy since these are, in many ways, more important to the thorny task of arriving at credible answers for the bishops' behavior.

Although the behavior of the hierarchy has somewhat overshadowed that of the predators, there is also a pressing need to examine the internal makeup of the clerics who abuse. This subject is explored in two chapters that do an excellent job of summarizing a vast amount of literature on the subject.

The only weak chapter of the section is chapter 8, which deals with the abuse of faith, or the effect of clerical child sex abuse on victims' faith. The author did an admirable job in presenting the basic issue and the initial symptoms or manifestations of a damaged belief system. The fault lies not with the writer of this chapter but with the fact that very little research and writing has been done on the spiritual trauma following the sexual violation of a child-believer by a cleric.

At the center of the collection are five chapters that make up Part 2, "Listening." Here we find the three most powerful contributions to the book: chapters by Colm O'Gorman, Marie

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Collins and Bishop Geoff Robinson. O'Gorman and Collins are articulate and wise survivors from Ireland whose courageous efforts in the campaign for recognition and justice for themselves and all survivors have been foundational in shaping the remarkable course the abuse scandal has taken not only in Ireland but throughout the world. Bishop Geoff Robinson of Sydney, Australia, is one of three bishops known to have stood up publicly in support of abuse victims and in criticism of the Vatican's inept response. He begins his contribution by saying "What follows is my personal story." His personal story, however, is far more than an autobiographical sketch of his connection with the victims. It is an incredibly courageous witness to the painful truth that must be found in the equally painful search for the cause of the nightmare that has plagued the People of God. The pope and Vatican officials, as well as every bishop, must look within the church for the antecedents of the abuse, rather than doing what the Vatican continues to do—seek reasons outside the church upon which to place blame.

The second section contains a valuable contribution by an anonymous priest-abuser. There are few such written accounts. This one is autobiographical but not an "apologia" intended to defend his actions. The writer shares his journey after exposure and provides needed perspective into the life of an abuser who benefited from both therapy and incarceration. His story puts a human face on at least some clergy abusers, moving them from the category of inhuman monsters to deeply flawed offenders who are capable of some degree of redemption.

The final chapter is titled "The Voices of Secondary Victims." It offers insight into the reactions of active laypersons as well as religious brothers and priests. Lay people are not only shocked and hurt by incidences of abuse, but the existence of an abuser close to home has a painful impact on their overall faith in the church. This chapter also helps dispel two erroneous notions: first, that every priest and religious not directly involved must have been aware of the incident and helped cover it up. The second misconception is that the majority of those not directly involved with the crisis are both supportive of the disastrously inadequate responses of the bishops and defensive about priest and religious perpetrators.

The third section, "Responding," departs from the standard descriptions of treatment modalities or complaints about the hierarchy. The first chapter addresses immediate interventions with child victims, always a vital step in the healing process. Two chapters describe psychological treatment and spiritual healing of abusers, while the final segment is a description of the role of canon law in dealing with abuse.

This last chapter serves as a straightforward description of the available procedures and not an in-depth critique of the failure of the church's legal system. The fact that the author chose not to take his analysis to this level is illustrated by certain assertions based on the text of the law isolated from practice. One is that the best interests of the child are of prime consideration in canon law. This is true only on paper, since history has amply demonstrated that the opposite is true of the way canon law is usually applied. The other glaring inconsistency between canon law as written and as applied by the hierarchy is the matter of reporting offenders to civil authorities. The author of this chapter naïvely claims that the Holy See's practice and position is clearly that allegations must be reported to civil authorities. This is hard to swallow in light of the blatant statements of several curial cardinals insisting that bishops should not report accused priests. The chapter on canon law is about what should be done, not what has been done. The latter is a subject that merits its own study.

The final section is about "Educating and Preventing." This is the most theoretical area in that it speaks about the "charism of celibate chastity" and "teaching human sexuality in a ministerial formation course." Both are eloquent phrases, but in light of the consistent failure of mandatory celibacy over the past 20 years they betray an obvious disconnect with reality. The chapter on policies and procedures (Chapter 23) is an exposition of the environment in which policies are created rather than an attempt to present the various policies as the answer to the problem. The author offers some very realistic observations about the challenges involved in putting effective programs into place. It is an excellent chapter which might have been better with a summary of the problems encountered with the application of various policies, noteworthy among them the lack of support from bishops.

Lay people are not only shocked and hurt by incidences of abuse, but the existence of an abuser close to home has a painful impact on their overall faith in the church.

