Chapter One

Abortion in Asia

An overview

Andrea Whittaker

Aunty Phim

At my age [forty-five years old] it's not normal [to be pregnant] is it?… I'm not young and strong any more. There's no way I'd be able to raise it. So I went to Bangkok. My younger sister is in Bangkok so she took me… They injected some medicine in. Made my stomach hurt. I gave birth just the same as you'd give birth to a child. I didn't know how they did it, I just lay down. Lay down on a bed and gave birth there on the bed itself. I could see young people, they were crying, it wasn't just me who was there. They had nurses, but the doctors, they did their work. But they looked after me. Once they had gotten the *tua* [body] to come out, a *luuk* [child] came out, see. But it wasn't very big, quite small, just over two months. When it came out the pain went away just like giving birth to a child. They had me lie in the hospital for a night…

And Auntie when they injected you, did they give you saline?

They didn't inject me. They gave it [the medicine] to me by way of the *nam kleua* [saline intravenous drip]. Once the saline and the medicine had gone in I had stomach pain straight away. Then it was just one lump. It was just the same as giving birth to a child…

Did you lose a lot of blood?

No, no I didn't lose a lot, normal. I'd have to tell you straight that it was comfortable. But the young girls who went to do it, three months'

> [gestation], five months', dangerous. But the doctors took good care of them. But they were in a lot of pain. I saw kids, they'd be all bent up, W*ooh!* crying.…

Aunty Phim is a rice farmer with four years of education and lives in a village in Roi Et province in northeast Thailand. She has two daughters. One daughter (twenty years old) is already married and the other (fourteen years old) is still in school. The abortion cost five thousand baht (approximately US$ 100), or two thousand baht per month of gestation – nearly a third of her yearly family income. Following the abortion she was given medicine to treat infection, vitamins and pain killers.

> *What sort of feelings do you have now that you have gone to do it?*
>
> I've been to do it. There. I feel that we won't have any obligation to feel anxious over that child. I won't have to think about lots of different things and try to be happy that I have to raise a child, anything like that. I'm old already. We could raise them but not well enough. Now the thinking has gone away, I don't have to think any more. I just think it was born just thus far and I'll let it go according to merit [the Buddhist understanding of the balance of good and bad deeds during one's life]. Some people, they say to correct it I should make merit.

Aunty Laem

Aunty Laem is thirty-six years old and married with two children, one son aged three and one daughter aged four. She has had four years of education. She is also a rice farmer with more debt than income. Last year she had an abortion when she was approximately three months' pregnant. She hadn't been using contraceptives. She went to a local woman's house who gave her an injection per vagina. The abortion cost her two thousand baht [US$ 40]:

> She put medicine into a syringe and injected it into my vagina. It was black medicine, black but not very strong so I had no problem and no symptoms, it was just normal. Then I returned home and on the second day it [the pregnancy] came out. It came out normally like I had my periods but the last lump was big – then I had cramps and didn't feel very good. When the last lump came out I was OK. She said what she would do for me and she said that if I died or anything she wouldn't take responsibility and I said that I needed it and accepted that. But lots of people go. Lots of people from our village and [they]

> don't have any problem… She said it was *bap* [Buddhist sin] but only a small sin and not really a problem…
>
> My child was still breastfeeding so I wasn't ready and so I decided… I spoke with my friends and I decided we lacked any other path. So I forced myself to do it. We weren't ready to have another child and so what can you do? We didn't have any money and so it was a necessity.

Following the abortion, Aunty Laem started using injectable contraception and now is using the contraceptive pill. She has had a number of women come to ask her about her experience of abortion and has referred them to the woman.

> Now I think about it and I am not happy. I'm scared I will catch something. I am scared it will become something like cancer. Scared I may have caught AIDS or something. Five people went to do it [abortions when she was there]. That's how I think in my heart. But before I went I didn't think about that… But I hope I didn't catch anything. But I saw lots of people being done. No one had anything.

Aunty Phim and Aunty Laem shared their stories with me in 1997 during fieldwork in Thailand. At that time Thailand had one of the most restrictive abortion laws in the region, allowing legal abortion only in the case of rape, incest and a threat to the health of the mother, which was usually interpreted very narrowly. Debate over Thailand's abortion laws has raged publicly since 1980, pitting Thai women's groups and public health advocates against popular conservative politicians, a Buddhist religious sect and a sensationalist media. In these debates, abortion became a metaphor for westernisation, changing gender roles, and political corruption – a threat to cherished notions of what it means to be Thai and to be a Buddhist (Whittaker 2004). Within that debate the experience of women was rarely voiced. Faced with their personal dilemmas of unplanned pregnancies and uncertain futures, women acted with pragmatism to address their situations. But their choices were structured within the broader political-economic and legal context. For Aunty Phim that involved a technically illegal abortion under medical supervision but in conditions that fell short of high-quality care. After unsuccessful attempts with 'hot women's medicines' (local herbal mixtures said to act as abortifacients), Aunty Laem resorted to the services of a local injection abortionist. Both women were aware of the illegality of their act and possible risks. They were fortunate they did not suffer adverse complications, although they knew women who had. Aunty Phim looks back with relief and few

ILLUSTRATION 1.1 Small village stores in Thailand often stock herbal medicines and other patent drugs purchased by women in attempts to induce abortions (Photograph: A. Whittaker)

regrets. Aunty Laem still worries about the unknown karmic consequences of her act but also fears long-term problems – AIDS from the use of shared equipment, or uterine cancer believed to derive from the disruption to the womb.

Raising the Issue

Writing about abortion forces us to confront the effects of poverty and economic inequalities, the configurations and expectations of gender relations, the meanings attributed to motherhood, the value of children, local moral worlds and understandings of women's bodies. The authors in this book articulate the conditions and hard choices faced by women throughout Asia. We relate stories of women's experiences with abortion as well as the politics surrounding abortion reforms. We describe how structural factors such as the distribution of economic, political and institutional resources are fundamental to the degree of control women and men have over reproductive decision-making and how cultural processes shape the contexts and meanings of their reproductive decisions. This draws attention to state interventions into their citizens' reproductive lives

and the macro and micro relations of power, class and gender politics influencing reproductive experiences.

This book is also about the progress and possibilities for change. Despite the vociferous debate in Thailand, reform to the medical regulations governing abortion occurred in 2006 through the patient lobbying and quiet determination of a group of public health advocates and women's advocates working within existing bureaucratic and legal systems (see Nongluk Boonthai et al. this volume). This has made pregnancy terminations permissible under some circumstances such as for certain foetal conditions and mental health reasons, easing access to safe abortion services for some women. Despite this progress, abortion remains in the Thai Criminal Code and remains illegal for social and economic reasons as described by Aunty Phen and Aunty Laem. Work towards reform continues.

My ethnographic work in Thailand alerted me to the need for a volume bringing together current social research on abortion in Asia, in order to bring the diverse perspectives and insights from this region to a wider audience and to encourage further research of the consequences and implications of unsafe abortion in the region and the need for access to quality services. To date, relatively few books have addressed abortion in Asia.[1] This is surprising, given that the majority of the world's population lives in Asia and that over half of the world's deaths due to unsafe abortion take place in Asia.

This book aims to present a set of chapters detailing current work in Asia on abortion that reflect the diversity of experiences and perspectives from parts of the region usually under-represented in academic work, and to provide commentary on contemporary developments and understandings of the issue. The authors present cases ranging from nations with liberal abortion laws to those with strict restrictions, and highlight the fact that liberal laws alone do not ensure safe abortion services. Written by a mixture of Asian and Western researchers and activists, the book is comprised of eleven chapters that juxtapose anthropological descriptions of the lived experience of abortions with overviews of policy development and legal reform in the region. The contributors in this volume draw upon anthropology, demography, women's studies, public health and development studies in their approaches, and so the chapters require reading across disciplines but also across language written for different purposes. This book is intended to be a dialogue between academics and advocates and between anthropology and public health. The chapters are linked by their common attention to the cultural and historical specificities of abortion in each setting and

their common underlying advocacy of the reproductive rights and entitlements of women and men to control their fertility.

