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The Erosion of Rights to Abortion Care in the United States: A Call for a Renewed Anthropological Engagement with the Politics of Abortion

Women's rights to legal abortion in the United States are now facing their greatest social and legislative challenges since its 1973 legalization. Legislation restricting rights and access to abortion care has been passed at state and federal levels at an unprecedented rate. Given the renewed vigor of anti-abortion movements, we call on anthropologists to engage with this shifting landscape of reproductive politics. This article examines recent legislation that has severely limited abortion access and maps possible directions for future anthropological analysis. We argue that anthropology can provide unique contributions to broader abortion research. The study of abortion politics in the United States today is not only a rich opportunity for applied and policy-oriented ethnographic research. It also provides a sharply focused lens onto broader theoretical concerns in anthropology and new social formations across moral, medical, political, and scientific fields in 21st-century America. [abortion, United States, reproduction, reproductive health, ethnographic research]

This is a call to action. A woman's right to legal abortion in the United States is now facing its greatest social and legislative challenges since its 1973 legalization in the landmark *Roe v. Wade* decision. Since 2010, legislation restricting rights and access to abortion has been introduced and passed at both state and federal levels at an unprecedented rate. A report by the Guttmacher Institute (2016a) shows that more abortion restrictions were enacted during the 2011–2015 period than at any time since *Roe*. More than half of all U.S. states now have laws that do one or more of the following: (1) impose restrictions on abortion providers through the Targeted Regulation of Abortion Providers (TRAP) laws; (2) mandate wait times, ultrasound viewings, and/or reading of legislator-written scripts about fetal

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development prior to receiving an abortion; and (3) reduce the gestational age for legal abortion. The number of abortion providers has declined by about a third since the 1980s, a reduction widely attributed to legislative pressures, the eradication of abortion training from the curricula of obstetrics–gynecology in U.S. medical schools combined with the retirement of existing providers, and harassment and violence—even murder—directed at abortion providers and their staff.

In the face of this assault on abortion availability and access, we call for anthropologists to engage with this shifting landscape of reproductive politics in the United States (Council on Anthropology and Reproduction 2015). Anthropologists concerned with the politics of reproduction have examined access and meanings attached to abortion in various global sites (see Andaya 2014; De Zordo 2016; Gammeltoft 2002; Ginsburg 1989; Johnson-Hanks 2002; Mishtal 2015; Morgan 1997; Paxson 2004; Rylko-Bauer 1996). In the United States, however, a review of existing scholarship shows that abortion research has largely moved to other fields with more narrowly defined research questions, in particular public health, demography, sociology, and legal studies.[1] Apart from the few studies that consider abortion as the backdrop to prenatal genetic testing and its optimistic narratives of scientific progress (Press and Browner 1997; Rapp 1999), there have been no richly ethnographic—by which we mean holistic, reflexive, multi-level, and multi-perspectival—U.S.-based studies of abortion since Faye Ginsburg's path-breaking study *Contested Live*s (1989). We can only speculate why abortion has moved out of the anthropological gaze; reasons may include current intellectual fashions or concerns about the funding and hiring opportunities available to anthropologists working on abortion.

Given the renewed vigor of anti-abortion movements in the majority of U.S. states, the time is ripe for sustained analyses of the articulation of abortion politics with new social formations across moral, medical, political, and scientific fields in 21st-century America. We argue that the study of abortion politics in the United States today is not only a rich opportunity for applied and policy-oriented ethnographic research. It also provides a sharply focused lens onto broader theoretical debates around gender and personhood, the legitimacy of scientific knowledge, neoliberalism, women's roles and rights in a liberal democracy, church–state relations, and social justice movements, among others. Further, we argue that anthropology's disciplinary commitments, including long-term holistic ethnography and cross-cultural comparison, can provide unique contributions to broader abortion research. To this end, this article is divided into three sections. After considering the major avenues through which abortion has been approached anthropologically, we outline recent legislation that severely limits abortion availability and access in the United States. We end by mapping possible trajectories for future ethnographic and theoretical engagements with abortion that we hope will be of use to anthropologists studying abortion both in the United States and globally.

Abortion through the Anthropological Lens

Attention to abortion in anthropology, of course, is not new. Early cross-cultural studies, largely descriptive and ethnomedical in nature, examined abortion in the context of beliefs about reproduction and knowledge about fertility regulation (e.g., Devereaux 1955). In the 1980s and 1990s, feminist scholars of gender and the newly

reinvigorated kinship studies articulated a new field of analysis—the "politics of reproduction" (Ginsburg and Rapp 1995)—that firmly situated reproduction at the nexus of power and politics. This development provided a new theoretical language and analytic optic for anthropological research on abortion. Building on a growing body of knowledge about reproduction around the globe, a number of ethnographies demonstrated how attitudes and beliefs around reproductive disruptions such as infertility, pregnancy termination, and pregnancy loss are embedded in culturally and historically specific ideologies about gender, motherhood, femininity, kinship, and personhood (see Franklin 1997; Inhorn and van Balen 2002; Layne 2002). Tensions around abortion, in particular, often trigger wider social debates about gender roles and expectations of the (female) life course, shifting ideas of moral personhood, and contested economic, cultural, and political futures.

