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Council on Anthropology and Reproduction (CAR)
Policy Statement

The Council on Anthropology and Reproduction (CAR) Opposes Legislation that Creates Barriers to Safe Abortion Care

What Is CAR?

The Advocacy Committee of the Council on Anthropology and Reproduction (CAR), a special interest group of the Society for Medical Anthropology, seeks to ensure that anthropologists have a voice in public conversations about reproductive and sexual rights and health. CAR is a U.S.-based organization whose members come from and work in a variety of countries and settings. Our membership holds that sexual and reproductive health are fundamental to human rights and the well-being of societies around the globe. Our global orientation makes us sensitive to and knowledgeable about women's and men's fundamental need for reproductive and sexual health services.

Our collective expertise provides research-based commentary and critical perspectives on parenting, childbearing, infertility, obstetrics, midwifery, contraception, abortion, adoption, and reproductive technologies. In addition, CAR takes a special interest in women's and men's lived experiences of reproductive policies, both domestic and foreign. Many CAR members are also educators who oppose policies that deliberately provide incomplete, misleading, or inaccurate information about sexual health and reproductive options. We pledge to educate ourselves, educate others, and, most importantly, to act. On this occasion, CAR joins other activists and public health advocates in opposing recent legislation aimed at curtailing access to abortion in the United States.

CAR Opposes State and Federal Legislation that Creates Barriers to Safe Abortion Care

Since 2010, legislation restricting rights and access to abortion has been introduced and passed at both state and federal levels at an unprecedented rate. More than half of all states now have laws that: (1) impose restrictions on abortion providers through the Targeted Regulation of Abortion Providers (TRAP) laws; (2) mandate wait-times and mandatory ultrasound viewings prior to receiving an abortion; and/or (3) reduce the gestational age for legal abortion.

Anthropologists working in countries where abortion has been outlawed or is otherwise inaccessible have documented the social, economic, and emotional impacts that such restrictions have on women, their families, and broader communities (e.g., Kligman

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1998). Unsafe abortion continues to be one of the leading causes of maternal mortality and morbidity worldwide. Moreover, the burden of both unintended pregnancies and unsafe abortions disproportionately impact poor, young, rural, and minority communities, both in the United States and abroad.

CAR members recognize the need for evidence-based, non-partisan health policies to ensure that abortions are provided in safe, legal, and supportive environments by qualified practitioners. However, we argue that the main purpose of recent legislation is to limit or eliminate access to abortion rather than to ensure women's health and well-being. Restricting access to safe and legal abortion forces women to make the difficult decision between continuing with an unintended pregnancy, expending needed resources to travel to areas where abortion is more readily available, or undergoing a clandestine and potentially unsafe abortion procedure. By undermining each woman's ability to determine what is best for herself, her family, and her future, laws restricting access to abortion do harm to women, their families, and their communities.

Recent Legislation that Restricts Access to Abortion Care

Targeted Regulation of Abortion Providers (TRAP) Laws

Proponents of TRAP laws claim that they ensure women's safety by imposing strict requirements on both abortion providers and their clinical spaces. However, we argue that the main purpose of TRAP laws is to disable or limit the ability of abortion-care providers to offer abortion services. As of September 2014, 25 states have passed TRAP laws, and 60% of women of reproductive age reside in these states (Guttmacher Institute 2014b). Since 2010, over 50 clinics providing abortion have closed due to these new regulations.

In some states, TRAP laws require that abortion providers hold hospital privileges or equivalent, despite studies demonstrating less than 0.3% of U.S. abortion patients experience a complication that requires hospitalization (Henshaw 1999). The risk of dying from a legal abortion in the first trimester—when almost nine out of 10 abortions in the United States are performed—is no more than four in a million (Bartlett et al. 2004). In fact, the risk of death from childbirth is about 14 times higher than that from abortion (Raymond and Grimes 2012). Moreover, any woman suffering from abortion complications may be admitted to any emergency room in the United States, regardless of her provider's affiliation. For many providers in states hostile to abortion, it has proved virtually impossible to secure hospital privileges, ultimately leading to clinic closures. Other states have required clinics to be located no more than 30 miles from a hospital, leading to clinic closures in rural areas.

TRAP laws also force clinics providing abortion to meet far stricter structural standards than those required by surgical centers, even in facilities that only offer medication abortions (e.g., Mifepristone). These laws often regulate physical properties of the building, such as the width of hallways, which in no way impact the health and safety of women receiving abortion procedures. Clinics have been forced to close or can no longer provide abortion services because they cannot afford the structural renovations.