The authors address a range of issues of importance in approaches to abortion, such as the difficulties faced by providers of reproductive health services to vulnerable populations; the linkages between violence and abortion; patients' assessment of quality of care versus costs of abortions; the sensitivity and care required of health providers for women experiencing mid-trimester or later term abortions for medical reasons; and the necessary collaboration with government ministries and other strategies employed for policy and legal reform. Through the use of anthropological methods, a number of authors are able to present insights into the micro-politics of gender relations and the lived experiences of abortion decision-making with a depth not possible through other, more quantitative means. The final chapters remind us of the dogged persistence and negotiations required to implement legal and policy reforms and the need to defend hard-won successes in reproductive rights. The book is ambitious in that it attempts to provide insights into the diversity of Asian countries, cultures, religions and historical experience. It will quickly become clear to readers that one cannot necessarily assume commonalities between 'Asian' countries and their approaches to the issue of abortion. As the essays in this book demonstrate, across the region different political systems, religious groups, colonial and postcolonial histories and legal developments have all influenced the nature of women's access to abortion.

ILLUSTRATION 1.2 Northeast Thai village women gathered for a focus group (Photograph: A. Whittaker).

Counting the Costs

It has become a public health mantra to cite the International Conference on Population and Development (ICPD) 1994 statement that in circumstances where they are legal, abortions should be safe, and that all women should have access to life-saving post-abortion care (PAC) services. The Fourth World Conference on Women (FWCW) further called upon governments to consider reviewing laws containing punitive measures against women who have undergone illegal abortions (United Nations 1996, paragraph 106) and reaffirmed the human rights of women in the area of sexual and reproductive health, including their right to 'decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and their right to attain the highest standard of sexual and reproductive health' (United Nations 1995, paragraph 7.3). Despite much activity and rhetoric over reproductive health rights, over a decade later this commitment remains a distant goal for most countries in the Asian region.

The statistics speak for themselves. Approximately 10.5 million unsafe abortions take place in Asia each year, almost one for every seven live births. An unsafe abortion is one 'either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both' (WHO 2003: 12). Thirty per cent of unsafe abortions in Asia are performed on women under twenty-five years of age and 60 per cent are obtained by women aged under thirty (Aahman and Shah 2004). It is estimated that each year 35,000 women in Asia lose their lives due to unsafe abortions, around half of the global deaths from unsafe abortion (Shah 2004). Apart from maternal death, at least one in five women suffer reproductive tract infections causing infertility as a result of their unsafe abortions (WHO 2003: 14). Complications from abortions are also costly to health services; it is estimated that in 2005, five million women across the world were admitted to hospitals due to complications caused by unsafe abortions (Singh 2006).

For many women in Asia, abortion and its consequences remain a common threat to their sexual and reproductive health. Many women do not yet have access to basic safe abortion services or post-abortion care. Instead, many women such as Aunty Phim and Aunty Laem face induced abortions in fear, pain and insecurity, seeking treatment wherever it is available, often at high cost to themselves and their families. 'Deciding freely' or 'choice' as it is articulated within the international human rights documents is bound up with

Western notions of the autonomous rational individual subject who rationally selects between the available options. As the chapters of this book reveal, the 'right to choose' is not a mere question of the legality of abortion, but depends upon questions of culture, political economy, class and gender relations.

Regional Overview

In almost all countries in Asia laws permit abortion to save a woman's life. However, considerable variation exists in the legal permissibility in other circumstances. Debates have taken place over the relationship between the legalisation of abortion and rates of maternal mortality. A study of 160 countries found that, in general, those with liberal abortion laws had a lower incidence of unsafe abortion and lower mortality from unsafe abortions when compared to those countries where abortion is restricted (Berer 2004). The countries with the most restricted abortion laws in Asia include Sri Lanka, Pakistan and the Philippines. Those with the least restrictions include Cambodia, Vietnam and China. It must be noted that this refers to the legality of abortion in various states' Criminal or Penal codes and may accurately reflect neither the 'grey law' regulatory frameworks which operate in various locations, nor the enforcement of that law. As will become evident below in the selected national profiles, a range of administrative and regulatory barriers restricting women's access to abortion services may operate even in states with liberal laws. The overview also illustrates that access to safe abortion services remains limited in most localities, whether because of economic or social barriers, the negative attitudes of health providers, or the failure of health systems to provide quality comprehensive reproductive health services. For example, in India, where abortion has been legalised for three decades, the high rate of unsafe abortion continues to be an issue (Ramachandar and Pelto 2002; Pallikadavath and Stones 2006). As the overview also reveals, there is a lack of comprehensive data on the prevalence of unsafe abortions. Legal restrictions make the collection of such data even more difficult and render the extent of unsafe abortions and the injuries to women invisible.

Unwanted pregnancies and the unsafe abortions which follow them are indicators of the gendered economic, social and political inequalities in societies and the extent to which women's needs and interests are not recognised or addressed. Trade liberalisation, struc-

tural adjustment programmes and the 1997 Asian economic crisis have negatively affected economic inequalities and the availability of national public resources for social programmes and public health interventions. Health care has become increasingly privatised across the region and less accessible to the poor. Economic barriers have limited both governments' abilities to implement quality reproductive health programmes of the sort recommended by the Cairo Population and Development Conference, as well as affecting individual women's access to quality services. In many countries in the region, risk of and from unsafe abortion is stratified along economic lines: regardless of the legal situation, the wealthy can access safe abortions, while the poor cannot.

It is impossible to separate discussion of abortion from the relations of power structuring gender relations and sexuality (Hardacre 1997). A pattern evident across the region is that strongly patriarchal societies tend to have a greater prevalence of unsafe and clandestine abortions. Persistent gender inequalities in education, marriage, citizenship, employment, property and political participation experienced by women affect their ability to control their fertility, negotiate their reproductive health needs with their families and health services, locate safe providers, mobilise money or influence political debate. In particular, poorer women in South Asian countries often have little control over decision-making within their families, with decisions over their fertility often being made by other family members. Likewise, women may have little ability to use contraceptives without their husband's permission and hence are at risk of unwanted pregnancies and subsequent abortions. Each chapter of the present volume engages in its own way with the politics of gender relations and societies' expectations of women and men. The meanings of abortion and the experiences of women undergoing abortion reveal much about the status of women in a society. The meanings of abortion vary in differing cultural systems where the social value of women depends upon their ability to bear children, or the number of children they bear, or the paternity of those children, or the sex of those children. As these chapters describe, in countries where abortion remains illegal, punitive measures almost invariably target women seeking abortions, not men. Transformations in gender relations wrought through social changes such as industrialisation, increased education for women, rural–urban migration and increased participation in the workforce, the effects of conflict, and state policies are all reflected in the practices and meanings of abortion and competing constructions of sexuality and motherhood.

Although Western scholars tend to emphasise religion in determining attitudes and practices regarding abortion, this is based on the assumption that religion carries the same influence in other countries as it does in determining practices, policies and debates in countries such as the United States. On the contrary, an analysis in the region reveals that countries with similar religious profiles may in fact carry very different legal approaches and different attitudes to the issue of abortion. For example, despite both having a majority Muslim population, Malaysia and Indonesia vary greatly in the restrictiveness of their abortion laws. Countries with Mahayana Buddhist traditions as practiced in Japan, Korea, China, Taiwan and Vietnam show greater tolerance for abortion than those with Theravada Buddhist traditions such as Thailand, Laos and Sri Lanka, yet Cambodia (also Theravada Buddhist) has very liberal laws. How can we account for such differences? A significant explanation can be found if we differentiate the particular religion practised from the degree to which a religion is associated with state legitimation. This varies from place to place, depending upon the colonial histories and legal structures inherited by states; the degree to which religion is mobilised as a unifying force in nationalist projects by the state; contemporary political histories, including the growth of politically active fundamentalist religious movements; and the involvement of the military in national politics. To put it simply, I suggest that it is when religion and nation become mutually supportive that we may expect the enforcement of restrictive abortion laws and intense sanctions against abortion.