Other anthropological studies have interrogated the concept of the fetus in historical and cultural context, demonstrating the temporal and cultural variability in the attribution of personhood and kinship to fetuses and young infants (Duden 1993; Kertzer 1993; Mattalucci 2012; Morgan 1997, 2009). Growing out of a concern with the medicalization of pregnancy and childbirth, research in North America and Europe has paid particular attention to the effects of the routinization of biomedical prenatal interventions, such as ultrasounds, prenatal anti-smoking campaigns, and fetal surgery, in materializing the fetus as real (Casper 1998; Mitchell 2001; Oaks 2001; Taylor 2008). While not studies of abortion per se, these findings underscored how scientific and medical processes are deeply implicated in the cultural construction of fetuses as persons with rights outside of, and even in opposition to, those of pregnant women. Assertions about fetal personhood in turn shape the terrain on which arguments about the morality of abortion are waged, shaping policy and popular attitudes toward pregnancy termination.

Another strand of research has examined abortion from the vantage point of the state and state governance. Building from the work of Ginsburg and Rapp (1995), the concept of reproductive governance advanced by Lynn Morgan and Elizabeth Roberts (2012) provides a theoretical language for examining the centrality of reproduction to a variety of moral regimes and diverse religious, economic, and demographic agendas. Attention to reproductive governance, for example, highlights the relationship between abortion policy and state visions of modernity as governments sought to bring desired populations and futures into being through controlling birthrates (Greenhalgh 2008; Kligman 1998; Oaks 1998). Although evident in nonsocialist contexts, such efforts were particularly pronounced in socialist states. In Romania, the pronatalist dictatorship of Nicolae Ceauşescu banned abortion, while China's One Child Policy relied on abortion to implement a national project of "social modernization." The relationship of abortion to modernity was not only a question of demography; many state socialist nations also linked the legalization of abortion to the expansion of women's rights. In the post-Soviet era, these historic linkages have made abortion policy debates central to discussions over the nature of post-socialist society, democratization, and national imaginings of a post-socialist "moral renewal" (Andaya 2014; Gal 1994; Greenhalgh and Winckler 2005; Mishtal 2009, 2014; Rivkin-Fish 2005).

In both socialist and nonsocialist countries, constrained national and familial economies, women's participation in higher education and employment, and

changing gender and kinship norms have propelled desires for smaller families that are achieved through both contraception and abortion (Andaya 2014; Douglass 2005; Paxson 2004). In some countries, state anxiety about falling birthrates has triggered the re-politicization of abortion through inflammatory political and media rhetoric about the dangers of population aging and women's "irrational" decision to limit childbearing (De Zordo and Marchesi 2012; Krause 2009). Closer attention reveals deeply entrenched state and ethnic politics at play, as some politicians and others bemoan the low birthrate among desired reproducers while critiquing the "overfertility" of national, religious, and ethnic Others.

Moving from the macrolevel of political economy and state interests to the ways in which women resist or negotiate these policies, research on abortion also furthers our understanding of stratified reproduction, which Shellee Colen (1995) defined as the processes by which the reproductive capacities of some groups of women are enabled and encouraged while that of other groups are devalued. This is particularly true in the light of sustained political polarization around abortion rights and growing economic inequalities, both in the United States and globally. In the United States, considering abortion within the framework of stratified reproduction underscores the unequal access to reproductive health care across axes of race/ethnicity, class, region, and nationality. In the context of reproductive health and rights, inequalities perpetuated through state and morality politics continue to be decisive and must be central in anthropological analyses of abortion (Marsland and Prince 2012).

Restricting Access to Abortion Care: Recent Legislative Trends in the United States

In this section, we return to our concern with restrictions on abortion in the United States, a trend likely to continue and even amplify given recent GOP political successes. The legal antecedents to many current laws can be traced to the *Planned Parenthood v. Casey* case brought before the U.S. Supreme Court. While the Court upheld abortion rights in its 1992 decision, its language shifted from requiring "strict scrutiny" of proposed laws that might impinge on the right to abortion to tests of "undue burden," which merely dictates that the law should not be too burdensome on the right to abortion (Joffe 1995). This decision laid the groundwork for greater state legislative restrictions on abortion, including parental notifications, mandated counseling, and waiting periods, thereby altering abortion care from state to state.

