2014

Centre for Cultures of Reproduction, Technologies and Health (CORTH)

University of Sussex

CONFERENCE REPORT

RE-SITUATING ABORTION:

BIOPOLITICS, GLOBAL HEALTH AND RIGHTS IN NEOLIBERAL TIMES

13th-century manuscript of Pseudo-Apuleius's *Herbarium*: a midwife prepares a pennyroyal concoction, *Contraception and Abortion from the Ancient World to the Renaissance* by John M. Riddle

IDS Institute of Development Studies

brighton and sussex medical school

wellcome trust

Sussex Research

Contents

Introduction

On 13th and 14th November 2014, the newly-launched Centre for Cultures of Reproduction, Technologies and Health (CORTH) at the University of Sussex held an inaugural workshop on 'Re-Situating Abortion: Bio-Politics, Global Health and Rights in Neo-liberal Times'. The event brought together an international group of senior and junior researchers, practitioners and policy makers to deliberate upon the relationship between abortion, globalisation and neo-liberal reform. The meeting addressed the transformation occurring in medical and legal cultures, its effect on practitioners, and on the lived experience of abortion across the Global North and South. Participants debated whether new forms of health governance and rights-based development paradigms present new opportunities or limit abortion provision conceptually and 'on-the-ground'. The workshop served as a platform to launch the Centre's Reproduction, Technologies and Health network.

As an event that explicitly set out to re-situate abortion, the workshop's key themes included the issue of sex-selective abortion in the Global North and South, the modern landscape of reproductive technology, and researching neoliberal construction and subjects through the issue of abortion. In her opening address to the conference, Maya Unnithan, Director of the Centre, pointed out that for its inaugural event CORTH was tackling the marginalised topic of abortion in a way that emphasised the importance of not only an interdisciplinary conversation, but of a dialogue between the Global North and South.

The workshop was organised into six thematic panel sessions on i) the experiences and narratives of abortion, ii) the challenges of son preference and sex selective abortion in the UK, iii) the moral context of abortion in law, policy, and individual narratives, iv) abortion and reproductive governance, v) abortion litigation and policy frameworks, and also, vi) a roundtable session on practitioner based insights

The workshop featured lively debate and ended with discussions on potential future collaborations. In the final wrap-up session participants deliberated on the future of the newly-formed network of abortion researchers, proposals for the publication of the papers presented at the workshop, and the setting up of a virtual space through which to stay in touch and continue to share knowledge and host discussion. The workshop launched CORTH as a dynamic and interdisciplinary Centre, and showcased a wide array of contemporary, global and critical abortion research and practice.

Session One: Experiences and Narratives of Abortion

Session One opened with a paper presented by Tulsi Patel (University of Delhi) entitled 'Experiencing abortion rights through issues of autonomy and legality'. This was followed by Gillian Love's paper (University of Sussex) entitled 'Contextualising abortion: A life narrative study of abortion and social class.' Presenters Patel and Love explored the factors that play in to the decision to end a pregnancy; Patel through the lens of sex-selective abortion in India, and Love through the issue of social class in the UK. Both raised questions about received wisdom regarding women's experiences and decision-making, and the methodological choices researchers are faced with in order to challenge this.

Patel began by outlining the context of abortion in India. Abortion has been legal since 1971 where it emerged as a development issue, in contrast to its framing in terms of reproductive rights in other countries such as the US and the UK. Abortion provision neatly fell in alongside the anti-natalist policy of the Indian state who were (and are still) pro-active in framing family planning as a population reduction strategy for the country. Although abortion is legal in India, 56% of abortions are unsafe.

This fact raises questions about risk and choice for Indian women. Census data indicates that there is a disparity in the number of girls born each year to the number of boys, suggesting that sons are being favoured. The Indian state has banned sex-selective abortion, and as a result medical gatekeepers must keep information about the sex of a foetus – which can be determined at 20 weeks gestation – from potential mothers. Indeed, Patel remarked that the effect of these regulations means that sex-selective abortion as such is not illegal; knowing the sex of the foetus is. Despite this, women who can afford to can pay to discover the sex of her foetus.

In keeping this information from women, Patel argues that they are being left to make crucial decisions about their families and finances blindly. Rather than a simple aversion to daughters, sex-selective abortion is often carefully considered by pregnant women, who balance their obligations both to family and society in deciding whether to go ahead with the pregnancy of (in many cases) another girl. There are many competing factors at play in women's decisions; for example, despite the fact that in 2005 daughters were legally granted the right to inherit property, this law is not well implemented. Overall, as the sophistication of

reproductive technology has advanced, regulation over women's access to the knowledge this technology imparts (such as the sex of the foetus) has increased, and only the wealthy have access to this knowledge.

The issues of stratified reproduction and medical gatekeeping were also prominent themes in Gillian Love's paper. She presented a rationale for her doctoral research into social class and abortion narratives in the UK by suggesting that the current climate of austerity creates a timely opportunity to examine the ways in which neoliberal discourses appear (or are absent) in women's narratives around reproduction. Social class – in the Bourdieusean sense of a matrix of economic, social and cultural factors – has historically been an important part of the construction of womanhood; working-class women have always been the deviant Other against which regulated, chaste middle-class femininity is defined. Previous research has indicated that women in different class locations hold different attitudes to motherhood and abortion; for example, middle-class women are more likely to delay childbearing, and to terminate pregnancies in their early adulthood.