As will be discussed later in this chapter, prospects for change in the region vary. The restriction or absence of civil society organisations or a strong established feminist movement affects the ways in which abortion reform advocates can mobilise support or educate the public about the effects of unsafe abortion, or counter gender stereotypes. In a number of countries, much progress has been made to reform laws and policies as part of the implementation of ICPD principles, and most importantly to improve the delivery of services. Yet in others, the growing political influence of religious fundamentalisms threaten to erode progress in the provision of a range of reproductive health services. The region has also been subject to international politics, affecting donor contributions to their reproductive health programmes, the ability of organisations to provide abortion services, to lobby for abortion rights, or to undertake programme research.

Finally, it is clear from the overview below that many countries in Asia continue to struggle to provide quality family planning ser-

vices or appropriate post-abortion care, and lack staff trained in the safest techniques. In many cases this is due to governments assigning a low priority to funding for reproductive health. Paradoxically, while the agenda for reproductive health services has become more ambitious following ICPD and Beijing, it becomes so at a time of a parallel shifts in the national priorities of many countries and a withdrawal of the state from the provision of health services. When reproductive health services are left solely to private services, the potential for exploitation and high cost to clients increases. In addition, in poorly resourced public services, the quality of care received by patients can be very low (Ramachandar 2005). In those countries where abortion continues to be highly restricted, women and medical professionals may face fines and imprisonment. In these locations women often have few options but to seek the services of untrained practitioners utilising a range of techniques with little follow-up care. They may also fear presenting to medical services if complications occur.

The following profiles of a selection of countries in Asia briefly describes the current capacity of women to access safe abortion services in the country and serves as background to the following chapters. Not all countries are represented, nor is much information available on the situation in some countries such as North Korea or Bhutan. These profiles do serve, however, to highlight the diversity of approaches to the issue across the region.

Country Profiles

Southeast Asia

Thailand

As I have described in previous work (Whittaker 2004) the current criminal code and regulations in Thailand regarding abortion make it illegal except in cases of a women's health or in the case of rape or incest. Amendments to the medical regulations in 2006 made it possible for women to obtain abortions in the case of rape or foetal impairment, and the definition of health has been expanded to include the mental health of the woman as a factor in legal abortion provision (Royal Thai Government 2005), although no change to the Penal Code occurred. This will allow for increased access to abortion for some women. But access to pregnancy terminations will remain difficult for the majority of women who seek them on economic grounds, or for adolescents experiencing an unwanted pregnancy

(Warakamin et al. 2004), forcing them to resort to illegal means. My own work on abortion in Thailand described how Thai abortion laws operate to stratify the risk: poorer rural women or embarrassed, uninformed adolescents tend to seek unsafe illegal abortions, while richer, middle-class urban women can afford to have their illegal but safe abortions in private clinics and hospitals (Whittaker 2004). Despite the legal restrictions, approximately 300,000 abortions take place in Thailand each year. Research conducted in public hospitals in 1999 found that 32.1 per cent of women who presented to public hospitals following abortions suffered serious complications (Warakamin et al. 2004).

Public debates in Thailand over abortion legal reform throughout the 1980s and 1990s constructed abortion as un-Buddhist, anti-religious and therefore un-Thai behaviour (Whittaker 2004). Those opposing repeated attempts to reform abortion laws in the Thai parliament described abortion as the product of corrupt Western materialist values that threaten the integrity of the Thai nation and Thai values. A repeated theme throughout these debates was patriarchal concerns with women's body boundaries as icons of the borders of the nation within which Thai citizens are nurtured. Women seeking an abortion are depicted as having uncontrolled sexuality and Western proclivities; in their parallel role as 'mothers of the nation', they are also therefore depicted as threatening to destroy/abort the nation. Abortive technologies are thus positioned as instruments of evil, threatening the body of the nation and hence are strictly regulated.

Laos and Union of Myanmar (Burma)

Two other predominantly Buddhist nations have highly restrictive abortion laws. Little information is available about abortion in Laos; however, abortion is illegal except to save a woman's life (United Nations 2007a). Abortion is also illegal in Myanmar according to section 312A of the Penal Code, and strong social sanctions against abortion affect women's ability to seek care. With a low prevalence of contraception (estimated at only 34 per cent in urban areas and 10 per cent in rural areas), complications from induced abortions remain a major public health problem. This problem is particularly acute in conflict areas on Myanmar's borders and in rural areas with poor health services. Estimates of the incidence of women admitted for complications from abortion (both induced and spontaneous) vary, but are assumed to account for up to 60 per cent of direct obstetric deaths recorded in hospital-based studies (Ba-Thike 1997:

94). By 1995, abortion was ranked as the ninth most important health problem and ranked third among the leading causes of morbidity in Myanmar. Crude methods such as the insertion of abortion sticks or feathers, metal rods, or drugs into the uterus, curettage or external massage, as well as the consumption of herbal medicines are common methods used to induce abortions (Ba-Thike 1997; Belton 2001). Under the current regime, there has been little debate over the issue in Myanmar, although there are current efforts to introduce better protocols for the treatment of post-abortion complications within the health system (Htay et al. 2003). It is unclear what opposition groups' policies will be on this issue.

Cambodia

Despite having similar Theravada Buddhist traditions to those of Thailand and Laos, Cambodia has liberal abortion laws following legislation enacted in 1997 despite the opposition of some groups who argued that it was against Buddhist values. Abortion is available on request in the first twelve weeks of pregnancy but must be performed by medical doctors and medical assistants or by secondary midwives who are authorised to perform abortions. Abortion must be carried out in hospitals, health centres or clinics authorised by the Ministry of Health. After twelve weeks, abortion can be performed on the ground of foetal abnormality or if the pregnancy poses a danger to the mother's life; if the baby who will be born 'can get an incurable disease' (*sic*) or if the pregnancy is caused by rape. In such cases, the abortion requires the approval of a group of '2 or 3 medical personnel' (United Nations 2007b).

Cambodia's legislation was adopted in an attempt to reduce the country's high maternal mortality rate of 900 per 100,000 live births, of which it was estimated that one third of maternal mortality resulted from unsafe abortions performed by unskilled practitioners. According to the 2000 Demographic and Health Survey, 6 per cent of women aged fifteen to forty-nine reported at least one previous abortion. Primarily the difficulty is the impoverished health system. Cambodia is one of the poorest countries in the Asian region, struggling to provide services to its population after years of conflict. There is little access to quality family planning services in the country and this is combined with widespread fear of contraceptive side effects, resulting in many unplanned pregnancies (Sadana and Snow 1999). Few government clinics have the training or personnel to offer abortion services, so women must travel to the capital, Phnom Penh, for services. Reports suggest that few people are

even aware that abortion services are legal and available to women, and there is widespread self-medication using drugs purchased over the counter (including substances such as strychnine) as well as the continued use of traditional techniques such as massage and the insertion of objects for the induction of abortions. A study of sex workers in Cambodia found that abortion was widely utilised due to low contraceptive use, but that it was perceived to be risky and costly (Deavaux et al. 2003).

Vietnam

Apart from Cambodia, Vietnam has the most liberal abortion laws. The 1989 Law on Protection of People's Health recognises a woman's right to decide to have an abortion. Vietnamese women have one of the highest rates of abortion in the world, estimated at 2.5 abortions per woman during her lifetime (Henshaw et al. 1999). A major goal of the National Reproductive Health Care Strategy 2001–2010 in Vietnam is to reduce the number of unwanted pregnancies and to manage abortion-related complications effectively (Centre for Reproductive Rights and ARROW 2005: 219). Vietnam's abortion rate reflects a history of poor quality of care and lack of choice within family planning services throughout Vietnam along with a lack of post-abortion contraceptive counselling. The use of mifepristone and misoprostol for medical abortion was introduced into the Vietnam National Reproductive Health Guidelines in 2002 (Ganatra et al. 2004) and is now available as a choice in public clinics for early terminations alongside MVA. Sex-selective abortions were banned by the government in 2006 (see the chapter by Wolf et al., this volume).

