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Editorial

Abortion in legal, social, and healthcare contexts

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Worldwide, abortion is one of the commonest gynaecological procedures (Sedgh et al., 2012). The common occurrence of abortion around the globe, however, belies considerable diversity in the social, political, and ethical meanings of terminating a pregnancy, as well as the practices surrounding abortion. All of these vary from locale to locale, from one historical time to another, and among social groups within particular times and places.

In this two-part Special Issue, we present feminist scholarship that addresses some of the diverse contexts and circumstances in which abortion takes place and the psychological implications of such contexts. This issue, *Feminism & Psychology,* 27(1), is Part 1 of the Special Issue ''Abortion in Context''; Part 2 will appear in May 2017 as 27(2). The pieces in Part 1 explore the legal, sociocultural, and healthcare contexts of abortion. These contexts set the conditions of possibility for women who seek to terminate a pregnancy and, to some extent, for the practitioners who provide them. Part 2 will be devoted to pieces that focus on women's experiences of abortion – for example, decision-making, stigma, and post-abortion distress – and that examine how women's experiences are embedded in the discursive, institutional, and material contexts of their lives.

Heretofore, *Feminism & Psychology* has contained few articles on abortion, unintended pregnancy, or contraception. The paucity of attention to abortion is in sharp contrast to the extensive attention given to heterosexual relations and (hetero)sex. Given that a substantial proportion of women are likely to terminate a pregnancy by abortion at least once during their lives, the topic of abortion merits consideration. We hope that this Special Issue serves to direct the attention of feminist psychologists to questions about abortion.

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The subject of abortion is both timely and of high relevance to feminists. In the past few months, women's access to abortion has been contested in various parts of the world. In many countries in Latin America, the Zika outbreak raised the demand for abortions among pregnant women who had contracted (or feared contracting) the virus, with its risk of severe foetal abnormalities. In Poland, mass demonstrations by women succeeded in turning back proposed legislation prohibiting abortions. The outcome of the U.S. elections in late 2016 raised grave concerns about the future of American women's access to abortion, which was already limited by stringent regulations and funding restrictions.

We chose the title "Abortion in Context" to signal that we sought to publish work that moved beyond examining abortion as a "stress experience" encountered by individual women or as a possible precursor of mental illness. Our goal was to assemble a set of articles that would prompt readers to think critically about practices and discourses surrounding abortion. We further hoped to include work that would address the meanings and practices of abortion in the global South and among minoritized groups in the global North. We were pleased by the enthusiastic response to our Call for Papers. We note that Eklund and Purewal (2017, this issue) address abortion in China and India. Thoradeniya's (2017, this issue) review of *Abortion in Asia* (Whittaker, 2010) provides a glimpse of the complex and varied practices, policies, and experiences of abortion in parts of South and Southeast Asia. Chiweshe, Mavuso, and Macleod (whose work will appear in Part 2 of the Special Issue) take up abortion in South Africa and Zimbabwe. Le Grice and Braun (whose work will also appear in Part 2), examine Maori perspectives on abortion.

In this Part 1 of the Special Issue, we present work that locates abortion practices and policies in legal, social, and healthcare contexts. Women's efforts to exercise agency with regard to bodily integrity in the context of pregnancy are shaped most obviously by the legal regulations in the jurisdictions where they live, but they are also shaped by social and cultural issues, biotechnological advances, and healthcare systems. The articles offer detailed examinations of some of these complex contextual framings of abortion.

Legal contexts of abortion

The legal context for abortion – whether or not the state allows abortions and how it regulates them – sets the framework for providers of abortion services and for the women who seek such services. At the start of the 20th century, abortion was illegal in almost every country of the world. Indeed, it appears that China is the only country that has not placed criminal restrictions on abortion (Berer, 2016). During the second half of the 20th century, however, a number of countries enacted laws that allowed abortion on specified grounds. This easing of restrictions on abortion was part of a broad social movement towards expanded rights for women. Currently, the circumstances under which abortion may be legally performed vary widely from country to country. At one extreme are countries (such as Chile and Nicaragua) in which there are virtually no grounds under which it is

legal to terminate a pregnancy. At the other extreme are countries in which laws impose few restrictions, other than a limit regarding gestational age.

Legal access to abortion varies greatly across regions of the world. The Center for Reproductive Rights (hereinafter CRR, 2014) has grouped countries into four categories from "most restrictive", where abortion is prohibited altogether or permitted only to save a woman's life, to "least restrictive", where there are no restrictions as to the reason for terminating a pregnancy. Overall, the CRR reported that at the time, 60% of the world's population lived in countries in which abortion was permitted without restrictions on the reason or for a wide range of reasons. However, more than 25% lived in countries where abortion was generally prohibited. Furthermore, the World Health Organization (2011) estimated that of the 21.6 million unsafe abortions[1] that took place globally in 2008, 21.2 million took place in "developing" regions; these regions typically had more restrictive abortion legislation.