These issues come together in discourses about women's reproduction, for example in the ubiquitous trope of the 'chav mum': the stereotypically vulgar, promiscuous working-class woman with a gaggle of children who shuns work and claims benefits instead. Such stereotypes embody fear of working-class women's reproduction, and are echoed in political discourse which shames single and young mothers. The same issues are also apparent in abortion practice; some research suggests that medical practitioners mobilise class as one factor in determining whether an abortion is justified, implicitly valuing middle-class women's fertility above working-class women's. As well as discourses *about* women's reproduction, it is necessary to examine women's own narratives about their decision to end a pregnancy and how this event lies in context of their economic, social and cultural position.

In recent years, the UK's Coalition government has been rolling back the welfare state, and both politicians and the media have engaged in victim-blaming rhetoric which scapegoats the poor and seeks to manufacture consent for austerity measures. In both Love and Patel's paper, the role of the state in attempting to regulate women's reproduction in some capacity, through discourse or through provision of medical technology, featured prominently, as well as the role of medical practitioners as gatekeepers.

Discussion following the opening papers was lively. Methodological issues were discussed, particularly in relation to Love's paper. The difficulty of accessing the narratives of women

with experience of abortion was raised, and it was agreed that researchers must be adaptable and creative in their recruitment; experienced researchers in this area shared their reliance on a wide variety of recruitment methods including snowballing, and approaching and becoming a part of mothers' groups.

Questions were also raised about the role of the law and its potential for counterproductivity, particularly in the context of India where laws around different aspects of reproduction have developed separately and can clash. In addition, the role of medical gatekeepers was an issue that provoked reflection both about the difficult job practitioners must do in balancing legal requirements with the welfare and autonomy of women.

The importance of factoring in the state's agenda when researching women's experiences was also emphasised; for example, considering how, in an anti-natalist state, individual narratives might be affected. The final reflection of the discussion was on the usefulness of this framing to connect the macro-level world of abortion policy and law to the micro-level experiences and narratives of women.

Session Two: Challenges of sex selective abortion

The second session focused on the challenges of sex-selective abortion in the UK. Featuring papers from Navtej Purewal (SOAS), Sylvie Dubuc (University of Oxford) and Ellie Lee (University of Kent), this session tackled the controversial issue from many angles including research on women's narratives and postcolonial discourse, the importance of quantitative data, and the importance of examining the effects on practitioners and the law that a ban on sex-selective abortion might entail. The three papers presented were varied in focus, but had a number of commonalities. The first shared theme was the issue of misrepresentation of data and the role researchers can play in informing the debate around sex-selective abortion in the UK. The role of the British media was also scrutinised, as well as the tropes and stereotypes the media have invoked in the debate. Finally, the discussion turned to researchers' relationships with abortion practitioners in the UK, and how those relationships can be strengthened in a time when practitioners are under unprecedented scrutiny.

The context of a proposed amendment to the UK's abortion laws was explored in all papers, particularly in those of presenters Dubuc and Lee. In November 2014, the Abortion (Sex-selection) Bill was given its first reading in Parliament, sponsored by Conservative MP Fiona Bruce; the bill seeks to clarify the law around abortion by explicitly banning sex-selective abortion. The bill's supporters claim that the Abortion Act's terms do not stretch to allowing sex-selective abortion, but that those terms are insufficiently clear, thus allowing doctors to permit the practice. Whilst Private Members' Bills such as this rarely proceed to becoming part of UK law (a particularly notable exception being the original Abortion Act of 1967), its first reading culminated in a vote of 184-1 in favour, meaning it will proceed to a second reading in January 2015.

The issue was covered widely by the British media in the run up to the bill's first reading. Purewal in her paper, 'Lost in the data: Exploring evolving contexts and contestations of enculturation and sex selection in the South Asian diaspora,' argued that much of the media discussion was divorced from a post-colonial framework; sex-selective abortion in the UK is an issue associated with the South Asian community, and the media has reinforced the trope of the deviant migrant and the discourse of assimilation in relation to the practice of prenatal sex-selection. The direct links to the civilising mission of the British colonial forces, and the

interventions enacted in the name of that mission, were emphasised in Purewal's paper and in discussion following the session.

The role of the media in Dubuc's paper, 'Implications of preference and prenatal sex-selection against females' was also a theme; she pointed out that the media attention to the issue of sex-selective abortion running up to November 2014 was preparing the nation for the introduction of the Abortion (Sex-selection) Bill. Less than 5% of Indian-born women engage in the practice of prenatal sex-selection in the UK, a fact that not all of the British media accurately reported. Whilst acknowledging that public perception and stereotyping of certain groups can be worsened by highly aggregated data, which must make broad ethnic and national groupings, Dubuc averred that failing to communicate quantitative evidence creates an open door for misinformation and further Othering of the South Asian population. One participant in the discussion following the session commented on the importance of not 'leaving others to interpret research for us', and to be proactive in using the data we have to make strategic gains (the example used was the use of maternal mortality data successfully prompting the provision of better post-abortion care in Nigeria). In tandem with Dubuc's call to further the use of quantitative data, Purewal's work on the lifecourse narratives of South Asian women was presented as a way to 'read between the lines' of the big data, paying attention to narratives of gender and diaspora.

The argument of both papers was that research must inform the debate which balances gender inequality on one hand and reproductive autonomy on the other. Lee followed with her paper, 'The "sex selection" controversy in Britain: Where does it leave abortion law and practice?'. She argued that the sex-selection bill is not about gender equality, but about furthering the pro-life agenda through shifting the rhetoric around abortion and undermining abortion law and practice. She noted that a key theme of feminist work on abortion has been critique of the medicalization of abortion, and arguing that the Abortion Act 1967 places the abortion decision not in the hands of women, but in the hands of doctors, whose authority is regarded by law as indubitable in this context.