Philippines

In the Philippines, the strong influence of the Catholic Church sustains highly restrictive abortion legislation which only allows abortion to save the life of a woman. The Philippines 1987 constitution defines human life as existing from conception and grants the foetus equal rights with a pregnant woman: '[the state] shall equally protect the life of the mother and the life of the unborn from conception'. The Revised Penal Code (1930) imposes a range of penalties for women undergoing abortion, including imprisonment. Similarly, health professionals providing abortion services may have their licenses to practice revoked. Despite the restrictions, it is estimated that 400,000 unsafe abortions occur each year in the Philippines (Centre for Reproductive Rights and ARROW 2005: 139),

most obtained through traditional birth attendants, midwives and doctors acting illegally (Cadelina 1999). The abortion issue remains a highly emotive one, in which the Catholic Church maintains a vociferous campaign against any reproductive health reforms, including discouraging the use of contraceptives. The Catholic campaign is supported by a worldwide Catholic network and uses a range of tactics and organisations, including sophisticated marketing campaigns utilising foetocentric imagery to mobilise moral outrage; targeted political efforts to support and elect members of parliament to help prevent the passage of legislative reform bills; and the support of Catholic medical associations to impact on health professionals' willingness to provide appropriate care. Women's groups are depicted in these campaigns as anti-family and immoral. In 2001, the emergency contraceptive Postinor was banned on the grounds that it was considered an abortifacient; however, a review of that decision has since determined that it is both legal and safe (Centre for Reproductive Rights and ARROW 2005: 139).

Indonesia and Malaysia

Malaysia and Indonesia form an interesting comparison. Both nations have a majority Muslim population, both inherited restrictive colonial legal legacies, and both share emerging fundamentalist religious movements that are increasingly politically influential. As Hull and Widyantoro note in this book, Indonesia has a number of laws governing the provision of abortion: under Articles 346–348 of the Penal Code, all abortions are prohibited. However, article 15 of the Law on Health gives an exception to this law, allowing 'certain medical actions' to be performed to save the life of 'the pregnant mother and/or her foetus'. Despite the efforts of women's organisations, the growing strength and influence of fundamentalist Islamic political parties makes the prospect for legal reforms unlikely in the near future and indeed threatens a range of reproductive health services.

By contrast, Malaysia has a liberal abortion law, yet it suffers from a lack of implementation (see Rashidah Abdullah and Yut-Lin Wong, this volume). Health providers are reluctant to provide abortion services, even to women who are legally entitled to services, and there is widespread misunderstanding and confusion about the legal provisions governing abortion. Although there has been agreement between Islamic leaders over the permissibility of abortion under certain conditions, there is a widespread misconception that abortion is totally forbidden under Islam. Nine abortion-related

deaths were reported in Malaysia in 2002 (Centre for Reproductive Rights and ARROW 2005: 18, 96).

Timor-Leste

Timor-Leste experiences high maternal death and fertility rates. Sources suggest a maternal mortality rate of 800/100,000 to 890/100,000, or double that of Indonesia (Povey and Mercer 2002; UNDP 2006). The accuracy of this figure is doubtful given the lack of reliable statistical data in Timor-Leste. It is likely, however, that complications from unsafe abortions contribute to a high maternal mortality rate. Although the exact number of induced abortions currently taking place in Timor-Leste is unknown, evidence from three of its four hospitals suggest that 40 per cent of all emergency obstetric care involves managing and treating complications from early pregnancy losses. Post-abortion care in hospitals remains limited and does not utilise evidence based protocols. Access to family planning information, education and supplies is limited especially for vulnerable groups such as young people (Belton, Whittaker and Barclay 2009).

In 2005, East Timorese lawmakers began drafting a Penal Code for the new nation, an opportunity to revise the highly restrictive Indonesian laws left over from Indonesian occupation, which currently makes abortion illegal in all cases, even when a woman's life is in danger. Debate and consultation on this continues, with women's organisations, other NGO representatives, members of the Catholic Clergy, officials of the Ministry of Health and the UN Specialised Agencies participating in public fora on the issue. The National Reproductive Health Strategy of the government of Timor-Leste supports the provision of modern methods of contraception and access to post-abortion care, although is not supportive of access to abortion services. The influence of the Catholic Church remains strong and affects attitudes towards the provision and use of contraception and abortion.

East Asia

China

China's notorious one-child policy has produced a range of human rights abuses, including forced abortions (for discussion see Greenhalgh and Winkler 2005; Greenhalgh 2003). The Chinese policies generated enormous controversy in the West and influenced political decisions in the U.S. and Australia to restrict donor funding to organisations working in China. Although in recent years the one-

child policy has been relaxed and greater emphasis has been placed upon improving the quality of the family planning programme, concerns remain about the quality of care, especially pain control and health consequences for women undergoing abortions (Zhou Weijin et al. 1999). Abortion is available on request up to six months' gestation, with the consent of family and spouse. Despite an extensive family planning programme, in 1999 four million abortions took place in China, but reliable statistics are difficult to locate (Centre for Reproductive Rights 2005: 45–46). Non-medical sex-selective abortions are strictly prohibited by the Population and Family Planning Law (2002) (Centre for Reproductive Rights and ARROW 2005: 45), yet despite this prohibition, the practice is known to continue (Chu Junhong 2001; Löfstedt et al. 2004).

Taiwan

Abortion was legalised in Taiwan in 1985, although before that time, abortion was readily available. By the 1990s nearly one third of all pregnancies were terminated. As Moskowitz (2001) notes, abortion is common in Taiwan, yet it is also seen as an act which defies Confucian ideals of filial responsibility to continue the family line, Buddhist beliefs regarding the sinfulness of killing sentient life, and challenges dominant Taiwanese cultural ideals of women as nurturers. As in Japan, temples and religious masters across Taiwan offer appeasement services for foetus ghosts, sometimes at considerable cost (see discussion of similar understandings in Vietnam from Gammeltoft, this volume).

Japan

Japan is notable for its ready social acceptance of abortion. Its abortion rate is among the highest in the world, with an estimated two-thirds of Japanese women having had an abortion by age forty (Oaks 1994). This is partly due to the fact that, until recently, government restrictions have limited the availability of the contraceptive pill on 'public hygiene grounds'. It has been argued that the continued limits placed on oral contraceptives has also ensured the continuation of a lucrative abortion business by physicians.

Under the Eugenics Protection Law of 1948, abortion on demand is legal in Japan up to twenty-two weeks' gestation if a 'woman's health may be affected seriously by continuation of pregnancy or childbirth from the physical or economic viewpoint' (Oaks 1994: 513). The Eugenics Protection Law was reformed during the post-war occupation of Japan. The clause allowing abortions to be per-

formed in cases of economic hardship was included in 1949 and in 1952, restrictions requiring that each case be approved by a local eugenics council were abolished, allowing individual physicians to judge their patients' needs (Hardacre 1997: 56–57).

As Hardacre notes, challenges to the Eugenics Protection Law in Japan have come from the 'new' religion *Seicho no Ie* which especially focuses on the soul and views abortion as homicide. In 1964, it founded a conservative right-wing nationalist political lobbying group called the *Seicho no Ie Seiji Rengo* (The Political Association of *Seicho no Ie*). A number of attempts have been made to restrict the law in Japan, spearheaded by *Seicho no Ie* with support from Japanese Catholic groups. The campaign to change the Eugenics bill reached its zenith in the early 1980s (coinciding with a similar campaign in Thailand) when a fifth and final campaign failed in 1983. Opposition to the *Seicho no Ie* campaign by Japanese feminists mobilised a coalition of doctors and family planners in opposition to the move to eliminate the economic hardship condition in the law (Hardacre 1997: 76–77). Although small campaigns to oppose abortion continue to be active during provincial elections, these have not attracted widespread support.