Legislative attacks on abortion access are thus mounted and contested on both national and local stages: While many state politicians receive funding, campaign advice, and legislative templates from national organizations, the ways that these bills are selectively accepted, rejected, or implemented is shaped by state and local challenges and discussions. Moreover, given their recent and polarizing nature, the constitutionality of these bills is challenged in many states where they were accepted. Thus, rather than an exhaustive account of this morphing political arena, we provide here a brief overview of key legislative abortion challenges. We suggest that these diverse legislative actions can be considered under four different, although sometimes overlapping, rubrics: (1) claims to the protection of women's health; (2) assumptions of fetal personhood; (3) restrictions on funding for abortion in federally financed health care; and (4) support for religiously based conscientious objections.

Discourses of Women's Health: TRAP Laws, Wait Times, and Mandatory Counseling

In her recent analysis, feminist writer Katha Pollitt (2014) argues that the apologetic tone adopted by pro-abortion rights advocates since the 1970s has inadvertently paved the way for the current rollback on abortion rights and access. In *Roe v. Wade*, the Supreme Court ruled that states could prohibit abortion only after presumed fetal viability—then estimated between 24 and 28 weeks—and that exemptions must be allowed to preserve women's health, defined broadly as any factors relevant to the woman's well-being, including her emotional, psychological, or familial circumstances. Yet, Pollitt argues, after the initial success of *Roe v. Wade*, mainstream politicians and even some women's groups increasingly tended to make the argument for keeping abortion legal and accessible through reference to the tragic circumstances of pregnancy—life endangerment, rape or incest, or congenital fetal malformations. Accordingly, those supporting abortion rights moved from a discourse of women's choice to the less controversial language of women's health, with its broader and clinical overtones. This attempt to find common ground with more liberal supporters of the anti-abortion movement, she suggests, has ultimately backfired; in framing abortion as the lesser of two evils rather than as a social good that should be available to every woman, they have had made further restrictions on abortion seem eminently reasonable.

The passage of Targeted Regulation of Abortion Providers (TRAP) laws in more than half of U.S. states provides evidence of Pollitt's argument. Increasingly, the battle over abortion rights is being waged through discourses about the protection of women's health. TRAP laws, which usually contain multiple provisions regulating abortion access and availability within a single bill, constitute probably the most significant challenge to abortion care in the United States today. As of January 2016, 28 states had passed some version of TRAP laws, making abortion—even pharmaceutically induced abortions by medications such as Mifeprostone or Misoprostol—more closely regulated than many surgical procedures (Guttmacher Institute 2016c).

Proponents of TRAP laws claim that they ensure women's safety by imposing strict requirements on abortion providers and/or their clinics. Many states require that abortion providers hold hospital privileges or equivalent; in some, these have proved virtually impossible to secure, forcing clinics to close. Some states have required clinics to be located no more than 30 miles from a hospital, leading to rural clinic closures. These requirements are justified through reference to abortion "dangers" and the need to ensure women's safety during procedures. However, studies demonstrate that less than 0.3% of U.S. abortion patients experience a complication that requires hospitalization (Henshaw 1999).The risk of dying from a legal first trimester abortion—when almost nine out of 10 U.S. abortions 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, a referral system to hospitals in the case of an emergency could be easily implemented if not for the hostile environment that impedes cooperation between facilities. Other TRAP provisions also force clinics providing abortions to meet far stricter structural standards than those required by surgical centers, even in facilities that only offer pharmaceutically induced abortions.

These laws regulate buildings' physical properties, such as the width of hallways, which were historically designed for hospitals and are irrelevant to the safety of women receiving abortion. Clinics have been forced to close or cease providing abortion services because they cannot afford these renovations.

The impact has been substantial; 60% of women of reproductive age reside in states that have TRAP laws. In Texas, a vote on the omnibus TRAP law known as HB2 was stalled by a valiant 12-hour filibuster by Senator Wendy Davis on June 25, 2013, during which she read hours of testimony from women and health care providers who opposed the bill. Despite this protest from abortion rights groups, the legislature passed HB2 in July 2013. By April 2014, 50% of the state's 44 abortion clinics had either closed or withdrawn abortion care from their services, leaving a 400-mile swathe of rural Texas without any abortion providers.[2] In October 2014, a district judge struck down provisions that abortion clinics meet the same building requirements as ambulatory surgical centers, arguing that HB2 "creates a brutally effective system of abortion regulation that reduces access to abortion clinics ... for substantial numbers of Texas women" (Feminist News 2014). A Fifth Circuit decision in June 2015, however, upheld the constitutionality of HB2, leaving only 10 clinics to provide abortion care for the entire state. The U.S. Supreme Court is expected to rule on the case by June 2016.