The increased scrutiny of abortion practice in recent years, however, presents a challenge to this emphasis on medicalization, as practitioners have been targeted for investigation by ex-Health Secretary Andrew Lansley on the suspicion of carrying out sex-selective abortions (a claim made by the newspaper the Daily Telegraph). An advantage of medicalisation is that abortion is somewhat protected by being firmly a matter of public health and in the realm of

doctors' expertise. From a scandal over pre-signed abortion documents to an 'exposé' in the British media ostensibly revealing that doctors are willing to perform sex-selective abortions, not only doctors but the Abortion Act itself is undermined by the introduction of restriction, Lee argued. Currently, the Abortion Act is silent on sex-selection, and indeed on any specific reason a person might have to request an abortion; doctors must simply conclude in good faith that a continued pregnancy would harm a pregnant woman's mental or physical health. The introduction of any restriction specifying which abortions are more justifiable than others opens the door to further restriction.

The discussion following all three papers focused on multiculturalism and the legislation of 'deviant' cultural behaviour. One participant drew a parallel between the debates around sex-selective abortion in the UK to those around female genital mutilation (FGM), both of which are positioned as deviant cultural practices in the UK. Tighter laws around FGM have been introduced in the UK, and several participants argued that taking this picture as a whole is essential as it demonstrates a pattern of legislating around certain groups. The position of self-identified feminists supporting the sex-selection bill was also critiqued, and was linked again to previous 'odd alliances' (as one participant put it) between feminist groups and regressive or neo-colonial legislative procedures on forced marriage, FGM and other issues deemed to be deviant cultural practices. The discussion was rounded off with a consensus that countering these worrying trends is essential, and a current campaign from the British Pregnancy Advisory Service (BPAS) for full decriminalisation was highlighted as a promising effort in this direction.

Session Three: Moral framings

Day two of the workshop began with a session on moral framings of abortion, featuring Jessica Newman (Yale University), Emilomo Ogbe (Belgium and Nigeria) and Lesley Hoggart (Open University). This session was wide-ranging, including analysis of attitudes to unwed mothers and women w

ho have abortions in Morocco, the legal environment in Nigeria, and the moral framings young women in the UK use when deciding to end or continue a pregnancy.

Newman (Yale University) presented reflections from her ongoing ethnography of single mothers' collectives and maternity clinics in Morocco. Focusing on two groups of stigmatised women – unwed mothers and women who have abortions – Newman explored what activists in Morocco referred to as *schizophrénie sociale* (societal schizophrenia or hypocrisy). Abortion is illegal in Morocco, as is pre-marital sex; despite this, hundreds of abortions happen every day and unwed mothers abound. The term *schizophrénie sociale* refers to the relegation of maternal sexuality to the realm of the morally reprehensible despite the rates of unwed pregnancies, child abandonment and unsafe or clandestine abortions which physically disrupt this denial of maternal sexuality.

Unwed mothers in Morocco are positioned as sexually deviant, contrasting with the cultural (and legal) construction of mothers as married, somewhat chaste, and moral. This conflict is reinforced with the positioning of the woman who has an abortion as similarly deviant, although women who have abortions are also seen as victims of greedy abortionists; Newman pointed out that there is no agentic position for women who have had abortions to assume. These complex moral labyrinths are negotiated by women in maternity clinics, who, to access services (which often focus on 'rehabilitating' unwed mothers) must temper their deviance with evidence that they are victims. Newman identified these 'shadowy' areas – the back alley where deviant women become victims of abortionists, and confessional clinics where unwed mothers are judged on their potential for rehabilitation – as crucial to understanding the ways in which women are negotiating a moral context which positions them as without agency.

Newman's presentation had interesting links to Emilomo Ogbe's (Belgium and Nigeria) paper, 'Abortion stigma and definitions of womanhood in Nigeria.' Abortion is also illegal in

Nigeria, where both doctors and women who seek abortions are criminalised. It is in the 'shadowy' areas here, too, that interesting conflicts can be found. For example, Ogbe's analysis of national policy documents and strategies shows that there is an acknowledgement of the need for post-abortion care for the many women who suffer complications from unsafe abortions; this is framed as a public health concern which is tied to maternal mortality rates (a framing Newman also identified in Moroccan activism against unsafe abortion). The provision of post-abortion care has been exploited by some doctors to allow them to train medical staff in abortion techniques like vacuum aspiration.

The stigma surrounding abortion in Nigeria also relates to other discourses about reproductive health – abortion and contraception are perceived by many women to carry heavy risks, such as infertility – and in West Africa, infertility rates are high. In Nigeria it is not easy for many women to have a fertility or sexual health check-up from a medical professional, or have an open conversation with family or friends about sexual health and contraception, and the only time many women access health services are as mothers, or as someone who is infected with HIV. Concern about fertility was identified by another participant as salient for women across the Global North and South, as was stigma which surrounds discussion of sexual health generally. It was agreed that in understanding abortion stigma, these other sources of stigma and their relation to constructions of womanhood must be addressed and understood.

Hoggart's paper focused on a very different moral context, but one that spoke to the theme of conflict-ridden moral spaces from the previous papers. Entitled '"I didn't like killing my baby": teenage pregnancy, the construction of risk and the moral framing of abortion in the UK', Hoggart's paper presented findings from several different qualitative studies of young women's experiences with teenage pregnancy and abortion. She identified that whilst teenage pregnancy is positioned by policy (and also wider discourses) as socially undesirable – and abortion as morally undesirable – the young UK women in her studies themselves did not necessarily share these moral frameworks.