South Korea

South Korea makes an interesting contrast to Japan in that it shares liberal attitudes towards abortion. However, abortion remains technically illegal except in limited circumstances. Attempts to liberalise the law in 1966 and 1970 failed. A Maternal and Child Health Law was passed in 1973 by a martial law authority permitting abortions with the consent of a woman and her spouse in cases of hereditary defects in the foetus, certain infectious diseases, when a pregnancy resulted from rape or incest, or when the pregnancy is deemed to be detrimental to the health of the mother. However, despite the technical ban on abortions, the laws are not enforced. Korean society in general is very tolerant of abortion and obtaining one is relatively easy. Common estimates posit that approximately one million abortions are induced annually (Tedesco 1999: 130). Due to a strong son preference, sex-selective abortions are common and are resulting in a distorted gender ratio in the country, despite the fact that legislation passed in 1987 and 1994 made prenatal sex selection illegal. Tedesco notes that Buddhist groups in Korea have generally not been involved in the abortion issue, with the Catholic Church instead leading opposition to liberalisation.

South Asia

South Asia accounts for one third of the world's unsafe abortions. Unsafe abortion is a leading cause of death among women in South Asia: an estimated 29,000 women die every year in the region from unsafe abortion (Center for Reproductive Rights and ARROW 2005: 16). These figures reflect the generally low status of women and the gender inequalities in the region. However, they are also indicative of poverty, lack of access to health services, particularly family planning services, and restrictive legal frameworks in a number of countries.

Sri Lanka

Sri Lanka has a highly restrictive law regarding abortion dating from 1883, prohibiting abortion except when performed to save a woman's life. There is no national-level data on the incidence of abortion. However, it is estimated that around 25,000 to 30,000 abortions are induced each year. Abortion remains a leading cause of maternal death (Hewage 1999). A number of attempts have been made to reform the Sri Lankan Penal Code in order to relax restrictions on abortion. The most recent of these took place in 1995, when changes were proposed to parliament as part of a Penal Code Bill encompassing a number of women's issues to allow abortion in cases of rape or incest or in cases of foetal abnormality. As in Thai debates on the issue, arguments based upon notions of culture, religion or tradition were used to oppose any form of liberalisation and the clause liberalising abortion was deleted from the second reading of the Bill to parliament (Abeyesekera 1997). In addition, the civil war in Sri Lanka has also been used to justify the need for a pronatalist policy. Hence, abortion remains a criminal offence and women continue to be prosecuted by police.

India

According to government data, an estimated 1.7 per cent of pregnancies in India end in induced abortion; between four million and six million abortions are performed illegally, and unsafe abortion accounts for upwards of 9 to 16 per cent of maternal deaths (Center for Reproductive Rights and ARROW 2005). A study conducted in rural Southern India (Varkey et al. 2000) found that 65 per cent of abortions had been carried out by untrained practitioners, although there are indications that such a pattern may be changing (see Ramachandar and Pelto 2004). The 1971 Medical Termination of Preg-

nancy Act in India includes a range of indictors for safe abortions, including to save a woman's life or health or in cases of rape, contraceptive failure in married women, foetal abnormality or socio-economic hardship. Despite these liberal conditions, studies show that illegal abortions outnumber legal procedures. However, this does not mean that all illegal procedures are unsafe. On the contrary, a number of studies (Duggal and Ramachandran 2004; Ramachandar and Pelto 2004) demonstrated that in many cases, women chose to attend 'illegal' but medically trained providers who lacked the government registration to provide abortion care, because these providers' quality of care and outcomes were better than the government registered providers. Recent simplification of the regulations governing the type of clinic able to perform early abortions, as well as improvements in services at public clinics, is meant to address this problem (see the chapter by Ramachandar and Pelto, this volume).

Access and the quality of care in public-sector abortion services in India remain patchy. Inappropriate technologies, poor quality services and judgmental staff can lead women to choose more expensive private clinics. For the poorest women, cost may remain a barrier and hidden costs at public clinics may encourage them to seek unsafe abortions with unskilled providers. Likewise, unmarried women in particular still face difficulty accessing legal procedures and often seek unsafe abortions (Ganatra and Hirve 2002). Medication abortion is available in government-approved hospitals and at all registered abortion clinics and its use has become widespread, even in rural areas; however, ethnographic studies demonstrate considerable variability in its use among providers, with incorrect regimes and over-the-counter sales (Ramachandar and Pelto 2005).

The Pre Natal Diagnostic Techniques Act of 1994 prohibits sex determination of a foetus or informing a couple about the sex of their foetus. However, the ready accessibility of ultrasonography and other technologies to determine the sex of a foetus make the Act difficult to enforce and ensure a continuation of the strong preference for male children (George 2002; Nidadavolu and Bracken 2006). Studies also suggest an increase in sex-selective abortions. The sex ratio among children aged 0–6 declined steadily over the 1990s, from 945 girls per one thousand boys in 1991 to 927 girls per one thousand boys in 2001 (Center for Reproductive Rights and ARROW 2004: 17).

Research in India also raises questions about the presumed association between legal abortion and the enjoyment of reproductive and sexual rights. Studies indicate that the utilisation of induced

abortions rather than of reversible contraceptives among married women in India is partly due to the lack of women's sexual and reproductive rights within marriage. Ravindran et al. (2004) found that non-consensual sex, sexual violence and women's inability to refuse their husbands' sexual demands appear to underlie the need for abortion in both younger and older women. A large number of women in that study were denied their sexual rights but were permitted, even forced, to terminate their pregnancies for reasons unrelated to their right to choose abortion. The relationship between violence, denial of sexual rights and abortion requires further investigation across Asia. Similarly, a study by Gupte et al. (1997) in rural Maharashta found that many women felt uneasy about abortion, but often found themselves in 'no choice' situations due to pressure from their husbands or family to undergo abortion, including sex-selective abortions. Most women were dissatisfied with the quality of services provided. Many used abortion as their means of fertility control due to their husband's lack of permission to use contraceptives.

Bangladesh

Abortion is illegal in Bangladesh under the penal code, except to save the life of the mother. In these cases abortion must be performed by a qualified physician in a hospital. However, official government policy allows menstrual regulation (MR) as a means of establishing non-pregnancy, as opposed to terminating a pregnancy. It is allowed up to eight weeks from the last menstrual period by a trained family welfare visitor under the supervision of a physician, and up to the tenth week by a licensed medical practitioner and is available for married women only. However, the term MR is commonly used to describe a range of procedures (see the chapter by Rashid in this volume). MR has been available in government health facilities since 1979 and a range of private clinics also provide MR and abortion services (Caldwell 1999). However, the quality of care remains poor (Chowdhury and Moni 2004). A study of 143 women who had had MR procedures in rural Bangladesh found that a quarter of the abortion procedures were dangerous or inadequate, and that the number of women who developed complications was very high (43 per cent); one death was reported (Ahmed et al. 1999).

Given the high number of clandestine abortions, figures estimating the prevalence of induced abortion in Bangladesh are likely to be underestimates. A total of 28,000 women die each year due to pregnancy-related causes, of which 8,000 deaths are estimated to be

from abortion-related complications. Overall, about 26 per cent of all pregnancy-related deaths in Bangladesh are thought to be due to induced abortion, with one study suggesting that as many as 50 per cent of admissions to obstetric wards are for abortion-related complications (see Ahmed et al. 1999).