In addition to claims to protecting women's physical health, anti-abortion activists argue that abortions pose a risk to women's emotional well-being. Such beliefs have been given a medicalized veneer in the controversial post-abortion stress syndrome, a diagnostic label that purports to identify symptoms of "abortion trauma" similar to those of post-traumatic stress. Asserting that women must have both time and proper information before making this decision, as of 2016, 27 states have imposed a mandatory waiting period of 18–72 hours between requesting and receiving an abortion. These wait periods are often in addition to required counseling, which in some states must be conducted in person rather than via phone, email, or fax. Anti-abortion groups argue that these mandatory waiting periods and counseling provide women with information about abortion risks and allow them time to reconsider their decision. In response, abortion rights supporters charge that the information given at these counseling sessions is misleading or even false and is designed to discourage women from continuing with the procedure (Richardson and Nash 2006).

Laws mandating wait periods and counseling link anti-abortion discourses of women's health to assertions about fetal personhood, which we discuss below. Such legislation assumes that, given time and "facts" about fetal development and abortion risks, women will reconsider their decision to end a pregnancy.

Fetal Personhood Arguments: Ultrasound Viewing Laws and Reductions of Gestational Time Limits for Legal Abortion

In addition to TRAP laws, wait times, and mandatory counseling, a number of states have passed the Women's Right to Know Act, which requires the non-medically indicated use of ultrasound technology during an abortion procedure. Ultrasounds are used routinely in abortion care to estimate gestational age, visualize the position of the embryo, and ensure the proper removal of all tissue. However, the

Women's Right to Know Act mandates that providers perform ultrasounds for the express purpose of displaying and/or describing the ultrasound images to women seeking abortions. As of January 2016, 12 states require providers to perform such ultrasound and to ask women if they wish to view the ultrasound display, while three of these states (Louisiana, Texas, and Wisconsin) require providers to display the screen and describe the image without asking women for their preference (Guttmacher Institute 2016c). Some states also require that clinicians read to patients pre-set scripts about fetal development that were drafted by legislators, not medical professionals.

Such legislation is fundamentally informed by cultural beliefs and political agendas around fetal personhood. Thus far, movements to legally establish fetuses as persons from conception have failed in every state where the policy has been introduced. Yet the Women's Right to Know Act assumes that the visualized fetus will serve as an irrefutable fact in these personhood debates. Mandatory ultrasound viewing laws and fetal development scripts thus take for granted that if women knew "the truth," they would make the informed choice of rejecting an abortion. As feminist anthropologists and others have argued, this rests on the assumption that embryological evidence is more real or compelling than the other considerations that lead women to seek an abortion. Further, in assuming that the fetal image can "speak for itself," it obscures the social–historical labor and cultural work that has materialized the fetus, imbued it with meaning, and made it possible to project ourselves back into utero (Dubow 2010; Hartouni 1998; Morgan 2009).

Available research, however, suggests that the power of the visualized fetus is highly contextual. Abortion rights advocates point to studies that demonstrate that viewing an ultrasound is extremely unlikely to convince a woman to discontinue with an abortion procedure if she believes that ending the pregnancy is the appropriate decision (Gatter et al. 2014). Further, they argue that mandatory viewing laws and legislator-written scripts intervene in the provider–patient relationship, impose requirements that make abortion more costly and burdensome, and diminish medical professionals' ability to do their jobs with care, compassion, and consideration for patients' wishes. Recent studies of mandated scripts suggest that both providers and patients view requirements to describe fetal development as an imposition, and that doctors often resent being forced to ventriloquize state positions with which they may disagree (Buchbinder et al. 2015; Mercier et al. 2016).

Arguments about fetal personhood also underpin attempts to legislatively reduce the gestational time frame for legal abortion. From 1995, Congress began introducing bills against intact dilation and extraction abortions, a procedure used for the rare later-gestational-age procedures, which anti-abortion-rights activists dubbed "partial-birth abortions." A ban on the procedure was enacted in 2003 and upheld by the U.S. Supreme Court in a 5-4 vote in 2007. Today, although the U.S. Supreme Court requires provisions for some procedures to preserve the life and health of the woman, 17 states restrict later-term abortions, thereby violating this constitutional right. Eleven states have also passed 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. In January 2015, Republicans in Congress sought a vote on the Pain-Capable Unborn Child Protection Act, which would prohibit abortions after 20 weeks. Although the

bill was withdrawn following concerns about lack of protection for rape victims, it is likely the next step in the gradual dismantling of abortion access and availability on the grounds of fetal personhood.