The papers identified the theme of hypocrisy which emerged at two levels: firstly, in the incongruence between the relatively liberal Abortion Act and the existence of societally-constructed good or bad abortions, and secondly, as in the way teenage pregnancy and abortion is addressed in policy versus how young women actually experience and perceive these issues. The idea that there are 'good' or 'bad' abortions was regarded as emerging not

so much from the law – which does not specify circumstances under which abortion is justifiable under 24 weeks other than threat to the mother's mental or physical health – as much as from social narratives used to regulate young women's behaviour. For example, young women having multiple abortions in Hoggart's study reported that they were treated by medical staff as if they had to be rehabilitated, and were firmly given recommendations for long-term contraception. Competing moral imperatives could be observed in many women's narratives as a result of experiences like these, and it was the case that where incongruence was identified between their decision and the value systems surrounding them, women were more likely to regret their decision (whether it was to terminate or continue a pregnancy).

The three papers demonstrated that different types of stigma converge in these 'shadowy' moral spaces which women must occupy , spaces in which their autonomy is constrained as mothers, as sexual beings, as villains ('terminators') or indeed as all three. The factors of choice and risk were highly complex in each of the three contexts the papers explored, and were often overlaid with strong moral discourses from family and society and on which law and policy were silent. In the UK, Hoggart suggested that normalisation of abortion was one way for the issue to come out of the 'shadowy' spaces and become part of the everyday. In the Global South, however, participants suggested that strategic use of statistics and concern for maternal health and fertility are important, if imperfect, tools, for combatting stigma.

Roundtable session: Abortion in practice

Bethan Cobley, the Senior Policy Advisor at Marie Stopes International, Roger Ingham (Director, Centre for Sexual Health Research, University of Southampton) and chair Jackie Cassell (University of Sussex) led the roundtable discussion which generated a lively discussion between conference delegates. The theme of the session was that of collaboration and sharing of knowledge between providers and researchers, as well as understanding abortion in practice. Whilst Cobley's paper focused on the international challenge (and opportunities) of providing abortion and reproductive care, Ingham's paper 'Second trimester abortions; women's explanations and experiences' focused on the UK. What emerged from the discussion following the two papers was affirmation that each context spoke to the other in important ways.

Cobley presented some of the challenges and opportunities that MSI face as one of the world's largest reproductive health organisations (MSI operate in 37 countries, providing safe abortion where it is legal, post-abortion care where it is illegal or restricted, and other family planning services). Whilst a goal for MSI is 'leaving no woman behind' in their work to ensure every birth is wanted, they are an organisation that depends on donor contributions, and has the long-term aim of becoming self-sustaining. This means that in some places MSI charge for their services, potentially leading to tension between ensuring MSI can continue operating and provide more services, and the necessity of serving all women who need them. As an international organisation, another challenge is translating an international service to national contexts, an issue that participants raised as a key theme of many of the other conference papers. In some contexts, a focus by MSI on rights and pro-choice politics is replaced by a focus on health. For example, in some countries MSI presents itself primarily as an abortion provider, whilst in others it is seen as a reproductive health service. Cobley expressed the careful balance MSI must maintain in being sensitive to the local contexts in which they operate, in order to better reach women who find it hard to access services, and the importance of working for liberalisation of abortion laws.

The integration of HIV and sexual health services with reproductive services was also raised as an issue that has fallen off the international agenda. Cobley emphasised the benefits of integrating these services for ease of access, but commented that this is not being recognised in international discussions and, in fact, there is sometimes an element of competition

between funding for family planning and HIV services. The importance of addressing both services together was further emphasised by another participant who noted that research in South Africa has found that some providers' attitudes to HIV+ women – for example, the idea that they should not have children – has lead in some cases to issues around coerced sterilisation and abortion.

The final key issue arising from Cobley's paper was MSI's goal of de-medicalising abortion, to the extent that clinics are made less intimidating, more accessible, and emphasise women as decision makers rather than the providers. Part of this effort is reflected in the universal service MSI aims to provide; a woman's experience in a British clinic should resemble a woman's in Afghanistan, Nepal, or any other country MSI operates in. One area in which clinics differ, apart from the range of services they are legally able to provide, is in the emphasis on encouraging women to use long-term contraception such as the implant; this was more of a priority in some countries than others (and amongst some populations more than others). Lesley Hoggart in Session 3 noted that this was the experience particularly of British women who had repeat abortions, and Gillian Love's paper in Session 1 indicated that certain women's reproduction is seen as undesireable, another factor that may play into this encouragement to take up long-term contraception. MSI's empowerment model becomes less clearly defined in these situations where the agency of women using services is balanced with the fact that practitioners must make pragmatic decisions. For example, many women might never access reproductive services apart from at the point of abortion access or post-abortion care, and therefore this moment may be the only chance a practitioner has to talk to that woman about contraceptives. The link between providers and researchers becomes clear here: Cobley noted that MSI were not only providers, but were becoming bolder in addressing the politics of reproductive care.

Ingham's paper provided an insight into one specific issue that providers encounter, that of second trimester abortions. He raised the point that issues such as practitioners feeling obligated to pushing long-term contraceptives on women who access abortion services can partly be alleviated by better sex education and better knowledge about women's decision-making when it comes to accessing reproductive services.