Mandatory Wait Times and Pre-abortion Counseling

As of 2014, 26 states have sought to restrict access to abortion services through the imposition of a mandatory waiting period of 18–72 hours between requesting and

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receiving an abortion. These mandatory wait periods are often in addition to required counseling, which in some states must be conducted in person rather than on the phone, via email, or fax. The ostensible rationale for these forced wait periods is to provide women with information about the supposed psychological and physical risks of abortion and to allow them time to reconsider their decision to seek an abortion. Yet information given at these counseling sessions has been demonstrated to be misleading—or, at times, false—and is clearly designed to discourage women from continuing with the procedure (Richardson and Nash 2006). Such paternalistic policies diminish women's own decision-making abilities; by assuming that women have not already carefully weighed their options, such policies may cause further emotional and psychological distress in the name of safeguarding women's health.

The imposition of mandatory counseling and waiting periods also creates additional and unnecessary hardships on women, since the obligation to attend two clinical visits means that they must take additional time from work or other responsibilities. For women living in states with few abortion providers, the mandatory wait time may mean incurring added costs of overnight accommodations or multiple trips to a clinic. This is especially onerous for women with little economic means or for those who would prefer to keep the procedure private from family and co-workers. Furthermore, the combined effect of mandatory waiting periods and the tighter restrictions on gestational age for legal abortion in many states may mean that some pregnancies are too advanced for a legal abortion by the time the waiting period has elapsed. In such cases, women may be forced to continue with an unintended pregnancy or seek an illegal, unsafe abortion.

Mandatory Ultrasound Viewing Laws and Legislator-written Scripts

While ultrasounds are a routine part of abortion care, many states have passed laws that mandate that providers perform ultrasounds for the express purpose of displaying and/or describing the ultrasound images to women seeking abortions. As of September 2014, 12 states require providers to perform an ultrasound prior to the abortion and ask women if they wish to view the ultrasound display, while three of these states (Louisiana, Texas, and Wisconsin) require the provider to display the screen and describe the image without asking women for their preference. Some states also require that clinicians read to patients pre-set scripts about fetal development that were drafted by legislators, not medical professionals (Guttmacher Institute 2014c). Proponents of mandated ultrasound viewing laws argue that ultrasounds give women information that might persuade them from opting for abortion. Recent research by Gatter et al. (2014), however, demonstrates that viewing an ultrasound is highly unlikely to convince a woman to discontinue with an abortion procedure if she believes that ending the pregnancy is the appropriate decision. Further, laws that require providers to read legislator-written scripts about fetal development to their patients undermine medical professionals' ability to do their jobs with care, compassion, and consideration for their patient's wishes. We hold that mandatory viewing laws and legislator-written scripts intervene in the provider–patient relationship, impose requirements that make abortion care more costly and burdensome, and may cause additional and unnecessary distress for some women.

Reduced Gestational Timeframe for Abortions

Legislation reducing the gestational time frame for legal abortion has also been used as a means to erode access to abortion. Forty-four states restrict abortion procedures in the second or third trimester, although the U.S. Supreme Court requires provisions for some

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procedures to preserve the life and health of the woman, yet 15 states ban later-term abortions in violation of this constitutional right. Eleven states have also passed new legislation that reduces the timeframe for legal abortions from 24 weeks (assumed to mark fetal viability) to 20 weeks post-fertilization, based on the contested belief that at this point a fetus can feel pain (Guttmacher Institute 2013).

Funding Restrictions

Anti-choice legislators have also used funding restrictions to limit access to abortion. In conjunction with the Hyde Amendment, which has restricted the use of federal dollars for abortion since 1976, the majority of states provide no state funding assistance for abortion care for economically disadvantaged women. Thirty-two states and the District of Columbia provide only the federally mandated funding for abortions, which are limited to cases of life endangerment, rape, or incest. South Dakota is in violation of the federal standard and only provides funding in case of life endangerment. Public funding restrictions for abortion at the state and federal level have, and continue to, impose extreme burdens on low-income women who bear the brunt of these restrictions.

Conscientious Objection

The growing prevalence of conscientious objection—in which health care providers may refuse to provide reproductive health services such as abortion or contraception by citing religious objections—further limits women's access to abortion care services. Currently, abortion opponents in many nations promote conscientious objection as a way to circumvent the legalization of abortion. Since women seeking abortion services may not always be offered referrals to other health providers, these conscientious refusals can impinge upon women's right to receive needed care (Chavkin et al. 2013). In the United States, mergers between Catholic and nonsectarian hospitals mean not only the prohibition of abortion services in the merged facility, but also prohibitions on the provision of emergency contraception for rape victims who are brought to the facility's emergency room (MergerWatch and ACLU 2013).