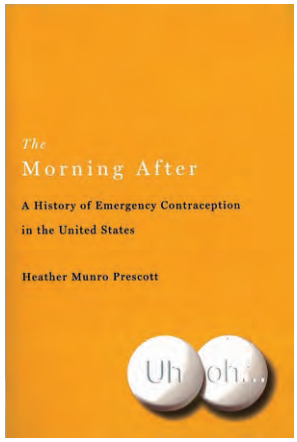
The Dark Night of the Catholic Church is a very valuable book. One hopes it will prove to be a catalyst to more intensive, extensive and fearless research into this complex issue. Thus far the official church on the Vatican and local levels has avoided serious, objective research into the many dimensions of clergy abuse. This book proves that scholars affiliated with the church have the capability and sensitivity to advance into unknown areas. The lesson from a quarter century of experience is that research will take place in spite of and not because of the hierarchy. ■

Politics and Science: The Tortuous Road for Emergency Contraception in the US

By Carole Joffe

The Morning After:
A History of Emergency Contraception in the United States
Heather Munro Prescott
(Rutgers University Press, 2011, 184 pp)
978-0-8135-5162-3, $22.95

The Morning After: A History of Emergency Contraception in the United States begins by detailing the long, tortuous road that Emergency Contraception (EC) followed to normalization in the US, with a particular focus on the dismaying behavior of the Food and Drug Administration (FDA) during the George W. Bush presidency. Toward the end of the book the author offers a note of cautious optimism, pointing to the "more progressive leadership of the FDA" appointed by President Obama. Indeed, fairly early in the Obama presidency, as Prescott reports, the FDA did approve, in an efficient and professional manner, ellaOne, a newer version of an EC product. But of course, as readers of *Conscience* are undoubtedly aware, the Obama administration too has let "politics trump science" when it comes to EC, as the painfully familiar phrase connected with that saga goes. In December 2011, after this book had gone to press, Kathleen Sebelius, Obama's Secretary of Health and Human Services, made the unprecedented decision to overturn the FDA's approval of allowing Plan B, a dedicated EC product, to be available without a prescription to women under the age of 17.



Prescott's well-researched, well-written history starts in the 1960s, with the emerging recognition among some reproductive scientists and clinicians that a larger than normal dose of oral contraception used after unprotected intercourse was effective in preventing pregnancy. Significantly, though this knowledge apparently soon became known in many college health centers and some rape units in police departments and hospitals, it did not cross over into the knowledge base, or practice, of mainstream medicine. Prescott gives no clear answer to this question of why "postcoital contraception," as it was once called, remained so unknown, but her account suggests that this can be best understood as a case of willful ignorance, given the controversy that has always accompanied anything to do with contraception in the United States. (The author offers a quite powerful indication of this controversy when she points out that in 1980 there were nine US pharmaceutical companies involved in contraceptive research and development, but by 1990 the number had fallen to only one, Ortho Pharmaceutical).

Given the avoidance of the topic in mainstream reproductive health circles, it is very moving to read of the tireless efforts of the early crusaders to disseminate knowledge about EC, some of whom remain active to this day. James Trussell, today a professor of economics at Princeton University and a member of the interdisciplinary group that has produced numerous versions of *Contraceptive Technology*, the "bible" for family planning clinics, started his advocacy work on behalf of contraceptive education while an undergraduate in the 1960s. He later wrote some of the first influential papers on the potential of emergency contraception to prevent unintended pregnancies, including some in collaboration with the late Dr. Felicia Stewart, a renowned specialist in women's health. Trussell was also a pioneer in providing information about EC on the web, once that technology became available.

Prescott also mentions Dr. Stewart's practice of providing "do it yourself" EC kits for her patients, which consisted of cut up packets of regular oral contraception, along with typed instructions as to how and when to use these pills for back-up contraception. (A surprising omission in this otherwise thorough book is any mention of Stewart's tenure as Deputy Assistant Secretary for Population Affairs in the Clinton administration, a position in which she strongly advocated for approval of a dedicated EC product.) Thanks to the efforts of these pioneers, and others, particularly the Reproductive Health Technologies Project, by

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Bookshelf

Women and Redemption: A Theological History

Rosemary Radford Ruether (Fortress Press, 2012, 328 pp)

The book helps unearth the lives of historical women and men and their many paths towards redemption. This is a much-needed affirmation of a tradition many Catholics sense lies just out of reach within the more frequently told stories about Catholicism. St. Thomas Aquinas, whose many contributions have been discussed in other publications, is revealed to have been a key architect in the imposition of systems that impose an inferior status on women in the church, which continues to stymie reform-minded Catholics today.

The second edition of this work builds upon the first version, published in 1998. The additions to the original material include: timelines for each chapter, suggestions for further reading and research, as well as a focus on what the author calls the "Fourth World." This Fourth World is a postcolonial view that encompasses stateless peoples, indigenous groups and marginalized social and sexual minorities. The author examines the feminist critique developed by each of the four "worlds," in which "redemption" is often understood to include critiques of existing structures related to race, class and colonialism. The book focuses on the 2000 years of the Christian tradition and a broad selection of its many antecedents and offshoots. Jewish, African, Protestant and Catholic views are incorporated into this work.