Funding Restrictions

For many women, the availability of abortion has also been severely limited by the virtual eradication of public funding for abortion care. In conjunction with the 1976 Hyde Amendment, which limits federal dollars for abortion, the majority of states provide no state funding assistance for abortion care for economically disadvantaged women, primarily affecting those on Medicaid. The Hyde Amendment was the first major restriction placed on abortion access after *Roe v. Wade*, and allowed abortions only if the woman's life was in danger. In 1994, the Clinton administration added exceptions for rape and incest. The implementation of the Hyde Amendment varies by state: 32 states and the District of Columbia provide only the federally mandated funding for abortions, which is 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. By contrast, since Medicaid is a joint federal–state program, some 17 states have chosen to dedicate their own revenues for abortion care to supplement this gap in Medicaid (Guttmacher Institute 2016b). Overall, however, the effect of the Hyde Amendment is a highly stratified abortion access, whereby women with extremely limited resources must pay for their own abortions or continue with an unintended pregnancy.

State and federal public funding restrictions for abortion thus impose significant burdens on the low-income women who bear the brunt of this legislation. Research demonstrates that economically disadvantaged women whose insurance does not cover abortion care will nonetheless piece together the necessary money by diverting funds from rent, food, utilities, and other needs (Jones et al. 2013). Medicaid-eligible women tend to receive the service up to three weeks later than women with more resources (Ostrach 2014); this later gestational age is associated with increased potential risks as well as the greater cost of later-term procedures.

While vigorous debates about public funding for abortion took place shortly after the 1976 implementation of the Hyde Amendment, its injustices today stir little public debate. Yet, as site of extreme reproductive stratification, it is ripe for further anthropological analysis.

Conscientious Objection

The growing use of conscientious objection creates significant barriers to abortion access in a variety of contexts (Chavkin et al. 2013). Conscientious objection occupies a gray legal area, in which providers may deny access to legal medical care by citing religious objections, and has been promoted by abortion opponents 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 refusals can impinge on women's right to receive needed care (Chavkin et al. 2013). Conscientious objection thus raises concerns about safeguarding women's health in areas with a shortage of providers, especially where providers may also refuse to give referrals or

where pharmacists refuse to provide emergency or routine contraception. In many cases, appeals to conscientious objection—intended for individual use—have been employed as a top-down directive of a health care facility.

Merger Watch and the ACLU (2013) have documented numerous cases in which religiously affiliated hospitals have refused to provide either planned or emergency abortion care to women presenting at their clinics, even when this refusal posed additional risks to the women's life and well-being. Several studies of Catholic-affiliated hospitals have revealed that patients are denied prompt, medically indicated abortions to manage miscarriage and ectopic pregnancy, while rape victims who are brought to the facility's emergency room are not offered emergency contraception (ACLU 2002; National Women's Law Center 2011).

The prevalence of conscientious objection reflects an escalating tension between secular and conservative religious agendas in the contemporary United States. "Conscience clauses" are not simply restricted to abortion; provisions of the Affordable Care Act, minimum wage, and protections afforded to female, LGBTQ, or transgender workers are all under legal attack by conservatives using the rubric of religious liberty. Highlighting questions about the balance between a provider's right to refuse based on conscience and a woman's right to lawful abortion care, conscientious objection raises questions about the degree to which individually held religious beliefs can justify the violation of rights guaranteed under secular laws.

While rights to decisions based on individual conscience are dear in U.S. culture, the American Congress of Obstetricians and Gynecologists, as well as international health organizations, have continually affirmed the priority of women's health, safety, and right to care over the right to object (e.g., ACOG 2007). Moreover, frequent arguments about separate spheres of practice between religious and secular institutions are confounded by the fact that many of these private religious organizations receive public funding. Yet, despite statements by professional organizations, researchers have reported a rise in conscientious refusals both in the United States and globally and the use of rhetoric of conscientious refusal in denials of medical service in scenarios unrelated to conscience, such as the desire to safeguard one's professional reputation against potential stigma (Cook and Dickens 2006). Notwithstanding vigorous policy discussions about the increase in conscientious objection and debates over regulation, the experiences and perspectives of women, health care providers, and reproductive health and rights advocates have been understudied and are therefore poorly understood.