Ingham began by highlighting the tension between the inherently greater risk and specialisation second trimester abortions (which occur between 13 and 20 weeks' gestation) entail, and the potential of shaming or stigmatisation that can stem from discourses around

reducing them He noted that terms like ‘late’ abortion are particularly unhelpful as they play into the latter type of discourse. There was also a suggestion from another participant that practitioners have been found to be more averse to second trimester abortions, not only due to their greater risk or specialisation but also due to discomfort around the procedure itself (the surgical method involves breaking up a more developed foetus).

Ingham presented some findings from work on the experiences of women in the UK who have had second trimester abortions. Reasons for having the abortion in the second trimester were often linked to issues of delay, for example, delay in discovering a pregnancy, but also delay in the medical setting. Medical delay was either due to inefficiency or, in some cases, obstruction by medical staff. In the UK, doctors have the right to conscientiously object to referring patients for abortion, but are required to refer their patient on to another doctor. In some cases, women reported this referral was delayed, or that doctors were obstructive in ways that fell short of conscientiously objecting, for example one woman reported that her doctor told her abortions after twelve weeks were not funded by the NHS (the NHS do not have a time-limit for funded abortions). The possibility that a minority of doctors were deliberately obstructing abortion referral was raised as an area for further research, and came up in discussion again in Session 5 following Silvia De Zordo’s paper on conscientious objection. Similarly, links were drawn to Gillian Love’s paper in Session 1 and the possibility of doing further work on the links between, for example, deprivation and reasons for (or rates of) second trimester abortions.

The importance of collaboration between providers like MSI and researchers was demonstrated by this session’s emphasis on the sharing of knowledge, which encompassed a wide scale from the international, macro level of provision and policy to the local, micro level of individual experience. The session also highlighted the fact that the work of organisations like MSI are sometimes assumed to be relevant only to the Global South and countries where abortion is illegal or restricted. Ingham’s paper – and other Global North-focused papers throughout the conference – demonstrated that this is a false assumption. Themes of empowerment and coercion, for example, occur in many different provider contexts, and questions arise from Cobley’s paper which should concern abortion researchers North and South: who is marginalised in reproductive services? What barriers or misinformation exist? Finally, do the experiences and needs of women always correspond to the goals of service providers, and the international agenda?

Session Four: Abortion and Reproductive Governance

The theme of reproductive governance was a thread running through several papers throughout the workshop, but in the fourth session it was examined in more detail. In this session, the focus was on providers and policy makers. Several common themes emerged from papers which focused on quite different contexts: the first common theme was the role of religion and morality as it operates at the personal level of practitioner, for example through doctors' conscientious objection to abortion practice. Another theme was that of the production of new citizens, closely tied to reproductive governance in the form of the foetus as a citizen with rights, and also the role reproduction takes in certain contexts as rebuilding or shoring up the nation. Finally, the role of international organisations and agendas in shaping the reality of safe abortion access in countries in the Global South was addressed through the examples of Cambodia and South Sudan.

Silvia De Zordo (Universitat de Barcelona) opened the session with her paper, 'From the edge to the centre of the screen: foetal rights and abortion rights in Italy and Spain.' The focus of this paper was on the foetus as a biopolitical subject, whose personhood is increasingly established in both Italy and Spain in tandem with advances in reproductive technology. De Zordo examined the role conscientious objection to abortion plays in reproductive governance, particularly in Italy, where 80% of doctors in the South of the country have declared their inability to provide abortion services. Whilst there are indications that conscientious objection is increasing in many countries, there is a dearth of research examining exactly why and what barriers this presents to abortion access.

Using Italy as a case study, De Zordo demonstrated that the macro-level processes of reproductive governance interact in complex ways with the micro-level. In Italy, abortion is legal up to twelve weeks for economic, health or social reasons, and from 12 weeks to 'foetal viability' if the mother's life is at risk or a foetal abnormality is detected, and abortions are provided free of charge. However, Italy is a strongly Catholic country, and conscientious objection rates are high; reasons for this include individual morality and religiousity, but also forms of abortion stigma. Abortion is viewed in medicine as 'dirty' and unskilled work – a view, it was noted by another participant, not limited to Italy, particularly with the rise of medical abortion – and due to high objection rates, any doctor who does *not* object in Italy will likely spend a great deal of their time performing abortions. This stigma and fear of

physicians of being pigeonholed creates somewhat of a self-fulfilling prophecy; it should also be noted that some Italian doctors are registered as objectors but provide illicit abortions for which they can charge a great deal of money.

This situation had some parallels to the Cambodian context, as explored by Pascale Hancart-Petitet's (Instuit de Recherche pour le Dévelopement, Lao/Paris) paper 'Abortion politics and practices in Cambodia: Local forms, global issues.' In 1997 abortion was legalised in Cambodia up to twelve weeks (and beyond in some circumstances). Despite this, many women have unsafe and illegal abortion. Legal services are expensive (around 50 dollars in the public sector, and 100-150 in the private; the average income in Cambodia is 90 dollars per month), and the abortion 'market' is very well established and can be very profitable. Some illicit providers are trained or practisers of traditional medicine, but many are completely untrained; the range of abortion methods amongst these providers is wide, from curettage to ingestion of herbs and other substances. Additionally, a new product has emerged fairly recently in Cambodia, the 'Chinese pill', which is a mixture of Mifepristone and Misoprostol. It is an unregistered drug but is widely available in pharmacies and markets, and Hancart-Petitet's fieldwork indicated that many women viewed it positively as they could easily identify practitioners who sold it and is often less expensive than other methods.