The section on 12th-century mystic Hildegard of Bingen depicts the tension between this prophetic woman and her self-image as a "poor little female figure." She broke new ground for women in her day, but she didn't see her role as transforming social norms. Instead, the outspoken visionary saw existing male and female social roles as supporting the rightful domination of men over women. Hildegard believed the worldly differences between men and women were not without remedy, but she saw social classes as being much more rigid: only noblewomen were allowed to join her monastery.

As the book moves through time it reveals a tradition of female spiritual seekers that was never truly obscured by the many voices that had a better platform within established religion. Solid scholarship and the true historian's gift at getting inside long-vanished heads make *Women and Redemption* a worthy read.

Church Militant: Bishop Kung and Catholic Resistance in Communist Shanghai

Paul P. Mariani, SJ (Harvard University Press, 2011, 282 pp)

Like history itself, this book can be read on a number of levels. As a Jesuit writing about a nation whose Catholicism has been heavily influenced by that order, it's understandable that the author is telling the story from a step or two closer than one would expect from a history book. The result is anything but dry: rather, it is a well-researched and well-told narrative that has the tone of a book about war. It has all the tragedies, tactical maneuvers and heroism one would expect about a conflict between two great enemies, one of them with a clear moral ascendancy, with the part of heroes played by Catholic clergy and laypeople resisting government repression.

That Chinese communism was a political regime with an expressed enmity for religion, especially Catholicism, and that many faithful people paid a high price in that system, is clear from the author's painstaking research. Even those readers who are less likely to take sides with the way the Catholic church has interacted with secular powers in the last century will find *Bishop Kung* a compelling read. The battles Chinese Catholics were forced to fight against the government also drew in Catholic missionaries and the secular and religious powers from their home countries, meaning this segment of history was not two sides, good versus evil, but the complex interactions between a variety of secular and religious entities. This book illuminates a new section of the sprawling and complex tapestry woven by Catholics as they engage with the world—as missionaries, faith communities and sometimes as dissidents.

1998 the drug Preven became the first FDA-approved EC product.

Subsequently, a different EC product, Plan B, became the center of a political firestorm during the George W. Bush presidency. The makers of Plan B asked that the FDA approve "over the counter" (OTC) status for the drug, arguing that ample scientific evidence demonstrated the safety of such a move. This application was subject to numerous delays and, predictably, the vociferous opposition of antiabortion forces, but finally was approved by the joint advisory committee of the FDA in 2003. Nevertheless, in an unprecedented action, Steve Galson, the acting head of the FDA's Center for Drug Evaluation and Research, rejected the recommendation of the advisory committee. He argued that Barr Laboratory, the makers of Plan B, had not shown that "young adolescent women" could safely use the drug "without the supervision of a practitioner." As Prescott points out, this was the first time that the FDA had ruled that a drug be assigned a prescription status based on age. Barr Laboratory resubmitted its application, including data that demonstrated the drug could be safely used by adolescents, but the FDA repeatedly postponed its decision over the next two years. This postponement, widely believed to be driven by the Bush administration's desire to please its social conservative base, led to the well-publicized resignation of Dr. Susan Wood, head of the FDA's Office of Women's Health. Not until Senators Patty Murray and Hillary Clinton made good on their threat to hold up the confirmation of a new head of the FDA did the agency finally release its decision in 2006: approval for over-the-counter status was granted, but only for women 18 and older. Later a judge ruled that this order had to also encompass women who were 17. Advocates again pushed to extend this ruling to those under 17, leading to the Obama administration's overturning of the 2011 FDA decision mentioned above.

Most readers of this book will probably already be aware of the two main opponents in the enduring conflict over

EC—on the one hand, antiabortion forces, who have relentlessly argued that EC itself is an "abortifacient," and on the other, reproductive health advocates wishing to extend women's contraceptive options. A particularly valuable contribution of this book is Prescott's tracing of the internal dynamics and shifting alliances within the reproductive health community. In this regard, it is fascinating to note the counterintuitive nature of the positions held by some of the main actors: the physicians who pushed for the demedicalization of EC by advocating for OTC status and freely handed out prescriptions of the drug to participants at the gigantic 2004 March for Women's Lives in Washington, versus some of the best-known feminist health organizations, such as the National Network for Women's Health, which were initially wary about making EC available over the counter due to concerns about safety factors and the fact that insurance programs typically do not cover non-prescription drugs. Eventually, as Prescott concludes, "Emergency contraception has served as a bridge issue that has brought together former adversaries, including feminist health organizations, population and family planning people and groups representing women of color."