New Sites for Anthropological Engagement

To the consternation of abortion rights advocates, polls have revealed a slight but noticeable decline in support for legal abortion as compared with polls conducted two decades ago.[3] This phenomenon begs for further analysis. Why do longstanding pro-abortion rights arguments about women's right to bodily autonomy have less appeal to young women and men than in the past? Does this reflect a social landscape in which women's rights have less traction than gay rights, as Justice Ruth Bader Ginsburg recently observed (Liptak 2014)? Although we refuse a "divide and conquer" politics in which gay rights apparently compete with women's rights, it behooves us to consider how and why this appears to be taking place in

contemporary U.S. social life. What are the processes by which some claims to rights are made "thinkable" while others lose ground? Is this, as feminists who came of age prior to *Roe v. Wade* often argue, a generation of women who can adopt an anti-abortion rights stance because they cannot possibly fathom its consequences? Marjorie Dannensfelser, president of the anti-abortion advocacy group, the Susan B. Anthony List, describes an intensity gap, whereby many of those working for the repeal of abortion laws derive their sense of identity, community, and purpose from anti-abortion activity, whereas abortion rights supporters no longer orient themselves so singularly toward this one cause (Sanneh 2014).

Have abortion rights advocates been "out-messaged"? In a culture that celebrates both technology and the visual—and in which babies occupy a near-sanctified status—images of fetuses seem to offer irrefutable proof of the personhood of the unborn. Is this simply a more conservative America? Anti-abortion advocates have successfully folded the anti-abortion rights message into the Republican platform; elected Republicans often find themselves bound to espouse anti-abortion rights ideologies lest they be accused of not being sufficiently conservative. Yet, at the same time, the same youthful demographic that is ambivalent about abortion rights expresses a growing support for other liberal social issues, such as gay marriage. This shifting political landscape underscores the urgent need for attention to social movements and other forms of political engagement among contemporary youth.

This social landscape makes clear that no single line of questioning can illuminate the complex entanglements of abortion activism with (trans)national and local articulations of power. We argue that anthropology's disciplinary commitments have the potential not only to enrich our understanding of the processes and effects of legislative restrictions on abortion, but also to generate important new research questions—and answers. Anthropology is particularly well situated to take on the topic of abortion for at least three reasons.

First, its emphasis on long-term ethnography and holism can uncover unexpected relationships and concepts, reveal unforeseen or unintended consequences, and/or elucidate connections between seemingly disparate fields of social life, which may be obscured in less open-ended methodologies. Inspired by a Latourian actor-network approach, which considers both the human and non-human as actors in producing material–semiotic networks, anthropologists seeking to chart this new territory must track new representations and configurations of science, gender, social movements, economy, and politics, as they circulate in the United States and transnationally.

Second, given the discipline's historical roots in cross-cultural research, anthropologists provide comparative perspectives that challenge the naturalization of ideologies around gender, science, and personhood, among others. Our concern with diverse worldviews and forms of knowledge can potentially unsettle dominant frameworks and terms of debate, provoking discussion in popular, policy, and scholarly domains and fostering new research directions and analytics.

Third and finally, anthropology has much to contribute to discussions of ethics and methods. The stigma of abortion makes it notoriously difficult to study (Jones and Kost 2007); the long-term relationships with individuals and communities that many anthropologists develop, in addition to the nuanced and deeply reflexive considerations of research ethics and methodologies that emerge from these interactions, give us expertise that can enrich abortion research.

In this final section, we delineate just a few of the ethnographic and theoretical domains in which anthropologists could make valuable contributions to abortion research. These are far from the only salient questions, and we hope to inspire others to explore these and other questions, both in the United States and globally.

Tracing the Contested Domains of Gender and Women's Health

Access to safe and legal abortion and contraception has resulted in dramatic improvements in women's health worldwide. Despite studies demonstrating a negative relationship between the number of abortion restrictions and other measurements of women's and child health in the United States (e.g., Center for Reproductive Rights and Ibis Reproductive Health 2014), arguments about the protection of women's health are central to legislation that seeks to restrict access to abortion.

Rather than simply dismissing such claims as a cynical ploy, we call on anthropologists to critically examine how conceptions of gender and womanhood are elaborated and disseminated in these overlapping scientific, legal, political, and social fields. One way to engage this issue might be to ask how discourses of risk and danger play on and reinforce a gendered script that associates women with reproduction and nurturance. Such associations are particularly clear in legislative arguments for mandatory counseling and wait times, which are founded on the assumption that women who choose to end a pregnancy risk lifelong regret and emotional distress.

Some pro-abortion rights groups have challenged these legislative actions on the basis of misinformation, invasion of privacy, and the potential to heighten women's suffering. Others have taken issue with the basic assumption of such legislation, pointing to research that demonstrates that the majority of women feel relief on completing the procedure and report that the decision to terminate the pregnancy was an easy one (Rocca et al. 2013). Similarly, the extreme concern about the physical danger posed by abortions—especially relative to statistically more risky yet less regulated procedures—could also be viewed as a moral response to the danger caused by a transgression of expected gender categories.