There are several reasons that many women have little choice but to use illegal and unsafe abortion methods. It was only in 2004 that the Cambodian government began to implement training and protocols for safe abortion, a full 10 years after it was legalised; in 2008 a study found that 40% of practitioners who were asked about abortion did not know that it was legal under twelve weeks. Religion also plays a role in delaying acceptance of safe abortion services: 90% of the Cambodian population are Buddhist, a key precept of which is not taking life.

Cambodia is an interesting example of the ways in which national and local forms of governance complicate the effect that macro-level international agendas have, and the ways in which the global health agenda can shape women's experiences on the ground. Two-thirds of Cambodian healthcare costs are paid by international organisations, and the role of international actors in Cambodia may make the scarcity of safe abortion surprising considering reduction of maternal mortality (a significant cause of which is unsafe abortion) is part of the U.N.'s Millennium Development Goals. However, the USA is a significant donor in Cambodia, and until 2009 did not allow foreign aid to be used to fund abortion as a

method of family planning. This has significantly slowed the progress of safe abortion implementation in Cambodia (although some progress can be seen in the successful registration of the abortion pill in 2011).

The role of macro-level international agendas was also a key focus of Jennifer Palmer's (London Sch. of Hygiene &Tropical Medicine) paper, 'Configuring "appropriate" international engagement with family planning and abortion in South Sudan.' In her ethnography of the reproductive policy environment, Palmer found that amongst NGOs and other organisations, South Sudan is considered to be highly receptive to international actors. This is partly attributed to the important role Western nations are perceived to have had in achieving independence from the North, and are often referred to as the 'midwives' of the new nation. Interestingly, South Sudan has not been as receptive to reproductive care and family planning initiatives as this received wisdom may suggest.

Palmer found that NGOs, donors and other international actors considered implementing family planning in services in South Sudan as a difficult task, and in the balance between being sensitive to the local context and implementing important services, many stay away from the subject of abortion (abortion is legal under certain circumstances, but is widely believed to be illegal). In South Sudan, large families are the norm, and after the civil war women's fertility was mobilised as essential to rebuilding and repopulating the nation; talking about abortion and family planning in this context is perceived by international organisations to be difficult. However, recent policy documents in South Sudan have sought to negotiate this by framing family planning as patriotic, and resistance to it as halting the nation's development. And yet, in 2010 only 1% of South Sudanese women were using modern contraceptives, and post-abortion care after unsafe abortion continues to put strain on health services.

In light of this, international donors commissioned research into South Sudanese attitudes to family planning, the results of which have been interpreted as signalling an openness to modern contraceptive methods. How conclusive this is is debateable, and policy documents still barely mention abortion. The exception is a mention of 'comprehensive post-abortion care' in one family planning document, and Palmer noted that the process of negotiation behind this issue making it into policy documents would be important to examine. Overall, Palmer suggested South Sudanese policy can be described as tentative, with the role of international actors being pragmatic. It remains to be seen how the country's most recent

family planning policies, based on international best practice, translate into services on the ground.

In the discussion following the presentations several common threads were highlighted. The issue of regulation was identified as not only emerging from national or international law, but also through professional and international guidelines. The place where these forms of regulation meet can be full of conflict and contradiction, and in each paper it was interesting to see how this played out in different contexts. The question that then followed was whether law is actually an effective tool of reproductive governance, or if other forms might be in the best interests of women on the ground. Finally, it was agreed that more research into how abortion stigma can affect and be propagated by doctors as well as women this area would be valuable.

Session Five: Abortion Litigation and Policy

The final session featured presentations by Fiona Bloomer of the University of Ulster, and Christina Zampas, a Senior Legal Advisor at Amnesty International. Whilst the session was international in scope, particular attention was paid to the case of Northern Ireland. Bloomer's paper, 'Abortion policy in Northern Ireland: Faith trumps evidence', explained that the Abortion Act, which came into force in the rest of the UK in 1967, has not been implemented in Northern Ireland because the Northern Ireland government at that time refused to recognise it. The abortion debate in the Northern Ireland Assembly is dominated by the Democratic Unionist Party and the Social Democratic Labour Party; both parties are heavily influenced by religious dogma and fundamentally oppose the extension of the 1967 Act. In 2008, the Labour government in the UK had an opportunity to push the Assembly to accept the Abortion Act, but MPs were instructed to drop this effort for fear of endangering the peace process.

Currently, abortion is only legal in Northern Ireland if the life of the mother is at risk or the pregnancy poses a "real and serious, permanent or long term" risk to her health; 45 legal abortions are carried out each year. However, there are no guidelines for medical staff to determine when an abortion is legal; the most recent guidelines issued for consultation do not even contain the word 'abortion' or 'foetus'. Coupled with the legal requirement that doctors report their colleagues if they suspect them of providing illegal abortions, since the issuing of the draft guidelines in 2013, medical practitioners are very cautious and fearful of providing any abortion services at all.

As a consequence of this limited access, over 1,000 women travel a year to England for abortions (the true number is likely to be higher, as some women may not give their real address), but they are not eligible for NHS cover. Travelling for abortions can therefore be expensive, running into the thousands of pounds for those at later stages, and organisations like the Abortion Support Network do what they can to provide women from both Northern Ireland and the Republic of Ireland with financial support for travel, accommodation and abortion services. It was noted that Northerm Irish politicians were content that women travelled to access abortions but the majority did not want wider access to abortion in Ireland, north and south. This ability to travel to have an abortion elsewhere is recognised in Northern

Ireland and the Republic, although recent high profile cases in the Republic have highlighted barriers to travel for particular groups such as asylum seekers.