Nepal

Until 2002, Nepal had one of the most restrictive and punitive abortion laws in the region, which saw women jailed for between three and twenty years for having abortions (Ramaseshan 1997). According to a number of studies throughout the 1990s, over 54 per cent of all hospital admissions were for women with post-abortion complications. Unsafe abortion contributed significantly to the very high maternal mortality rate in Nepal (Tamang and Tamang 2005). One study found that unplanned pregnancy accounted for 95 per cent of induced abortion among women and that the majority of the women were not using contraceptives (Tamang et al.1999). Following a concerted public campaign by activists, Nepal reformed its abortion laws in 2002 to allow for the performance of abortions on request for women during the first trimester, and in the case of rape or incest, up to eighteen weeks' gestation. Abortions may also be performed at any time during pregnancy with the approval of a physician, if the pregnancy poses a danger for the life of the pregnant woman, her physical or mental health or in the case of disability in the foetus. The new law also prohibits the use of amniocentesis for the purposes of sex-selective abortions (Shakya et al. 2004; Thapa 2004). The Nepalese health system now faces the challenge to appropriately implement this legal change and to ensure access to abortion, particularly for rural women. Women continue to utilise local untrained practitioners or self-medicate with a range of allopathic and indigenous medicines available on the Nepalese market to induce abortions (Tamang and Tamang 2005). Likewise, a significant challenge exists in improving access to contraceptives, particularly among impoverished rural populations, as it is estimated that only 59 per cent of demand is currently being met (Shakya et al. 2004: 77).

Pakistan

Abortion is illegal in Pakistan unless the procedure is necessary to save the woman's life or to provide 'necessary treatment' under the Islamic Qisas and Diyat Ordinance (1990). Without policies defining the requirements for obtaining an abortion under the 'life' or 'nec-

essary treatment' exceptions, the discretion to perform abortions rests with physicians, most of whom are reluctant to interpret the law liberally due to the risk of prosecution (Center for Reproductive Rights 2004: 170–171). Few government facilities provide abortion services even under those exceptions, and there is little data available on the incidence of abortion. Due to the highly restrictive laws on abortion, the majority of abortions are either self-induced or performed in clandestine clinics in urban areas, whereas in rural areas, they are performed by untrained practitioners. Mifepristone and misoprostol are available by prescription in Pakistan, although not for use as abortifacients (Center for Reproductive Rights 2004: 170–171).

Reproductive Rights and Abortion Reform: The Challenge for Activists

The synopses above reveal that across the region, there remain considerable gaps between law, practice and ideology. In many cases, the laws regulating abortion bear little relation to the realities of practice and become political weapons rather than protections for citizens (see Hull and Widyantoro, this volume). Religious values antithetical to abortion may bolster support for maintaining restrictive laws, but may not reflect the pragmatic actions of women when faced with unplanned pregnancies. Likewise, rhetoric claiming the implementation of the ICPD goals by governments may not be borne out when women seek to access services on the ground. Activists face challenges in bridging these gaps; in confronting the disparities between states' imaginaries and lived realities.

Across Asia, the notion of reproductive rights remains novel outside academic, NGO and policy circles. The very terms of reproductive rights discourse often do not translate easily into local languages. Petchesky (1998: 2) notes that the philosophical bases of principles of reproductive freedom rest in Western traditions, particularly the liberal notion of 'property in one's own person', which is not necessarily universal in Asian societies. This point forms the basis of critiques of the notion of reproductive rights from third world feminists. For example, Correa (1994: 77) argues that the emphasis on individual autonomy assumed in reproductive rights discourse is founded on the Western bourgeois concept of a discrete 'self', a concept that is inappropriate for many cultural settings in Asia. She suggests that the notion of bodily integrity be understood in the context of

significant family, cultural, social and economic relationships and that rights discourses need to take account of collective identities (1994: 79). Likewise, the International Reproductive Rights Research Action Group (IRRRAG) adopted the term 'sense of entitlement' to capture their informants' negotiated subjective component of rights. It is based upon a notion of 'the self both as individual and constructed through ongoing interaction and interdependency with others' (Petchesky 1998: 12–13). Wolf et al. (this volume) argue for a position that recognises the cultural diversity in constructions of rights, including reproductive rights. For example, they suggest that the language of rights in Vietnam is frequently couched in terms of the good of society and the nation. The challenge, they suggest, is to respect and recognise differing approaches to rights discourses so that in practice the exercise of an individual's rights coincides with that of the broader social good. However, Correa (1994: 82) also offers an overarching principle: 'when cultural practices only consolidate women's subordination and damage women's physical integrity or their freedom to make decisions about their own lives, we must question them'.

Women's advocacy strategies for abortion rights have developed around two major approaches: the 'health rationale', framing abortion as a major contributing factor in women's mortality around the world, and the 'rights rationale', asserting that the right to terminate a pregnancy is one protected by fundamental principles of human rights (Correa 1994: 70–71). These principles are not mutually exclusive, however. Until recently, the 'health rationale' rather than the 'rights rationale' has been emphasised in advocacy work across Asia, stressing morbidity and mortality rates attributed to unsafe abortion and the economic costs to public health systems of treating complications from unsafe induced abortions. As Correa notes, the danger of this rationale is that the issue of abortion becomes seen as a technical medical problem placed in the hands of the medical profession, rather than as an issue that must recognise women's rights and place women's desires and expectations at the forefront of the debate. Read against each other, the final two chapters on Malaysia and Thailand in this volume illustrate this tension between medically directed reforms versus the need to assert the primacy of reproductive rights as the fundamental principle driving abortion reform. The emergence of a number of reproductive rights coalitions such as the Reproductive Rights Advocacy Alliance Malaysia (RRAAM), Women's Health Foundation (WHF) in Indonesia and the Women's Health and Reproductive Rights Foundation of Thailand

(WHRRF) mark a shift in emphasis towards a rights-based approach. Hessini (2005) calls for a synthesis between the public health and human rights approaches and strategic alliances between such organisations and other social movements working in social justice as a foundation for legal reforms.

Given the political realities and the lack of a strong women's movement in many nations, it is often necessary for reproductive rights advocates to find a 'middle path' towards change, undertaking the transformation of law and social policy in pragmatic, slow and incremental steps. While public campaigns have succeeded in some countries such as Nepal (Thapa 2004), reform movements in Asia more commonly involve very small numbers of committed people, gradually raising the profile of the issue in public, in policy circles and within health programmes. Well-designed research can play an important role in this process by supporting efforts towards reform.

However, debate on the issue of abortion and reproductive rights faces concerted opposition in many locations. As noted in the regional overview, conservative religious movements and their political allies often target the issue of abortion. I have previously documented the rise of the Buddhist Santi Asoke sect, which greatly influenced attempts to introduce abortion law reforms in Thailand throughout the 1980s (Whittaker 2004). Such campaigns often take on nationalist overtones, with reproduction linked to fears about the moral corruption of the nation-state and the protection of 'Asian values'. While depicting themselves as representing authentic local cultural, religious and national values in opposition to Western values, the campaigns of such groups often draw support from international 'pro-life' and Catholic organisations.

But it is not only local conservatives influencing abortion access and debate in the region. The restrictive U.S. government policies reinstated under the Bush presidency in January 2001, known as the Global Gag Rule, forbade the use of U.S. family planning funds by organisations that perform, advocate for, or provide medical referrals or counselling for abortion, even when those activities were supported by their own non-U.S. funds and were lawful under their own national legislation. The impact of these policies cannot be overstated. The U.S. Agency for International Development (USAID) is the biggest bilateral donor in the field of family planning and reproductive health. In this way, internal U.S. policy influenced and limited what governments and NGOs in Asia could undertake with both their own and donor money, thereby silencing debate, restricting public education and leading to vital projects losing their

funding, even in countries where abortion is legal (Global Gag Rule Impact Project 2003; Crane and Dusenberry 2004). However, on 23 January 2009, the Obama administration lifted the ban, restoring funding to the United Nations Population Fund. While not directly funding abortion services, this will allow funding to resume to groups and NGOs that provide other services, including counseling about abortions. Likewise, in April 2009, the Australian government amended the AusAID Family planning guidelines which similarly restricted Australian aid funding to any services, education, training or information in regard to safe or unsafe abortion services for the past thirteen years. This illustrates how the internal politics of abortion in countries such as the U.S. or Australia have international ramifications with direct consequences for women in the region. It reminds us how funding and support for abortion as an issue of health and rights is especially vulnerable to international political trends.