Such an analysis also invites discussion about how risk is constructed and articulated in popular discourse, media, and in law and policy. How are risks—emotional, social, and economic—symbolically ordered and morally freighted? How might new economic and social formations and gender ideologies shape perceptions of reproductive risk and danger? Here, too, we are well placed to trace the production, legitimization, and circulation of various forms of knowledge through different domains of social life as well as how these contested knowledges are enlisted into political debates about women's health.

Attention to gender and health also raises provocative questions about the selective visibility of men in these discourses. Men are actively engaged in abortion activism on both sides and are often intimately involved in decisions about abortion; a nationally representative demonstrates that 82% of the male partners of women seeking abortions knew about the procedure and were supportive in the decision-making process (Jones et al. 2011). Given that decisions about abortion are often made as a couple and that women's access to legal abortion also allows men to realize hoped-for life trajectories, there has been insufficient anthropological attention to

the perspectives and attitudes of the partners of women seeking abortions (Dudgeon and Inhorn 2004). It is understandable that abortion-rights advocates have historically wanted to maintain their focus on arguments about abortion as a woman's right. In so doing, however, they reinforce gendered ideologies that associate women with reproduction and make it appear that only women are affected by access to legal abortion. The framing of abortion as a woman's issue likely has repercussions for broader social attitudes around legal abortion in ways that merit exploration.

Tracking the Scientific and Political Elaboration of Fetal Personhood

In her rich history of embryology, Lynn Morgan examines the process by which both scientists and the American lay public came to believe that a profoundly moral question, such as the limits of life and personhood, could be resolved through scientific description of fetal development. She argues that, "embryos are conjured into existence in response to specific social dramas ... scientists do not so much discover them as materialize them to show how they might be relevant to matters of social and political concern" (Morgan 2009:161). Following the ripple effect of the scientific production of knowledge as it enters popular, legal, and political discourses, anthropologists need to be on the ground to examine the social dramas to which embryos are made to speak today.

Reflecting the cultural value of science in the contemporary United States, anti-abortion activists now often stake their ground through reference to science in addition to more traditionally used religious objections. Indeed, fetal rights discourse is deeply entangled with political arguments about the regulation of scientific research on embryos and fetuses as well as the legal and ethical discussions about the use and disposal of excess embryos produced through assisted reproductive technologies. These debates have, in turn, given rise to new subject positions, such as "embryonic rights," that fuel arguments about the "dueling rights" (Morgan and Roberts 2012) assumed to exist between pregnant women and their fetuses. The discourses and images mobilized by abortion activists on both sides circulate transnationally, articulating with local configurations of economy and politics in often unpredictable ways. At the same time that anti-abortion activists in many global sites use imagery promoting fetal personhood drawn from U.S. pro-life campaigns, for example, abortion rights activists often call on human rights or women's rights to oppose calls to ban abortion (Amuchástegui et al. 2010; De Zordo et al. 2016; Mishtal 2015). Similarly, women themselves engage with transnational discourses around rights and modernity in addition to local moral cosmologies to situate their own abortion histories within new articulations of gendered personhood (Amuchástegui and Flores 2013; Andaya 2014; Gammeltoft 2002; Paxson 2004).

In the United States, the restrictions on gestational age for legal abortions in many states offer further openings for examining the production of fetal personhood through the interlocking domains of science, popular and moral discourse, and law and policy. Examining the arguments behind bills such as the Pain-Capable Unborn Child Protection Act, for example, pushes us to engage with deeply anthropological questions such as: How do claims to pain constitute the basis for assertions of (fetal) personhood, and in what situations do claims to pain make (or unmake) social persons (Livingston 2012; Scarry 1985)? Through what processes is assumed

fetal pain, framed as precultural, weighted over women's social suffering? How is pain "known" in scientific practice, and how are these findings translated and circulated for popular consumption?

As anthropologists continue to challenge popular belief in the power of science to determine the line between sentient and nonsentient beings, we need more ethnographic data on how fetal personhood is constructed or contested by pregnant women, their partners, kin and social networks, policy-makers, and medical experts, among others. In tracking these discourses and their material effects in law, policy, and social lives, we also call for further analysis of the understudied intersection of the medical and criminal justice systems in U.S. reproductive politics (Knight 2015).

In many states, feticide laws that were intended to ensure harsher penalties for assaults on pregnant women that resulted in the loss of the pregnancy are now being used against pregnant women themselves. Medico–legal concepts of fetal endangerment have led to the incarceration of women who use illegal drugs, or even legally prescribed Methodone, while pregnant, as well as murder charges against women who attempt suicide or suffer "suspicious" accidents while pregnant. Moreover, these charges are disproportionately brought against minority women, who often have little recourse to prenatal, economic, drug treatment, or mental health resources. The reproductive surveillance and gendered violence enacted over poor and minority women thus underscores the deeply stratified consequences of the elaboration of fetal personhood—and diminishment of the personhood of pregnant women—in the context of stark inequalities of health and opportunity.

