

Abortion

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Abortion is one of many types of fertility regulation, consisting in the termination of a pregnancy before full term is reached. According to historical and sociohistorical works, since ancient times and in various types of societies, there have always been ways of attempting to achieve this objective. The impetus of feminist studies and gender studies has been decisive in research and in the development of anthropological, sociological, and historical analyses of this issue.

Non-medicalized abortion methods consist either in the use of mixtures or in breaking the amniotic sac with a sharp object. While some abortifacient plants can be safely used, these methods potentially convey important risks, including death. The oldest medicalized abortion method is curettage: initially developed in the nineteenth century to treat miscarriages, it has been used for incomplete illegal abortions as well as for legal abortions. Vacuum aspiration has now replaced curettage as the default first-trimester surgical abortion method. Its invention process can be traced back to the 1860s, but its improvement and democratization extended over one century. Some techniques of early-stage aspiration abortion can be safely performed by non-professionals and do not require a hospitalization. They have spread in different parts of the world with slight variations and under different names: feminist activists have popularized the “Karman method” in some Western countries; “menstrual extraction” is used in some countries of the global South in order to circumvent restrictive abortion legislation (Walle and

Renne 2001); and “mini-abortion” was the official terminology in the Eastern bloc. Furthermore, medication abortion (a combination of mifepristone and misoprostol) was invented in the 1980s and has since spread unevenly across countries. According to some legislations, medication abortions must be completed in clinics, while other legislations allow them at home (sometimes with telemedicine). The choice of abortion method is not always guaranteed, even though aspiration and medication abortion are not equivalent in terms of procedure duration, confidentiality, pain, doctor–patient relationship, and psychological and social implications.

Abortions have long been used to avoid births outside of wedlock. During “demographic transitions,” populations began limiting the size of their offspring within marriage in an unprecedented scale, using contraception and sometimes abortion. In low-fertility societies, it has become less and less acceptable to leave the timing of births to chance. Therefore, contraception and abortion are used in order to comply with the “reproductive norm” prevailing in each society, i.e., “the socially defined ‘right conditions’ to have a child (right age, relationship type, and professional situation)” (Bajos and Ferrand 2006). Abortions may also be performed when pregnancies represent a health threat. Furthermore, from the 1960s onward, ultrasound and other technologies allowed the spread of abortions in cases of fetal anomalies (such as Down syndrome) as well as sex selection (avoiding the birth of girls, which is illegal but commonly practiced in some Asian countries). Abortion decision-making is thus deeply constrained by gender, socioeconomic, ableist, racist, and other inequalities that shape material conditions in which children are raised and representations about which births are (un)desirable. Since the 1990s, proponents of “reproductive

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justice” (inspired by intersectional feminism) do not only fight for the right to avoid unwanted births but also for the right to birth and raise children in decent material conditions, in a society free of injustices (Ross 2017).

The criminalization of abortion appeared or tightened in the nineteenth to twentieth centuries in many countries; some extended it to their colonial empires. At the beginning of the twenty-first century, most legislations worldwide allow abortion in cases of health threats; a significant proportion allow it in cases of rape or fetal anomaly; and fewer allow it on request (generally during the first trimester). The Soviet Union was the first country to allow abortion on demand, in 1920; this legislation was reversed between 1936 and 1955, and in the following years, most communist countries followed the Soviet path (some introduced restrictions later). In the “first world,” the (*de facto*) legalization of abortion on demand generally happened in the 1970s and 1980s. However, the majority of countries with such permissive legislations impose procedural barriers such as waiting periods and mandatory counseling containing information on alternatives to abortion (Levels, Sluiter, and Need 2014). Besides, a return to highly restrictive legislations was observed in Poland (after 1993) and in many US states (after 2022). In parallel, most countries of the global South do not allow non-therapeutic abortion; it is allowed in a significant part of Asia but in very few countries elsewhere. Prohibition does not eliminate abortions; instead, it creates inequalities between those who can afford safe illegal abortions and those who risk their health or even their lives. Nevertheless, in many countries, the wide availability of medication abortion drugs has made illegal abortions in part safer than in the past.