Putting Politics above Women's Health

Anti-abortion activism in the United States today is largely driven by claims about fetal personhood, whereby the fetus is considered a person that has "rights" in addition, and even in opposition, to those of the pregnant woman. Efforts to legally establish fetuses as persons from conception have failed in every state where the policy has been introduced. Yet fetal rights arguments have been deployed successfully to restrict the gestational stage at which women may obtain an abortion, or to limit access to abortion more generally. Anthropologists working in cross-cultural and historical contexts have demonstrated that the attribution of personhood to fetuses is a deeply cultural process that differs among communities and across time (Morgan 2009; Morgan and Michaels 1999). We argue that current legislative efforts to establish fetuses as legal persons at ever-earlier stages of development are thus rooted in U.S. politics rather than in scientific fact.

Since the 1980s, the number of abortion providers in the United States has declined by about a third, a reduction widely attributed to legislative pressures and a climate of violence—even murder—directed at abortion providers and their staff. Restricting access to abortions by driving reputable abortion care providers from their practice simply opens the door to unscrupulous practitioners who take advantage of desperate women to

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charge exorbitant prices for abortions or to offer substandard services that endanger women's physical and emotional health, future fertility, and even their lives. Ample evidence, both historical and in countries in which abortion is heavily restricted or illegal, has linked restricted access to safe and legal abortion to an increased rate of clandestine and unsafe abortion. Worldwide, unsafe abortion continues to be one of the leading causes of maternal mortality and morbidity. An estimated 220,000 children each year lose their mothers from abortion-related deaths; these children are at higher risk for neglect, ill-health, abandonment, and death (Haddad and Nour 2009).

Further, the current legislative assault on abortion access perpetuates long-standing health disparities across the United States. Rates of abortion have declined over the past three decades with the increasing availability of sexual education and safe and effective contraception (Guttmacher 2014a). Abortion is increasingly concentrated among women of color, immigrant women, and economically disadvantaged women, all of whom often have less access to the necessary health education and health care that would prevent unintended pregnancies.

This shifting demographic means that those who suffer most from the reduction in abortion access are precisely those who have historically been disadvantaged within U.S. society. Since women with resources can make the potentially expensive and difficult trips across county or state borders to obtain abortions, the burden of both unintended pregnancies and unsafe abortions disproportionately impact poor, young, rural, and minority women and communities. Moreover, given the elimination of public funding for abortion care in many states, it is poor women who must choose between ending an unintended pregnancy and paying for schooling for themselves or other family members, making rent, or feeding their families (Jones et al. 2013). Yet the same organizations and legislators who urge restrictions on abortion often lobby simultaneously to reduce public support for economically disadvantaged mothers and to restrict the use of public funds to subsidize family planning methods for poorer women. These conflicting agendas make clear that legislative efforts to restrict or eliminate abortion access is, in fact, a targeted attack against abortion—and, more broadly, women's reproductive freedoms—not a measure designed to safeguard the well-being of women and their children.

Supporting access to safe and legal abortion is thus simply one facet of a broader fight for reproductive justice. As scholars, activists, and teachers, CAR members stand in solidarity with other local, national, and global organizations that fight not only for the right to end unintended pregnancies, but also for the right of all women and men to bear children and to care for them in safe, healthy, and dignified environments.

CAR Calls on the Public:

- As voters, to call on lawmakers to rescind TRAP laws and stand in opposition to policies that restrict access to safe abortion.
- As activists, to support organizations like Planned Parenthood that provide reproductive health services to low-income women and that are being targeted by these laws.

CAR Calls on SMA and CAR members:

- As teachers, to educate students and the public about the real impact of laws that limit women's access to safe abortion procedures, both nationally and internationally. Further, to educate students to critically assess information about

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women's health so that they are better able to identify inaccurate, incomplete, or misleading information about women's health and reproductive options.
- As scholars, to continue to challenge the denial of women's reproductive agency and normalization of fetal personhood.
- As researchers, to conduct research that is responsive to current political and social debates. High priority areas for research include: (1) the ground-level effects of the TRAP laws and other legislation restricting access to abortion; (2) the rollout of the Affordable Care Act and its effects on the reproductive options of women of diverse classes, ethnic/racial backgrounds, regions, and ages; (3) the emergent scientific focus on fetal pain and its use by anti-abortion groups; and (4) conscientious objection by both individual providers and by institutions, and its effects on women's reproductive options.
- As activists, to support organizations like Planned Parenthood that provide reproductive health services to low-income women and that are being targeted by these laws.

Notes

This Policy Statement has been endorsed by the Executive Board of the Society for Medical Anthropology (SMA). The SMA is the world's largest association of professional and practicing medical anthropologists and includes a number of special interest groups dedicated to more specific concerns. Policy Statements endorsed by the SMA board deal with issues of national and/or international health importance and undergo an extensive review process.

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