Overview of the Book

Abortion in Asia begins with the personal stories of women and the factors influencing their need for induced abortion, their ability to access services and their experience of services. As Petchesky writes in her introduction to *Negotiating Reproductive Rights,* 'we need to situate … [the concept of reproductive rights] within direct testimonies about the daily constraints and relationships through which women – across a variety of countries and cultures – engage in reproductive and sexual transactions' (1998: 1). A number of chapters written by anthropologists in this volume take up that challenge, offering poignant descriptions and first-hand accounts of women's lives and decision-making and placing these accounts at the centre of their analysis. It starts with an account of decision-making around contraception and the resort to crude abortion methods in Cambodia. It moves to an emotive account of late therapeutic terminations in Vietnam, drawing attention to the ambivalence, sense of loss, grief and ethical subjectivity such decisions involve. The book then moves to accounts exploring the broader structural issues and institutional violence impinging upon women's decisions on the Burmese border Burma and in Bangladeshi slums. In these chapters women are marginal to the health system and must act outside it. Women's considerations and negotiations with health systems are further highlighted in a chapter considering women's decisions around quality of care and cost. The final chapters offer views on changing health

and legal systems through public health interventions and activism. In doing so, the book moves from the personal to the public: from the pragmatic actions of individuals to public activism, from acting outside and within health systems to changing them, from the micro-politics to macro-politics of reproduction.

Chapter Two explores women's decision-making with regard to family planning and the experience of unplanned pregnancy in Cambodia. The account of Oung's case highlights the cultural logic behind women's choice of use of contraceptives and the poor counselling and care received from local health services, which, in Oung's case, ultimately resulted in an unplanned pregnancy and unsafe termination. As the authors argue, despite Cambodia's liberal abortion laws, the legal status of abortion remains little understood in the country by both women and health professionals. Access to safe abortion services remains poor. Instead, women rely on the services of local women skilled in crude abortion techniques and self-care for any ensuing complications, with the attendant risks that this carries.

The tensions around religious beliefs and the act of abortion come into stark relief in a number of chapters. In my own work in north-east Thailand, I heard women speak of the private rituals they undertook both to seek protection before their abortions and to obtain reconciliation with the spirit of the foetus in order to ensure its re-incarnation and to recognise one's responsibility in the act of terminating one's pregnancy. In Theravadhan Buddhist Thailand, public temple rituals like those common in Mahayana Buddhist countries such as Japan, Taiwan or Korea, which seek to placate the spirits of aborted foetuses, are not practiced. Instead, women struggle to find their own language and means of reconciling their acts with their beliefs. Similarly, in Chapter Three, Gammeltoft offers an empathetic exploration of the experiences and dilemmas posed for women aborting wanted pregnancies for medical reasons following ultrasonography. The dilemmas faced by women over whether to bury the foetus, and thereby recognise it as one does other family members who have died, entails not only religious beliefs but, as she notes, Vietnamese ways of grieving and coping with painful events and contested views over the pain of memories. Vietnamese women's decisions over these matters are not individual decisions but usually entail the advice and counsel of elders and involve relationships with the living as much as with the dead.

Gammeltoft's chapter demonstrates the power of detailed ethnography to allow us to enter into another person's experience. Through women's eyes, we starkly experience the insensitivity of health care

providers, the unintentional cruelties and ignominious suffering caused by a lack of counselling and support. The reader is forced to confront and interrogate his or her cultural assumptions regarding the social status of a foetus and rituals surrounding death. In the ethnographic chapters in particular, a picture emerges of women submitting themselves for medical procedures surrounded by fear, a lack of information, misunderstandings, uncertainties and little support.

Chapter Four offers first-hand accounts of women's decision-making on the Thai-Myanmar border. Belton describes the daily realities of poverty, harassment by border patrols, domestic violence and suffering experienced by Burmese forced migrants, all forms of structural violence perpetuated against women in this region. Burmese migrant workers lose their jobs in Thailand if they fall pregnant, forcing many to procure abortions rather than face economic insecurity. The embodied symptom of 'weakness' becomes the language through which to express vulnerability. Poor post-abortion care, a lack of contraceptive counselling and the illegality of abortion contribute to the continuation of this cycle. The inadequacies of post-abortion care for women is a repeated theme throughout this book. Rather than finding quality care, support and counselling, women face inadequate care with outdated techniques, discrimination, little privacy, blame and in some cases forced sterilisation.

Several chapters in this book describe the ambiguous terms used by women to describe the act of abortion. These terms can refer to local ethno-gynaecological understandings of the processes of reproductive bodies and pregnancy, but they also index the moral frameworks informing women's actions. Descriptions of abortion as a prophylactic act of washing out the uterus, 'sweeping clean' the uterus through D&C (dilation and curettage), removal of a mere 'lump of blood', restoring blocked menstruation through MR, or tests to check for possible pregnancy are common across Asia. The use of ambiguous terms enables a conceptual space in which the act of abortion can be more easily accepted. Similarly, we find common humoral understandings of the process of pregnancy and the widespread use of self-administered 'hot' medicines as abortifacients and menstrual regulators; such patent 'women's medicines' are exported and marketed across the Asian region. Even modern pharmaceuticals considered 'hot' and other 'hot' substances such as aspirin and whiskey are consumed in the attempt to effect an abortion. Alongside the consumption of herbal preparations, the chapters also detail some of the more dangerous abortion techniques used, such as the insertion of sticks, leaf stems and feathers or the use of uterine mas-

ILLUSTRATION 1.3 'Hot' medicines, herbal abortifacients and assorted contraceptives purchased over the counter from village stores in northeast Thailand, 1997 (Photograph: A. Whittaker).

sage or forceful pummelling. As a number of authors assert, local knowledge and availability of such techniques remains widespread, evidence of both the long history of abortion as a form of fertility control in the region and also of the continued dependence upon such techniques for many women. While many such abortions take place without complications, other women do experience complications and end up in the emergency departments of local hospitals.

The following chapter by Rashid gives married adolescent women's first-hand accounts of their reasons for abortion and experience of discrimination at the hands of health providers. Like the women described in Belton's chapter, these young woman are subject to personal and institutional violence and have little choice in the services they must use. Rashid's chapter speaks of the vulnerability of married adolescent women in Dhaka's slums, and how their poverty forces women to abort pregnancies and also determines the quality of care they receive. Poorly paid NGO health workers accompany women to private abortion providers rather than their own public health services in order to receive a small commission for each new client. The cry of frustration Rashid recalls from a woman left waiting to see a health worker, resonates for women around the world with regard to access to quality, safe abortion services: 'How long can we wait like this?'

In Chapter Six, Ramachandar and Pelto describe the costs involved in women's abortion-seeking in Tamil Nadu. They have worked for many years, collecting detailed observations of women's decision-making processes and the changes across time that have affected women's choices, including service provider attitudes and their ability to provide quality care. Due to a long-standing distrust in the quality of care at government clinics, poorer women will go into debt to pay for their abortions with providers that they consider offer good-quality care. But on a positive note, the up-grading of services in government primary health clinics (PHC) over the last few years has yielded improvements in the quality of services compared to what they observed in their previous work (Ramachandar, 2004 a,b). This also appears to have contributed to a decrease in the proportion of women they find seeking unqualified providers.