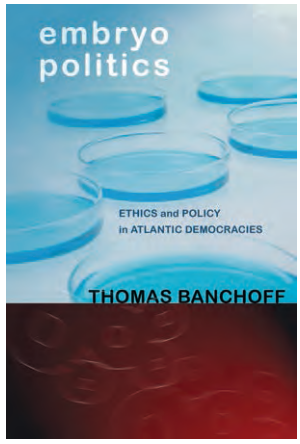
Even without knowing about the latest setback to EC that occurred during the Obama presidency, Prescott ends her book on a sober note. She points to the fact that EC has not lived up to the most positive scenarios depicted by some of its earliest promoters because the availability of the drug has not appreciably affected the unintended pregnancy rate in the United States. (Nor, one should point out, has the drug's availability led to the outbreak of "promiscuity" warned of by its detractors.) Most compellingly, Prescott acknowledges the economic inequalities in the US that decades of feminist health activism have been unable to address, and which "pose an insurmountable barrier to those unable to afford the products of this self-care revolution." ■

Body Building: Intervention in Evolution

By Gail Grossman Freyne

Embryo Politics: Ethics and Policy in Atlantic Democracies
Thomas Banchoff
(Cornell University Press, 2011, 272 pp)
978-0-8014-4957-4, $35.00

A FEW SHORT YEARS BEFORE the turn of the century Dolly the cloned sheep was born. "It's unbelievable," said Princeton geneticist Lee Silver in a 1997 *New York Times* article titled "Science Reports First Cloning Ever of Adult Mammal." "It basically means there are no limits. It means all of science fiction is true," Silver continued. That may seem like an oxymoron, but the same article features another medical expert musing about an idea he'd once had for a fictional tale about a scientist who obtains a spot of blood from the cross on which Jesus was crucified, and then uses it to clone a man. The lines between fiction and reality have already begun to blur. Just what may soon be possible is made clearer by Thomas Banchoff's *Embryo Politics: Ethics and Policy in Atlantic Democracies.*



Banchoff does not fall prey to the allures of science fiction and he avoids sensationalism, but his book is sensational. It is an exciting read and should generate a great deal of public interest because it sets out with clarity the many strands, both ethical and political, that make up in vitro fertilization (IVF), stem cell research and cloning. The author takes us on a journey through space and time: across four countries during four decades. The countries are the United Kingdom, France, Germany and the United States. In 1968 the first human egg was successfully fertilized outside the womb in Cambridge, England. In 1978, the first IVF baby, Louise Brown, was born. The derivation of human embryonic stem cells in 1998 led to the first verified cloning of a human embryo in 2008. Also in 2008 the British government disclosed that it had permitted scientists to solve the problem of the shortage of human eggs for research by the creation of animal-human hybrid embryos as a source of stem cells. This high-tech innovation paradoxically feels like being plunged back in time to ancient Greece and Rome and myths about centaurs, satyrs and other half-human creatures.

GAIL GROSSMAN FREYNE, LLB, PHD, *is currently a family therapist and mediator in private practice in Dublin, Ireland (www.gailfreyne.org). She has previously worked as a lawyer in Melbourne and Queensland in Australia and in New Orleans, La. She is the author of* Care, Justice & Gender: A New Harmony for Family Values *(Veritas, Dublin).*

It is my belief, as I laid out in *Care, Justice and Gender*, that philosophical reflection is always ultimately pared down to two questions: What is human identity and what is the best way for human beings to live together? As Banchoff's tale unfolds, the crux of human identity is contained in the question: is a human embryo a fully human being? Does it become human at the moment of conception or implantation? Is conception an event or a process? In an attempt to answer these and related questions, the author makes many suggestions about the best way for the embryo, the elderly and everyone in between to live together. Nation-states must deal in politics and policy for the good of all, yet, as the book makes clear, many individual citizens have very different views of what constitutes the common good.

What began with the race to produce the first test-tube baby continued with research that—in the beginning—progressed unhindered by intervention from the Catholic hierarchy. The author reminds us that in 1968 the bishops of England and Wales issued a statement supportive of IVF research, as did the future pope, John Paul I, then Cardinal Albino Luciani, who sent public congratulations to the Brown family. But IVF programs require many more fertilized eggs than are implanted. What is to be done with those that are left over?

As far as the Catholic hierarchy led by Pope John Paul II and Cardinal Joseph Ratzinger was concerned, IVF as a fertility treatment was to be completely rejected. The embryo—and they did not pronounce upon whether it had a soul or not—was to be treated as a human being with all the attendant rights from the moment of conception. Theologians differed in their opinions on IVF. One German Jesuit theologian, Karl Rahner, wondered whether rights could attach to the 50 percent of the eggs that failed to implant. Bernard Häring, another theologian from Germany, reasoned that if twins are not formed until two weeks after conception then "individualization seems not yet to have reached that point which is indispensable to personhood." Therefore, if the embryo up to two weeks is not a person, then maybe research, carefully controlled, should be permitted.

Once IVF was established as a fertility treatment, the contours of the debate began to widen. Respect for the embryo was universal, but was not biomedical research, underpinning an ethic of healing, also a moral imperative? As time passed, the debate became more polarized. The Catholic hierarchy and the Evangelical community in North America fused the issues of embryo research and abortion. Scientists, on the other hand, increasingly emphasized the healing powers of research. During this period it became clear that an ethic of rights was competing with an ethic of care. It was a classic case of defining the problem as an either/or situation when what was required was a both/and solution.