The CCR's categorizations conceal further variation within particular countries regarding the availability, accessibility, and affordability of abortion for specific groups of women. Given class, race, and locational inequities within countries, women do not have equal access to affordable abortion care within the parameters of the laws of the country. In addition, many countries have further regulations that limit women's access to abortion in various ways. In the U.S., for example, a patchwork of local (i.e. state) regulations, requirements, and restrictions poses numerous obstacles for women in need of abortions. As Beckman (2017) and Sisson and Kimport (2017, this issue) point out, the burden of these obstacles falls disproportionately on poor women. Moreover, in the U.S., the number of such restrictions has been continually increasing, propelled by anti-abortion activism.

Even when abortions are legally permitted, the locus of decision-making may not rest with the woman. In some countries, women may receive an abortion on her request prior to a certain gestation date; in others, however, a medical practitioner must certify that abortion is indicated. As McCulloch and Weatherall (2017, this issue) and Lee (2017, this issue) note, the latter is true in Aotearoa/New Zealand and in Great Britain. Although feminist scholars in Great Britain are critical of the paternalism implicit in giving such decision-making power to medical practitioners, they also point out that in actual practice, the British legislation has facilitated liberal access to abortion (Lee, 2004; Sheldon, 2016).

Decision-making by medical practitioners can be relatively benign in some situations. But in other situations, state regulation of abortion undermines women's autonomy and agency. In some times and places, women have been compelled to abort their pregnancies. As Eklund and Purewal (2017, this issue) describe, between 1979 and the late 1990s, China imposed on its citizens a variety of measures to control population growth. These included compulsory screening of women for unauthorized pregnancies and forced abortion.

Formal legislation, however, is not the full picture. There are many instances of slippage between abortion legislation and abortion practice. Laws may be open to loose interpretation, allowing abortion providers and their clients some latitude in

deciding on terminating a pregnancy. For example, as McCulloch and Weatherall (2017, this issue) point out, although abortion is criminalized in Aotearoa/New Zealand, women have good access to abortion. In other instances, statutes that limit abortion to situations in which the woman's life is at risk are broadly interpreted to include possible suicide. In yet other instances, the law is widely – though not openly – flouted. In Sri Lanka, for example, although abortions are permitted only to preserve the life of the mother, induced abortions are very common. It is estimated that nearly 45% of such abortions are carried out by qualified physicians (Arambepola & Rajapaksa, 2014). Similarly, in Zimbabwe, although the legal grounds for abortion are quite narrow, there appears to be a high rate of induced abortion (Chiweshe, 2015). In China and India, Eklund and Purewal (2017, this issue) note, policies that proscribed sex-selective abortion did not succeed in eliminating it. In yet other instances, healthcare policies may be dissonant with legal statutes. In Bangladesh, for example, although the law proscribes abortion, government policies permit so-called menstrual regulation up to 10 weeks after a missed menstrual period (Whittaker, 2010).

"Choice" and "rights" have been the cornerstone principles of mainstream feminist advocacy for the legalization of, and access to, abortion in Western high-income countries. Drawn from liberal political theory, these principles recognize and support women's autonomy in making decisions about their bodies, and they send a clear message that the state should desist from regulating women's reproductive lives (Ferree, 2003). Despite critiques of the concepts of "choice" and "rights", many feminist advocates argue that they should remain the core of advocacy around abortion (Ferree, 2003). McCulloch and Weatherall (2017, this issue) take this position in their discussion of abortion in Aotearoa/New Zealand. Highlighting the inconsistency between abortion legislation and actual practice in New Zealand, they argue for a pragmatic liberal feminist approach. The pragmatic element of their position consists of viewing unwanted pregnancies as a medical issue, not a legal or moral one. Pairing this with the right of women to act autonomously, they argue, offers a useful framework for considering abortion.

Social contexts of abortion

Legal statutes and regulations are, of course, not the only factors affecting women's access to abortion, their agency and autonomy in making decisions about abortion, and their abortion experiences. Cultural norms and values regarding abortion differ widely across the world. Some societies (such as Cuba, Japan, and some post-Soviet societies) have sometimes been characterized as having an "abortion culture". That is, abortion is widely regarded as an unexceptional way of terminating an unwanted or untenable pregnancy (Bélanger & Flynn, 2009; Karpov & Kaumläriäinen, 2005).