There is a long tradition of feminist activists resorting to civil disobedience and helping those who need it access safe illegal abortions (from the Jane Collective in the United States, the *Mouvement pour la liberté de l'avortement*

et de la contraception in France, or *consultori autogestiti* in Italy in the 1970s to Women on Waves in contemporary Poland and elsewhere). In the history of feminist fights over abortion, the medical profession has been both an ally and a target of criticism (Joffe, Weitz, and Stacey 2004). On the one hand, it has been an important driving force behind the fight to legalize abortion, and in some countries, abortion providers face a strong stigmatization and political attacks (and even terrorism, in the United States). On the other hand, permissive legislations have been analyzed as a redeployment of medical authority, giving medical professionals the mission to exert social control (Ferrand-Picard 1982). Moreover, these legislations often grant them the right of conscientious objection, and in some contexts, the high proportion of objectors fragilizes access to abortion (in Italy, for instance).

The criminalization of abortion is rooted in abortion stigma, and it reinforces this stigma. However, such a stigma can coexist with a permissive abortion legislation. Abortion stigma is a social construct and is not universal (Kumar, Hessini, and Mitchell 2009). When abortion stigma is internalized, individuals resorting to abortion tend to experience negative feelings such as guilt. On the contrary, there are instances of societies where abortion is normalized, and such negative feelings are not the rule. For example, many (post)communist countries were or are known for their “abortion culture” (Bélanger and Flynn 2009). The stigmatization and the criminalization of abortion can be analyzed in the wider context of compulsory motherhood and men’s appropriation of women’s reproductive capacities (Tabet 2005). Stigmatization and (calls for) legal restrictions can be framed in different ways, concomitantly or alternatively. Three instances of framings are presented hereafter: abortion as a sin; abortion as a demographic issue; and abortion as an irresponsible, unhealthy behavior.

Abortion can be framed as a sin. The three monotheist religions have sought to prohibit

abortion, either partially or completely. Religious definitions of the beginning of human life vary. From the Middle Ages until 1869, the Catholic Church used to consider that the sin of abortion was not equated with murder if termination took place before “animation,” i.e., before 2–3 months of gestation. Similar interpretations of “animation” and abortion are also found to this day in some exegesis of Judaism and Islam. Besides, in Judaism and Islam, for example, there is a consensus on allowing abortion when it can save the pregnant woman’s life, while the Vatican does not allow it.

Abortion can also be framed as a demographic issue. In the first half of the twentieth century, concerns about declining birth rates played a key role in the tightening of abortion legislations in many countries, such as France and Belgium circa 1920 or the USSR in 1936. After 1955, some Eastern European communist countries introduced restrictions that would only apply to women who had had less than a specific number of children (2–5) and not to women who had fulfilled their demographic duty. Since the 2000s, pronatalist anxieties have once again become the cornerstone of legal restrictions to abortion introduced in Russia, for example (in this case, procedural barriers). Some pronatalist policies have a racist or eugenic dimension. For example, in Nazi Germany, abortion was prohibited only in the Aryan population, while Jews, Gypsies, and disabled women would face forced abortions. In France, in the 1960s and the early 1970s, while non-therapeutic abortion was still officially banned, in practice, some doctors implemented a racist population control agenda in the overseas territory of Réunion, using forced abortions, with an indirect governmental support (Paris 2020).

Abortion can also be framed as inferior to contraception, easily avoidable with contraception, and therefore an irresponsible, unhealthy behavior. The use of criminal terminology to qualify individuals who have had several legal abortions (sometimes referred to as “recidivists” in medical settings) is a manifestation

of this framing (Mathieu and Ruault 2014). However, this framing has been criticized for its morally oriented exaggeration of abortion’s risks for physical and mental health (Pheterson 2009). The notion that the availability of highly effective contraceptive methods makes unwanted pregnancies easily avoidable is questionable as well. In France and the United States, for example, 50–65 percent of unintended pregnancies occur under contraception (Moreau et al. 2007).

Interestingly, religious anti-abortion activists do not rely solely on religious arguments but also increasingly on medical arguments. Their claims that abortion causes cancer, infertility, or psychological trauma (“post-abortion syndrome”) have been criticized for lack of scientific evidence. Yet, as a result of this strategy, biased, dissuasive counseling has become mandatory in many US states since the 1980s (Johnson 2014) and more recently in other countries such as Russia.

SEE ALSO: Contraception; Embryo and Fetus; Eugenics; Feminism; Gender, Health, and Constrained Choice

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