Banchoff describes this polarization as being most intense in the United Kingdom and the United States, at least in public debate. In America a ban on federal funds for embryo research was upheld even while private research was allowed to proceed unimpeded and unregulated. Britain was the most permissive, allowing embryo research—even the creation of embryos for this purpose—under carefully monitored conditions. In Germany, and to a lesser degree in France, the legacy of Nazi eugenics was the determining context for controversy. The idea that experimentation might interfere with the dignity of the human person informed both secular and religious thinking. As a result, eugenic anxieties led to a total ban on research. France, with its separation of church and state established by legislation passed in 1905, is a secular political culture. Even French Catholics couched their arguments about embryo

Reports Worth Reading

Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008
G Sedgh et al., The Lancet, *January 19, 2012*
Using data from the Guttmacher Institute and the World Health Organization, this report demonstrates that the global abortion rate has leveled off. Between 1995 and 2003, it decreased from 35 to 29 per 1,000 women of childbearing age, but seems to have reached a plateau in 2005, when the rate was 28. Chief researcher Gilda Sedgh said, "This plateau coincides with a slowdown in contraceptive uptake. Without greater investment in quality family planning services, we can expect this trend to persist." A breakdown by region showed that liberal abortion laws tend to be associated with lower abortion rates. Also examined are health and mortality measures associated with unsafe abortion and trends specific to the developing world.

Who Decides? The Status of Women's Reproductive Rights in the United States
NARAL Pro-Choice America Foundation, 2012
The year 2011 was an eventful one on the reproductive heath front. The 21st edition of *Who Decides?* helps make sense of the changing picture of choice in the US. State laws and legislative activities related to choice issues are listed according to topic (insurance, counseling rules, emergency contraception, low-income women's access to family planning, etc.) and also depicted by state in map form. The overall tenor of state and federal legislative bodies is mapped out according to where policymakers come down on the choice issue.

research in non-theological language. The result was the same as in Germany: experimentation on embryos was banned. Interestingly, it was Immanuel Jakobovits, chief rabbi from England and an expert in Jewish medical ethics, who provided a possible philosophical bridge. He supported research with surplus IVF embryos for worthy goals but insisted that "no embryo should ever be generated for the purpose of experimentation." Ultimately, both France and Germany criminalized all destructive embryo research.

So far, Banchoff's narrative has been concerned with my first question: what is human identity? Each nation was from the beginning concerned with the rights of the embryo, its protection and the contours of human dignity. Now, breakthroughs at the turn of the century in stem cell research and cloning suddenly offer the prospect of regenerative medicine—or, as Banchoff describes it, "a future horizon of regenerative medicine burst onto the public imagination." Immediately, new ethical considerations move the discussion to my second question: what is the best way for human beings to live together? What constitutes human flourishing? Embryo science's new concern with healing gave new traction to the ethic of care.

Not surprisingly, the official stance of the Catholic hierarchy did not change. In the summer of 2000 the Vatican stated again that the destruction of embryos was "a gravely immoral act and consequently gravely illicit." As Banchoff notes, it addressed an ethic of healing head-on with the familiar argument that the end does not justify the means.

At the same time, there were others who thought that new technologies might require new thinking. In 2006 a Japanese team reprogrammed adult body cells to act like embryonic ones. These induced pluripotent stem cells (IPS) held out the possibility of regenerative medicine without the destruction of embryos as, of course, did the use of adult stem cells. Then followed the procedure known as Preimplantation Genetic Diagnosis (PGD), a procedure that screens human embryos before transfer to the womb. Cystic fibrosis and Down syndrome may be identified early while the sex of the child can now be determined with certainty. The author quotes a 2006 study in the United States that found that three-quarters of US-based fertility clinics surveyed offered PGD services and two-fifths offered a sex-selection option. A healthy child of the gender of one's choice became closer to being a certainty. The next logical step might be genetic enhancement, meaning that Huxley's *Brave New World* is getting closer to science than fiction. What the German government once idealized—a society of healthy boys with fair hair and blue eyes—could now be created by science in the service of eugenics.

Certainly the old questions concerning the moral status of the embryo persist with respect to these new technologies, but they also raise new and larger questions about human freedom and equality, even the future of human evolution. Children selected or engineered for certain traits could be said to lack a degree of autonomy. Uneven access to technologies would simply reinforce social inequalities and the health of the poor would suffer disproportionately. As Banchoff points out, genetic enhancement could lead to a genetic caste system or even a race of superheroes.

As the book draws to a close there is a sense that the ever-present tension—in all four countries stretching through all four decades—between protecting life and alleviating suffering is in danger of becoming an unbridgeable chasm. As the rift widens there seems to be little policy discussion or political drive for regulation. The doers are far outpacing the thinkers. Most disturbingly of all, as the quality of public ethical debate declines there is no guarantee that ethical reflection will be central to the future of embryo politics. If you refuse to discuss the question, how can you be part of the answer?