Certain religions raise moral objections to terminating a pregnancy by induced abortion. Devout women who face an unwanted or untenable pregnancy may experience considerable difficulty in weighing their courses of action. Women may also face strenuous religious or moral objections from their spouses and

family members. Beyond personal moral dilemmas, opposition to abortion by institutionalized religions sometimes constitutes a significant barrier to women's access to abortion. *Good Catholics* (Miller, 2014), reviewed by Mavuso and Chiweshe (2017, this issue) details how the hierarchy of the U.S. Catholic Church not only has condemned the practice of abortion and artificial contraception by Catholics, but has also carried out vigorous campaigns to influence local and national electoral politics in the hopes of restricting access to abortion to all women. Generally speaking, countries with large Catholic populations have highly restrictive abortion legislation; examples include Malta, Dominican Republic, El Salvador, Nicaragua, Chile, and Vatican City.

Cultural factors other than religious beliefs also influence abortion policies, practices, and individual decisions. As Eklund and Purewal (2017, this issue) point out, pressures to bear sons rather than daughters have led to sex-selective abortion in India and China. These pressures, which are both cultural and economic, have been sufficiently strong to produce noticeable imbalances in the sex ratios of the populations of these countries. As the authors argue, the bio-politics of both population control and sex-selective abortion have limited women's agency, but neither country has adequately addressed contexts in which son preference inflects decision-making around abortion.

The role of the media in shaping, and being shaped by, public discourses, understandings, and attitudes about abortion has received attention in recent literature (Macleod & Feltham-King, 2012; Purcell, Hilton, & McDaid, 2014). Three pieces in this issue address the popular media. Sisson and Kimport (2017, this issue) show how depictions of abortion in American television downplay barriers to abortion; if such barriers are depicted, they are portrayed as easily overcome. Also, Lee (2017, this issue) analyses newspaper coverage in Britain, along with parliamentary debates and official documents, regarding the possible occurrence of sex-selective abortion in Britain. She examines the ways in which claims-makers effectively constructed sex selection abortion as a social problem, tainting South Asian migrant groups and vilifying physicians who provide abortions as putative law violators. In the third piece, Evans (2017, this issue), in a review of *Abortion Politics, Mass Media, and Social Movements in America* (Rohlinger, 2015), underscores the shifting media strategies of pro-choice and anti-abortion organizations in North America.

These articles are a strong reminder that experiences of abortion are always "situated", a point that Lewis (2017, this issue) makes in her review of *The Foetal Condition* (Boltanski, 2013). Lewis argues further that meta-theoretical analyses of abortion must always be grounded in the classed, racialized, geopolitical, and neocolonial contexts of women's reproductive lives.

Healthcare systems and biomedical technologies as contexts of abortion

Healthcare systems and biomedical technologies are a crucial part of the context of abortion (Cockrill & Nack, 2013). For example, in many countries, there are too

few providers who are willing to perform abortions (Lohr, 2008). In some instances (as in some locales in the U.S.), physicians' refusals to perform abortions stem from threats of harassment, physical violence, or destruction of property by anti-abortion activists. In other cases, such refusals may reflect moral reservations. The practice of conscientious refusal of care can make access to safe abortion difficult or even impossible (Berer, 2008; Council of Europe, Parliamentary Assembly, 2010; De Zordo, 2017).

The introduction in 2000 of medications that induce abortion offered new possibilities for abortion access. In the U.S., for example, medication abortions (which are also known as medical abortions or "pill abortions") currently account for roughly 25% of abortions that are registered in medical records. Such medication abortions are permitted by U.S. regulatory agencies (specifically, the FDA) until the end of the 10th week of pregnancy. Possibilities for administering medication abortions via telemedicine (e.g. using video appointment with physicians) are being explored (Galewitz, 2016). Apart from the use of pills in medical settings, women also use pills that induce abortion when abortions are illegal, too expensive, or otherwise hard to access.

A final technology worth mentioning, though it is not, strictly speaking, a medical technology, is the Internet. Widespread access to the Internet has made it possible for women to obtain the pills that induce abortions where they might otherwise not have access. The organization Women on Web, for example, provides over 1000 medication abortions a year to women in Ireland (i.e. Republic of Ireland and Northern Ireland), where abortions cannot be performed except to save a woman's life or (in Northern Ireland) to preserve her permanent physical or mental health (Aiken, Gomperts, & Trussell, 2016). Also, when the Zika epidemic broke out in summer of 2016, Women on Web experienced a dramatic spike in demand for pills in Zika-affected Latin American countries that proscribe abortion (Aiken et al., 2016).