Zampas' paper 'Litigation at international and regional human rights bodies,' complemented Bloomer's study with a focus on the context of international Human Rights Law. Despite any nation's claim that the right to life begins before birth, no liberal abortion law has ever been found to be in contravention of such a right. Similarly, the Universal Declaration of Human Rights states that '[a]ll human beings are *born* free and equal in dignity and rights' (my italics), which was deliberately specified to prevent any nation from using the Declaration as a reason for restricting abortion. The European Court of Human Rights recently had the opportunity to rule that Northern Ireland needed to liberalise their abortion laws; however, they ruled that no European consensus exists on when life begins, therefore there was no European standard to impose. Zampas noted that in spite of this the Court could have examined the standard for the 'risk to life' exception, but failed to do so.

The restriction or banning of abortion has been recognised by other international bodies as unjust; for example, the UN, whilst never calling for abortion on demand, has stipulated that legal abortion must be accessible to all women. The UN Committee Against Torture has addressed restriction of abortion as a form of torture, and the Committee on the Elimination of Discrimination Against Women (CEDAW) has instructed the UK government to put pressure on the Northern Ireland Assembly to remove barriers to abortion access. As discussed above, this has not happened.

During discussion following the two papers, the issue of how feminists can work towards liberalising abortion within frameworks like Northern Ireland's was raised. Bloomer described some of the work activists in Northern Ireland have been doing with the abortion pill, which can be procured through organisations like Women on Waves. Recently an open letter, signed by over 100 people, was published which stated the signatories had taken or procured the abortion pill in Northern Ireland, and although no legal action was taken against those people, there is fear amongst activists of the consequences of such action.

Questions were also raised about how international laws are enforced; the example raised was that of Northern Ireland's acceptance of CEDAW whilst restricting abortion access. Whilst there is no mechanism by which to enforce human rights law, other avenues exist. For example, the Committee Against Torture recently called on a country to implement a rape exception to their abortion laws, and this is technically legally binding; the type of

mechanisms that work to make this truly binding are often international pressures. The role of the media in Northern Ireland and beyond was noted as a key part of this pressure; Bloomer notes that the Northern Irish media now commonly display pro-choice attitudes where before they did not.

Bloomer also raised in discussion the fact that in 2010, NGOs requested that CEDAW undertake an inquiry into abortion access in Northern Ireland, and submitted a great deal of evidence. CEDAW are still considering whether to launch an inquiry, but the decision has not yet been made. The session ended on a positive note with the recognition that there is a global trend towards liberalisation of abortion laws, and in places where liberalisation has happened recently, international law has been invoked as justification.

Conclusions and future networking

CORTH's inaugural workshop demonstrated the great potential of interdisciplinary, global abortion research to tackle difficult issues and to engender essential relationships between researchers, practitioners, policymakers and activists. Indeed, the event demonstrated that these roles are not mutually exclusive. The key issues to arise from the deliberations over the two days included the importance of a postcolonial framework in dealing with issues around sex-selective abortion; the potential for qualitative, in-depth research into abortion experiences to 'read between the lines' of equally important quantitative data; the fascinating research taking place in 'shadowy' spaces where abortion restriction and the reality of women's sexuality and reproduction collide; the complex interaction between local, national and international reproductive governance; the need for researchers to examine the role of emotion and pragmatism in practitioners' day-to-day work; and the necessity of lending our voices to the demand for accessible abortion as a human right in all contexts and places.

In the wake of these issues, workshop participants put their ideas forward for collaboration, networking and research in the final session of the day. The possibility of publishing a Special Issue on the theme of abortion featuring some of the papers presenting at the conference was met with unanimous enthusiasm, and there was firm agreement that the CORTH network should lead to more exciting collaborations and publications in the future. Members also expressed a desire to continue networking and sharing knowledge; it was suggested that CORTH's website and intranet could serve this purpose. Finally, it was emphasised that CORTH should honour its commitment to linking the academic with the activist by ensuring research and knowledge is disseminated widely and accessibly.

THANKS: The organisers would like to thank all attendees and presenters for a stimulating two days of discussion. Special thanks are due to our funders, the Wellcome Trust and Sussex Research who made the event possible and the internal support from the School of Global Studies, the Brighton and Sussex Medical School as well as the Institute of Development Studies for hosting the workshop. The Centre and Network look forward to future events, and to the exciting collaborations that will arise in the future.

Report by: Gill Love and Maya Unnithan

Appendix 1: List of presentations

Name	Institution	Paper title	Page
Bloomer, Fiona	University of Ulster, UK	*Abortion policy in Northern Ireland: Faith trumps Evidence*	19
Cobley, Bethan	Marie Stopes International	*Increasing Access, Choice and Equity in Service Provision - current opportunities and challenges from service provider perspective.'*	12
De Zordo, Silvia	Universitat de Barcelona, Spain	*From the edge to the centre of the screen: foetal rights and abortion rights in Italy and Spain.*	15
Dubuc, Sylvie	University of Oxford	*Implications of preference and prenatal sex-selection against females*	6
Hancart- Petitet, Pascale	Instuit de Recherche pour le Dévelopement, Lao/Paris	*Abortion politics and practices in Cambodia. Local forms, global issues*	16
Hoggart, Lesley	Open University, UK):	*"I didn't like killing my baby": teenage pregnancy, the construction of risk and the moral framing of abortion in the UK*	10
Ingham, Roger	University of Southampton, UK	*Second trimester abortions; women's explanations and experiences*	13
Lee, Ellie	University of Kent, UK	*The 'sex selection' controversy in Britain: where does it leave abortion law and practice?*	7
Love, Gillian	University of Sussex, UK	*Contextualising abortion: a life narrative study of abortion and social class*	4
Newman, Jessica	Yale University, US	*Contesting criminality: abortion, unwed mothers, and the politics of worthiness in Morocco.*	9
Ogbe, Emilomo	Belgium and Nigeria	*Abortion stigma and definitions of womanhood in Nigeria: A discourse analysis and review of the literature*	9