For this reason, I have no hesitation in recommending this book. It is a store of information presented in a comprehensive, lucid and accessible format for the lay person. While Banchoff raises questions for the reader's consideration, the book does not contain comprehensive answers. Not because the author has failed in his task, but because such answers do not exist. As in most, if not all, moral reflection, we need to be satisfied with the best answers we can produce for the present, always acknowledging that as new technologies and circumstances come to light we might have to alter these answers. The proclamation of an absolute truth, even the search for it, is never wise. Human beings, however we define them, are finite creatures and so are the answers we produce. If ethical reflection teaches us anything it is that the questions are always more important than the answers—no matter on which side of the Atlantic we find ourselves.

The last word on these emerging debates belongs to Simone Veil, the French lawyer and government minister who suggested to her colleagues in the National Assembly, "The progress of knowledge is a challenge for the collective conscience." ■

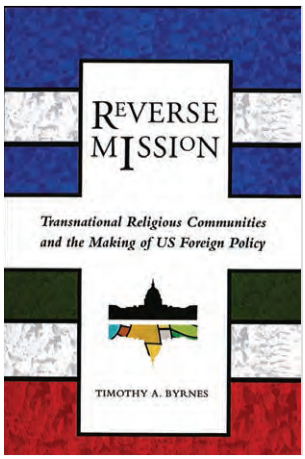
In 1968 the bishops of England and Wales issued a statement supportive of IVF research, as did the future pope, John Paul I, then Cardinal Albino Luciani.

The Ties that Bind: Religious Communities and Political Change

By Sarah Raleigh-Halsing

Reverse Mission: Transnational Religious Communities and the Making of US Foreign Policy
Timothy A. Byrnes
(Georgetown University Press, 2011, 196 pp)
978-1-58901-768-9, $26.95

UNITED STATES FOREIGN policy has been profoundly shaped by the desire to contain perceived threats of communism in Latin America, preventing them from reaching the US's backyard. Following this strategy in the 1970s and 1980s led to a history shared by many countries in the region—one of political repression, civil war, poverty and the installation of brutal military dictatorships supported and aided by the US. Drawing on his previous work and interest in religion and politics, Timothy Byrnes gives a unique perspective on the influence religion plays in shaping US foreign policy decisions in Latin America in his book *Reverse Mission: Transnational Religious Communities and the Making of US Foreign Policy.*



The title of the book is taken from the Maryknoll belief that, in addition to spreading the word of God and sharing in the plight of the communities where they are posted on religious missions, the consciences of US citizens and actions of the US government are also fair game for missionary work. Defining the term for the broader context, Byrnes states that a "reverse mission" is the process by which a religious community or some of its members advocate on behalf of their religious brothers and sisters abroad who are affected by US foreign policy but have no leverage in the United States to address their grievances. The book moves beyond a general history of liberation theology and the Catholic church's social justice work in Central America and Mexico and provides an in-depth and compelling examination of how religious communities have created change.

In the case of the Jesuits, one of the order's guiding principles, education, tied the men of the US Jesuit community to their counterparts in El Salvador. The 1989 murder of six Jesuit priests from the Universidad Centroamericana in San Salvador at the hands of the Salvadoran military was the catalyst for action by Jesuit leaders in the US. Following the murders, they spoke out against United States foreign policy, advocated for change in El Salvador and demanded legal action against the murderers.

The Maryknoll sisters' connection to Nicaragua represents a different approach to transnational religious communities advocating for change in US foreign policy, in the sense that the Maryknoll order has a traditional focus on missionary work. After witnessing the poverty, economic and social disparities and political repression in Nicaragua, many Maryknoll members returned to recount their experiences at Masses across the country and to ask for money for the people of Nicaragua. They also educated the American public about the violence inflicted on Nicaraguans at the hands of the counter-revolutionary forces known as Contras, who were supported by the US military and the Reagan administration. Many of the sisters expanded their missionary education work beyond the confines of Catholic parishes and schools and spoke at public rallies, non-Catholic religious institutions and NGOs in the United States.

In the third case study, Byrnes examines the Benedictine brothers at the Western Priory in Vermont. A traditionally monastic order, in the 1970s the brothers established a close bond with a group of Benedictine nuns living in Mexico known as Las Misioneras Guadalupanas de Cristo Rey. This connection served as an educational opportunity not only for the brothers, who learned about the political, economic and spiritual realities of their sisters in Mexico and the community they serve, but also as an outreach opportunity for US citizens as a whole.

The Western Priory community helps organize retreats for US laypersons who wish to spend time living at the Guadalupe Center, an outreach center run by the Benedictine sisters that offers support and services to the poor of Cuernavaca, Mexico. The experience of "la realidad [the reality] of Mexican poverty" helps make connections between the economic and political dynamics in the US and Mexico that retreat participants can take back to the community.