A further theme developed in this book is that of advocacy and the strategies used in the region to reform laws and assert the importance of women's reproductive rights at the national level. Chapter Seven provides a perspective from international NGO workers on collaboration with the Vietnamese government to improve service delivery and quality of care and to integrate principles of reproductive rights into government programmes. This chapter places abortion in a broader social and political context and gives an insight into the language used within policy changes. It also documents the Vietnamese government's attempts to both expand contraceptive availability and use and to improve abortion services in response to the high demand for abortion. The authors note the impact that U.S. policies such as the Global Gag Rule have had on donor funding for abortion programme work in Vietnam. They also make the observation that the sudden availability of large funds for other reproductive health issues such as HIV/AIDS has the potential to distort reproductive health programmes within small overworked ministries of health.

Conservative religious movements across the region lobby to block efforts to provide reproductive health services, including abortion-related care. As Hull and Widyantoro document for Indonesia in Chapter Eight, increasingly conservative Islamic politics threaten to harden Islamic interpretations of provisions in the law. They describe how abortion laws in Indonesia serve as an instrument for the harassment and manipulation of individuals. On the other hand, the Women's Health Foundation, a coalition of women's groups, obstetricians, gynaecologists and medical associations, has incorporated progressive religious groups into their discussions on repro-

ductive health and abortion. They draw upon progress in Malaysia where interpretations of Islamic texts and a *fatwah* outlining the Islamic position on abortion demonstrate Islamic support for women's rights to contraception and abortion before ensoulment has taken place (at 120 days). They describe the frustrating attempts to reform Indonesia's restrictive abortion law and the effects of a series of ambiguous legal rulings on abortion.

Even in settings where the laws are relatively liberal such as Malaysia, fear of conservative backlash limits the dissemination of information about existing available services. In Chapter Nine, Rashidah Abdullah and Yut-lin Wong detail how abortion in Malaysia remains difficult to access. Vulnerable groups of women such as those who live in poverty, unmarried women, survivors of domestic violence or rape face discrimination and stigma when they seek abortion services. Abdullah and Wong note that modern contraceptive use remains low in Malaysia, due in part to poor promotion by the government and a lack of accessibility to quality services. Widespread misinformation about the law and beliefs that abortions are forbidden under Islam lead to women not being able to access the abortion services they are legally entitled to. Their description of institutional practices in hospitals and attitudes of medical staff highlights the truism that reform alone is not enough. The final part of this chapter outlines an agenda for action within Malaysia to ensure dissemination of information, advocacy, research and integration of abortion services within quality reproductive services.

Reform may also be conducted through indirect regulatory reforms rather than direct confrontation. The final chapter, by Nongluk Boonthai and colleagues, offers a unique first-hand account of 'activism from within': the process through which the Thai medical regulations governing abortion were reformed. Given a history of repeated political opposition to legal reform, even a small reform of the medical regulations took a number of years of painstaking lobbying, negotiations and consultation. Little has been written about the actual ways in which reform does take place, particularly what happens 'behind the scenes' in public debates, making this chapter a valuable contribution. The reforms define the interpretation of the conditions under which abortion may be legally provided, in particular clarifying the definition of 'mental health' in the law and including foetal medical conditions as criteria permitting abortion. Since this reform took place, the Thai Ministry of Public Health has begun undertaking national training of government medical staff in MVA techniques for post-abortion care to replace outdated D&C

techniques, an additional opportunity for dissemination of the new regulations to health staff. A newly formed coalition, the Women's Health and Reproductive Rights Foundation of Thailand (WHRRF), will continue to support and lobby for reform.

Conclusions

Across Asia, states actively attempt to regulate reproductive behaviours and govern populations through various interventions: campaigns to encourage smaller families, safe-sex campaigns, contraceptive distribution and laws defining the availability of abortion. These interventions stratify reproduction, defining who is empowered to reproduce and the type of families validated by the state (Ginsburg and Rapp 1995), attempting to regulate and define the reproductive intimacies of the lives and bodies of citizens. In doing so they shape the modern Asian subject, redefining the 'Asian' value of 'the family' and creating new expectations of women's productive and reproductive roles, the 'quality' of children and their care, gender relations, the experience of motherhood and fatherhood and changing filial roles. This is occurring at a time of unprecedented social change in the region, which has seen a transition from largely agricultural economies to globalised industrialisation in the last fifty years. In the past, abortion was a private act undertaken by an individual or with the assistance of family and a local skilled woman. Today, across the region, abortion has become a public concern defined and regulated by the state and is often the subject of intense national and international politics.

The chapters in this book describe some of the various consequences of these forms of governance: from family planning accessibility to laws regulating abortion, to the quality of care received in clinics. But states are not hegemonic, and this book also raises examples of forms of intervention by non-state actors: women themselves, feminist groups, religious groups, international agencies and NGO advocates attempting to modify the nature of state regulations and laws. In the midst of it all are women who find themselves facing decisions about whether to abort a pregnancy, negotiating their relationships, pragmatically weighing options for care, consulting with families, pondering moral ambiguities, seeking support and care. The degree to which women are free to make their decisions with safety depends overwhelmingly on the economic, social, cultural and legal conditions defining abortion in their country of residence.

This tension between agency and structure runs throughout the chapters of this book. Petchesky (1990: 11) suggests that the critical issue for feminists is not so much the content of women's choices, but the social and material conditions under which choices are made: 'Women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions they create but under conditions and constraints they, as mere individuals, are powerless to change'. In my previous work on abortion in northeast Thailand (Whittaker 2004), one informant in a focus group on abortion eloquently summed up the dilemma: 'Speaking very simply, poverty decides to have it [the foetus] out and start at the beginning, a new life'. In this statement, poverty is anthropomorphised as the one who makes the decision to abort. In discussions of abortions, villagers frequently spoke of how poverty 'forces' the decision; how the poor economy 'strangles' women; and how 'the situation squeezes and forces us', which also refers to massage abortion, a common technique used in that region. Such descriptions provide a stark statement of the villagers' awareness and lived experience of economic inequalities in Thai society. They identify abortion as a decision grounded in broad social and economic contexts, not just a personal decision.

To write of abortion in Asia is an inherently political act. As the authors in this volume demonstrate, to write of abortion is to expose the social and economic disparities within countries. It is to write of poverty and violence against women and the institutional violence meted out through poor services in hospitals and health centres. It exposes the operations of patriarchy within our societies. The decision to abort is enmeshed in local and global politics, which profoundly influence the experience for a woman and the safety of that act. It is a public health imperative that health services cater fully for woman's reproductive health needs, including access to abortion services when required. It is a human rights imperative that women not be denied the ability to control and decide freely about a procedure so clearly linked to their health, with legal protection, good quality care and free of discrimination and fear.

Note

1. For the most part, social science research on abortion in Asia appears in journals such as *International Studies in Family Planning.* An exception is the journal *Reproductive Health Matters,* which carries the most Asian

content on the issue from anthropological, policy and advocacy perspectives. Advocacy groups such as the Center for Reproductive Rights (2004, 2005) ARROW and Ipas (Hessini 2004) produce authoritative overviews aimed at policy-makers and donor organisations, and much Asian social science research is found in the 'grey literature' produced within countries for internal consumption and lobbying and not readily accessible to an international audience. Academic volumes on the issue have generally included few chapters on Asia, usually focused on China, Japan, or India (see Githens and McBride 1996; Mundigo and Indriso 1999). However, these volumes tend to be public health and policy oriented. Most published social science books on abortion in Asia are religious studies by Western scholars focusing on non-Western religious practices, particularly descriptions of Buddhist rituals placating vengeful foetus spirits. These include the classic book by William LaFleur, *Liquid Life: Abortion and Buddhism in Japan* (1992), and later volumes by Hardacre (1997) and Moskowitz (2001). *Buddhism and Abortion* (Keown 1998) contains chapters on a number of Buddhist countries and focuses on religious perspectives. Exceptions to this pattern include Jing Bao Nie's (2005) book on abortion in China, and my own book *Abortion, Sin and the State in Thailand* (2004), both of which offer more anthropological perspectives analysing abortion within broader social, political and ethical contexts.

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