Palmer, Jennifer	London Sch. of Hygiene &Tropical Medicine, UK	*Configuring 'appropriate' international engagement with family planning and abortion in South Sudan*	17
Patel, Tulsi	University of Delhi, India	*Experiencing abortion rights through issues of autonomy and legality'*	3
Purewal, Navtej	School of African and Oriental Studies, University of London, UK	*Lost in the data: Exploring evolving contexts and contestations of enculturation and sex selection in the South Asian diaspora*	6
Zampas, Christina	Amnesty International, UK	*Litigation at international and regional human rights bodies: a focus on the European Court of Human Rights.*	20

Appendix 2: Contact details of participants, speakers and organisers:

Participant and Reproduction and Health Network contact information

Name	Affiliation	Email
Rebecca Ashley	University of Sussex	rebeccaashley23@googlemail.com
Dr Fiona Bloomer	University of Ulster	fk.bloomer@ulster.ac.uk
Bethan Cobley	Policy programmes manager, Marie Stopes Int	bethan.cobley@mariestopes.org
Dr Vinita Damodaran	University of Sussex	v.damodaran@sussex.ac.uk
Dr Silvia De Zordo	Universitat de Barcelona	silviadezordo@ub.edu
Evelyn Dodds	University of Sussex	e.dodds@sussex.ac.uk
Dr Sylvie Dubuc	University of Oxford / Dept. of Social Policy and Intervention	sylvie.dubuc@spi.ox.ac.uk
Prof Stefan Elbe	University of Sussex, Director of Centre for Global Health Policy	s.elbe@sussex.ac.uk
Dr Pascale Hancart Petitet	Institut de Recherche pour le Développement	pascale.hancart-petitet@ird.fr
Dr Tamsin Hinton-Smith	University of Sussex	j.t.hinton-smith@sussex.ac.uk
Dr Eva Hoffman	University of Sussex	Eh58@sussex.ac.uk
Dr Lesley Hoggart	Open University	Lesley.hoggart@open.ac.uk
Prof Roger Ingham	Southampton University	roger.ingham@soton.ac.uk
Dr Ellie Lee	University of Kent	E.J.Lee@kent.ac.uk
Prof Alan Lester	University of Sussex, Co-Director of Centre for Colonial and Postcolonial Studies	a.j.lester@sussex.ac.uk
Gillian Love	LPS, University of Sussex	G.Love@sussex.ac.uk
Dr. Erica Nelson	University of Amsterdam	Erica.marie.nelson@gmail.com

Lucila Newell	University of Sussex	l.newell@sussex.ac.uk
Jess Newman	Yale University	jessica.newman@yale.edu
Prof Melanie Newport	University of Sussex, Brighton and Sussex Medical School	m.j.newport@sussex.ac.uk
Sue Newport	Sue Newport Consulting	sue@suenewportconsulting.com
Dr Louiza Odysseos	University of Sussex	l.odysseos.sussex.ac.uk
Dr Emilomo Ogbe	University of Gent	emihoms@gmail.com
Dr David Orr	University of Sussex	d.orr@sussex.ac.uk
Dr Jennifer Palmer	London School of Hygiene and Tropical Medicine	jennifer.palmer@lshtm.ac.uk
Prof Tulsi Patel	University of Delhi	pateltulsidse@gmail.com
Dr Graeme Pedlingham	University of Sussex, Visiting Fellow	g.g.pedlingham.sussex.ac.uk
Dr Alison Phipps	University of Sussex, Director of Centre for Gender Studies	a.e.phipps@sussex.ac.uk
Clare Rogers	University of Sussex	c.rogers@sussex.ac.uk
Francesca Salvi	University of Sussex	f.salvi@sussex.ac.uk
Laxmi Prabha Shrestha,	Beyond Beijing Committee (BBC) & Women's Health & Rights Advocacy for Partnership (WHRAP)	laxmi@beyondbeijing.com
Dr Hilary Standing	Institute of Development Studies, University of Sussex	h.standing@emeritus.ids.ac.uk
Dr Navtej Purewal	School of Oriental and African Studies (SOAS)	np39@soas.ac.uk
Elsie Whittington	University of Sussex	Ew99@sussex.ac.uk
Christina Zampas	Amnesty International, Senior legal advisor, law and policy programme	christina.zampas@amnesty.org

Organiser contact information

Name	Position	Contact
Jackie Cassell	Corth governance (Brighton and Sussex Medical School)	j.cassell@sussex.ac.uk
Hannah Leigh	Corth coordinator	01273 678016
Gillian Love	Corth organiser (doctoral student)	g.love@sussex.ac.uk
Hayley MacGregor	Corth Governance (Institute of Development Studies)	h.macgregor@ids.ac.uk
Catriona Shepard	Organiser	07812 571870
Maya Unnithan	Director of Corth	m.unnithan@sussex.ac.uk