Byrnes argues that the level of influence attained by the religious communities in these case studies was dependent on the institutional structure and mission of the three communities he researched. For

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example, the Jesuits maintain the same military structure and outward disciplinary ethos established by the order's founder, Ignatius of Loyola, which helped them as the US community's leaders lobbied for change by using their political connections. Respected Jesuit universities like Georgetown University and Boston College were also well-placed to gain media attention and political support to change US relations with the Salvadoran government while advocating for legal action against their colleagues' murderers.

There are parallels between the rationales for action of the Maryknoll sisters and the Jesuits, two communities whose members confronted the murder of their colleagues at the hands of a US-supported military or government. The transnational community the Maryknollers established differed from that of the Jesuits in that the group they connected with was not other sisters or Americans doing aid work, but the Nicaraguan people themselves. Thus, the channels through which Maryknoll sisters advocated for policy change were less tied to traditional means of lobbying on Capitol Hill in Washington, DC, or working to influence the political elite. Byrnes does cite Speaker of the House Tip O'Neill, whose support for the Maryknoll campaign to change US policy in Nicaragua was linked to his close friendship with Sister Peggy Healy. The author concludes that the Maryknoll community's greatest impact on policy was due to the "sisters' efforts to evangelize US citizens by informing them of what was being done in their name."

The Benedictine brothers of Vermont's Western Priory have probably the least traditional means of advocacy for US policy change, which they use to improve the lives of Mexicans who are served by the nuns of the Benedictine order in Cuernavaca, Mexico. Like the Maryknollers, the brothers had an indirect approach to a reverse mission. They created groups of laypeople who cared deeply about the fates of the people of Mexico and spoke out against US foreign policy that had adverse effects on Latin Americans.

Drawing specific causal links between advocacy, influence and policy change is, as Byrnes states, "like trying to identify a black cat in a garbage can at night." That being said, the influence of these religious communities was felt in tangible policy changes. The Jesuits' role in influencing Congress to reduce US financial support to the Salvadoran government and consequently the Salvadoran military was significant. US Representative Nancy Pelosi stated on the floor of the House of Representatives, "Many of us in this body belong to the Jesuit family; either we have brothers, sisters or children who have been educated by the Jesuits, and know the close ties that bind…. We have been hearing from those of the Jesuit family for a ceasefire, for a negotiated settlement, for an investigation into the slayings and a second look again at our policy in El Salvador." Other prominent members of Congress like Senators Patrick Leahy and Chris Dodd also had direct and personal ties to the Jesuit community which they shared during congressional debates.

The Jesuit connection and the already percolating discontent in Congress toward US foreign policy in El Salvador resulted in military aid being cut in half in 1990. The financial support for the Salvadoran military was subsequently reinstated the following year as a bargaining tool to keep the military involved in peace accords, which were signed in 1992.

While public influence and political power certainly play a central role in creating policy change, Byrnes makes the important point that individuals and local groups, even those lacking the political influence of religious groups like the Jesuits, still play a significant role in challenging US foreign policy. The Sanctuary Movement, for example, was started in the early 1980s in Arizona by two men who assisted refugees in border crossings and asked local churches to house them. The churches offered sanctuary for those fleeing violence and poverty in Central America and Mexico, with the idea that immigration officials were less likely to force their way into a house of worship to apprehend refugees. The movement spread across the country, enlisting churches and monasteries as safe havens for individuals and families fleeing their home countries to escape political regimes. Without directly working against the US foreign policy—and US-funded militaries—that brought families across the border, the Sanctuary Movement sought to soften the humanitarian impacts of those policies.

The author briefly analyzes ideological shifts within the Catholic church during the 1960s, including the assassination of Archbishop Oscar Romero, liberation theology and the Second Vatican Council's vision of a church that is open to the world. These all profoundly influenced the Jesuit, Maryknoll and Benedictine orders, raising the political consciousness of these communities and helping them organize for maximum effectiveness as advocates for change.

In his analysis of the Maryknoll and Benedictine orders, Byrnes touches on the important role gender plays in defining roles in each group, as well as how gender can define the type of reverse mission and policy impact created. The contrast between feminine and masculine roles in religious orders deserves a more thorough investigation, but for a book whose thesis is defining how a particular transnational religious community affects US foreign policy, the author moves skillfully beyond the paradigms often used in comparative politics and political science that tend to omit both gender and community.

I found myself reading Mr. Byrnes' book with a deep interest in his comparison of the methodologies used by the three religious communities to implement policy changes. One of the most powerful arguments I found in the book was that change at the international level—and, I would argue, at the national level—is less driven by the concept of ethnic or national origins tying people together to advocate for change. Rather, the ties that bind are from a fundamental drive to identify and connect with those who share the same communal loyalties that we hold ourselves. ■

"[It] is about the size of an 18-hole golf course, so it's not that big." [1]

—Cardinal Timothy M. Dolan, describing Vatican City to journalists before his elevation to cardinal.