Sensitive issues

Many matters regarding abortion are complex, but some matters confront feminists with particular complexities in thinking about autonomy and "rights" in relation to abortion. Two such sensitive issues are sex-selective abortion and abortion in relation to foetal abnormality. Taken to its ultimate conclusion, the (liberal) logic of according a woman the right to decide the outcome of her pregnancy means extending this right to a woman who wants to terminate her pregnancy because of the sex of the foetus or because of a foetal abnormality (no matter how minor or how low the probability of its occurrence). This is clearly a controversial stance, not only from a feminist perspective but also from an intersectional perspective that connects multiple forms of oppression (disability and gender, for example). Feminist approaches that enable nuanced arguments are much needed in such cases.

In this issue, two articles offer contextualized accounts of sex-selective abortion: Eklund and Purewal (2017, this issue) and Lee (2017, this issue). Read alongside

each other, these accounts provide insights across national contexts – Great Britain, India, and China. Analysing recent debates in Great Britain concerning sex-selective abortion, Lee (2017, this issue) argues that abortion was problematized in new ways in these debates, partially through unsupported claims of "gendercide". This, she indicates, needs to be considered together with arguments about the power invested in the medical fraternity in "recommending" an abortion in the British legislation. Eklund and Purewal (2017, this issue) tackle this question in relation to China and India. Both countries have put policies in place to ban sex-selective abortion. The authors show how these policies are located within the bio-politics of population control (and do not reflect feminist concerns). As such, the policies fail to address the dynamics of abortion decision-making and the effects that such policies have on women in the context of cultural norms that favour males over females.

Medical technologies such as increasingly sophisticated prenatal screening, advanced foetal surgery techniques, and neonatal intensive care procedures have transformed an embryo/foetus into a "patient", that is a new bio-political subject that is entitled to health care (Morgan, 2009; Morgan & Roberts, 2012). Stephenson, Mills and McLeod (2017, this issue) discuss one of these technologies, obstetric ultrasound, and its capacity to identify actual or potential foetal anomalies. Stephenson and her colleagues tackle the matter of second trimester abortions subsequent to a diagnosis of foetal abnormality. They pose important ethical questions regarding how foetal life is valued through obstetric ultrasound, which enables both the ascription of personhood to a foetus and the possibility of foetal selection to terminate pregnancies. In their research, Stephenson and her colleagues show how healthcare professionals working in clinics that provide pregnancy scans replicate the public silence on ethical questions by circumscribing their roles to providing information to women and their partners, who are then left to make decisions regarding the outcome of the pregnancy.

Conclusion

Legal proscriptions of abortion do not prevent women who need abortions from obtaining them. Indeed, rates of abortions appear to be slightly higher (37 abortions per 1000 women between 2010 and 2014) in countries in which abortion is prohibited or highly restricted than in countries where it is available on request (34 per 1000 women) (Sedgh, Ashford, & Hussain, 2016). This striking finding underscores the fundamental importance of abortion in women's reproductive lives across the globe. Nevertheless, women's access to safe and affordable abortion differs substantially from place to place. Moreover, access to abortion has often proven to be tenuous. The articles in this Part 1 of the Special Issue address some of these issues.

In recent years, many psychologists who study abortion have been drawn into debates about the extent and severity of negative psychological consequences of abortion and even the existence of a psychiatric disorder called "post-abortion syndrome" (e.g. Coleman, 2011; Major et al., 2009). This is hardly surprising,

given the persistent but unfounded assertions by anti-abortionists of severe psychological distress following abortion. The articles in this Special Issue, however, point towards more fruitful directions for feminist scholarship. They underscore the myriad contextual influences that shape both women's experiences of abortion and public views of abortion. They also point to the shifting meanings of abortion in response to politics, biomedical advances, and public discourses. These articles, we believe, deepen and enrich our knowledge of abortion. We are proud to present them to you.

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Note

1. Unsafe abortion is defined as a procedure performed by personnel lacking the necessary skills, or in an environment not meeting minimal medical standards, or both. Often abortions performed legally are thought to be safe, and those performed illegally thought to be unsafe. However, not all abortions carried out by registered medical providers are safe, as illustrated by the 2013 case of the physician Kermit Gosnell in the United States (see Greasley, 2014). Nor are abortions carried out by non-physician practitioners necessarily unsafe. For instance, ''Jane'', a feminist collective in Chicago, safely performed over 11,000 abortions between 1969 and 1973, prior to the legalization of abortion in the state of Illinois (Joffe, Weitz, & Stacey, 2004).

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