Neoliberal Economies and Reproductive Justice

The analysis of contemporary abortion politics can thus provide a focused lens onto the entanglement of reproductive and economic imaginaries in 21st-century America. Justifications for limiting access to abortion care are often framed in the logic of neoliberalism that rationalizes cutbacks in social services, including health care, and views the free market as the antidote to a diverse range of social problems. This erosion of the social safety net takes place in the context of an increasingly dominant ideology of self-care, in which the "prudent citizen" (Rose 2007) takes active steps to manage and mitigate health risks. Under this rubric, discourses of rational behavior, free choice, and individual responsibility are frequently drawn on to paint women seeking abortions, especially those in lower socioeconomic strata, as undeserving of public funds and support.

In both policy analyses and clinical encounters, anthropologists can shed light on the process by which certain populations are constructed as differentially deserving of various services, such as contraception or abortion care. Similarly, as we track the unfolding of health insurance reform through the Affordable Care Act (Dao and Mulligan 2016; Horton et al. 2014), we need to examine the gendered consequences of provisions that continue to require the separation of abortion care from other reproductive care services to avoid the use of tax-payer dollars to cover abortion.

Building on the work of feminist critics of biomedical birth (e.g., Davis-Floyd 2004; Martin 1987), we must explore the systematic fragmentation of women's

bodies and experiences, whereby reproductive health is treated as distinct from other aspects of health, and abortion care is singled out for particular exclusion. Such artificial partitioning both reinforces assumptions about fertility control as an individual, female responsibility rather than a social good and adds to the further reproductive stratification and marginalization of low-income women who rely on federally subsidized health care. Further, given that claims around access to services has formed the legal basis for the recent expansion of same-sex rights, we could ask why access to reproductive services is not seen as critical to the promotion of women's rights among many sectors of the U.S. population today. This disjuncture calls for further attention.

The analysis of the uneven effects of neoliberalism also brings us into conversation with scholars and activists working on issues of reproductive justice. We are sorely in need of ethnographic data that track the effects of restricted access to both contraception and abortion care across lines of race, ethnicity, class, age, and region. Rates of abortion have declined over the past three decades with the increasing availability of sexual education and safe and effective contraception (Guttmacher 2013, 2014a). Abortion is increasingly concentrated among women of color, immigrant women, and economically disadvantaged women, who 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 impacts poor, young, rural, and minority women and communities. For women living in states with few abortion providers, states that require counseling and/or mandatory wait times 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 coworkers. Further, those women who must continue a pregnancy due to their inability to obtain a legal abortion are often placed at heightened social, economic, and health risks (Mauldon et al. 2015).

Such an analysis makes clear that the struggle for the right to legal abortion is one facet of a broader fight for reproductive justice that entails not only the right to end unintended pregnancies, but also the right of all women and men to bear children and to care for them in safe, healthy, and dignified environments. Given the elimination of public funding for abortion care in many states, it is poor women and men who must choose between ending an unintended pregnancy and paying for schooling for themselves or other family members, paying the rent, or feeding their families (Ostrach and Matthews 2015; Reproductive Health Technologies Project 2015). 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. Research on access to abortion care has to date largely been quantitative; anthropologists can complement and expand these efforts by offering in-depth ethnographic analyses of the consequences of funding restrictions and by

tracking how women, their kin, reproductive rights advocates, health care providers, and other actors cope with these challenges. These are urgent and rich areas for anthropological investigation.

Conclusion

In calling for a renewed attention to abortion politics and experiences in the United States, we are inspired by Didier Fassin's reminder that, "What politics does to life—and lives—is not just a question of discourses and technologies, of strategies and tactics. It is also a question of the concrete way in which individuals and groups are treated, under which principles and in the name of which morals" (2009:57). Abortion politics in the United States are today at a crisis point; as political and cultural struggles around this critical issue escalate, it is time to add anthropological perspectives and contribute our skills to the debate.

Notes

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1. See, for example, studies conducted by researchers with Ibis Reproductive Health (www.ibisreproductivehealth.org), Guttmacher Institute (www.guttmacher.org), and Bixby Center for Global Reproductive Health (bixbycenter.ucsf.edu), especially the longitudinal Turnaway Study.
2. http://fundtexaschoice.org/resources/texas-abortion-clinic-map (accessed May 2, 2016).
3. http://www.gallup.com/poll/1576/abortion.aspx (accessed May 2, 2016).

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