"As Catholic pastors, we wanted to remind the Governor that conscience, while always free, is properly formed in harmony with the tradition of the Church, as defined by Scripture and authentic teaching authority. A personal conscience that is not consistent with authentic Catholic teaching is not a Catholic conscience. The Catholic faith cannot be used to justify positions contrary to the faith itself." [2]

—Cardinal Francis George of Chicago, in a letter to the *Chicago Sun-Times*, criticizing how Governor Pat Quinn characterized his meeting with the bishops. Quinn said it focused on the poor; the bishop claimed it focused on abortion.

"Not everyone wants to talk about it, but that is a clear factor in the decline of the Catholic community." [3]

—Bishop Alexander Sample of Marquette, Mi., on the role of contraception in the declining Catholic school population.

"I can see [American Catholics being arrested for their faith], yes." [4]

—Cardinal Raymond Burke, head of the Apostolic Signatura, the Vatican's supreme court, speaking about the "war" between secularism and Christian culture in the US, which "will destroy us" if secularized culture prevails.

"We have only to look at Nazism and Communism and the manner in which they violated religious freedom to see how similar it is in today's world with the desire to redefine human life and its origins; to justify abortion; to redefine marriage to justify same-sex unions; and to redefine medical care to justify abortion, contraception, and euthanasia and then to impose these new definitions on people of faith." [5]

—Bishop Samuel J. Aquila of Fargo, North Dakota, comparing present-day health and social policies to those of the Nazis.

"Organizers (of the pride parade) invited an obvious comparison to other groups who have historically attempted to stifle the religious freedom of the Catholic Church. One such organization is the Ku Klux Klan.... It is not a precedent anyone should want to emulate." [6]

—Cardinal Francis George of Chicago, criticizing organizers of an LGBT pride parade.

"Women lie when they say they were raped." [7]

—Bishop Luiz Gonzaga Bergonzini of Guarulhos, Brazil, alleging that women claim they have been raped in order to access abortion services, which are legal in the case of rape.

"Pride of place goes to the family, based on the marriage of a man and woman. This is not a simple social convention, but rather the fundamental cell of every society. Consequently, policies which undermine the family threaten human dignity and the future of humanity itself." [8]

—Pope Benedict XVI called for "policies which promote the family" and the restriction of marriage to one man and one woman in his "State of the World" message to Vatican diplomats.

"It is very hard to give the church a fair shake when the church itself confuses the hell out of people." [9]

—Journalist Charles Lewis on the Vatican's "communication problem," explaining why "criticizing the Vatican shouldn't always be a sign of anti-Catholicism."

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1 Sharon Otterman, "His Message in Rome: New York Isn't Sin City," New York Times City Room Blog, February 14, 2012. **2** Neil Steinberg, "Is It Still OK to Elect Catholics?" *Chicago Sun-Times*, December 18, 2011. **3** Jim Graves, "Bishop Alexander Sample on the Need for a Renewal of Orthodoxy," *Catholic World Report*, November 1, 2011. **4** David Kerr, "Cardinal Burke Reflects on his First Year in the Sacred College," Catholic News Agency, November 28, 2011. **5** Bishop Samuel J. Aquila, "We must bring Christian values to public square to build just society," *New Earth* (Fargo, ND), December 2011. **6** Brian Slodysko, "Cardinal defends Klan comparison," *Chicago Tribune*, December 29, 2011. **7** PragmatismoPolitico.com.br, "Absurd: Bishop suggests that women are only raped when they want to be," June 20, 2011. **8** Philip Pullella, "Gay marriage a threat to humanity's future: Pope," Reuters, January 9, 2012. **9** Charles Lewis, "Criticizing the Vatican Shouldn't Always Be a Sign of Anti-Catholicism," *National Post*, November 2, 2011.

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Changes in abortion laws between 1997 and 2008[1]

Countries that expanded the grounds for legal abortions 17
Benin, Bhutan, Cambodia, Chad, Colombia, Ethiopia, Guinea, Iran, Mali, Nepal, Niger, Portugal, Saint Lucia, Swaziland, Switzerland, Thailand and Togo

Regions that liberalized abortion laws 2
Mexico City, parts of Australia

Countries that further limited restrictive laws 3
El Salvador, Nicaragua, Poland

Correlation between abortion law and abortion rates[2]

Restrictive laws	Abortion rate per 1,000 women of childbearing age in 2008
Africa	29
Asia	28
Latin America	32

Liberal laws	Abortion rate per 1,000 women of childbearing age in 2008
Eastern Europe	43
Western Europe	12
North America	19

Abortion-related deaths per 100,000 procedures[3]

United States 0.6
Worldwide 220
Sub-Saharan Africa 460

Yearly health impact of unsafe abortions in the Global South (2005 data)[4]

Women who need medical attention for complications . . . . . 8.5 million
Women who need medical attention but do not receive it . . . . . 3 million

1 Guttmacher Institute, "Facts on Induced Abortion Worldwide," January 2012.
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