

**Safe Illegal Abortion:
An Inter-Island Study in the Northeast Caribbean**

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A Working Paper of the Caribbean Initiative on Abortion and Contraception

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Colonial Legacy of Abortion Laws

Abortion law throughout most of the Caribbean reflects the region's historical and contemporary relation to Western Europe and the United States. The French Penal Code of 1810 is still the operating law prohibiting abortion in Haiti, as is the French Napoleonic Code of 1832 in the Dominican Republic, the English Offences Against the Person Act of 1861 in Jamaica, and the Dutch Common Law of 1881 in Curaçao. There are other non-independent countries whose governments were obliged to incorporate European or US abortion legal reforms in the 1970s, such as Guadeloupe and Puerto Rico. Some independent countries legalized abortion of their own accord, namely Cuba (the earliest to institutionalize reform), Barbados and Guyana.²

European and United States dominance in the Caribbean has shaped most abortion law in the region. However, abortion practice does not necessarily follow official law. To what extent are 19th century prohibitions currently enacted? To what extent have European and US legal reforms of the late 20th century been put into practice, whether or not officially imposed as law? How do old colonial prohibitions and modern rights affect attitudes, behaviors and local regulations?

Researchers in Puerto Rico found that their island government, health establishment and general public have not fully appropriated the abortion reform imposed by the United States Supreme Court in 1973. They attribute this resistance to the “limits of a colonial legality”. Specifically, the Puerto Rican government prohibits elective abortions in public

¹ This study falls within the *Caribbean Initiative on Abortion and Contraception*, a collaborative project co-directed by the researchers from Puerto Rico and France. The research was authorized by the Institutional Review Board of the University of Puerto Rico Medical Sciences Campus (#9080105) and supported by the University of Picardie Jules Verne, Amiens, France, and by grants of an anonymous donor and the Jesse Smith Noyes Foundation to *Saludpromujer*, School of Medicine, University of Puerto Rico. The first author is deeply indebted to her co-investigator for having initiated the project, for continuous inspiration and exchange, and for precious feedback on successive versions of this text. Heartfelt gratitude also to Alexander Pheterson for his encouragement and crucial suggestions. The research owes whatever information and insight it offers to the generosity and honesty of health professionals working on women's behalf in Anguilla, Antigua-Barbuda, Saint Martin, Sint Maarten and St. Kitts-Nevis.

² Information on independent countries comes from the United Nation. *Abortion Policies. A Global Review*. Vol.1,2,3. Economic and Social Affairs. New York, 2001. Information on non-independent countries comes from various sources cited in the body of this text, namely in the section on Current Abortion Laws.

hospitals, so the vast majority of abortions (97%) are performed in private clinics. Moreover, misconceptions about abortion in Puerto Rico are widespread among both women and their health care providers. One survey revealed that 26% of a representative sample of women seeking abortions in 2001 believed the act was illegal; another survey documented the same false idea among 50% of a representative sample of US federal Family Planning advisors working in Puerto Rico (Title X workers). A lack of public education and reliable information together with a shortage of qualified, available practitioners was shown to hinder abortion accessibility.³ Nonetheless, women are not dying from unsafe abortion, and there is some evidence that women on neighboring islands living under criminal laws travel to Puerto Rico for safe anonymous pregnancy terminations.⁴

What has been the impact of European and US abortion law on other Caribbean governments, health care establishments and women seeking abortions? If Puerto Rico illustrates a limited incorporation of colonial legal reforms, might there also be a limited incorporation of colonial legal prohibitions in countries where they remain? How does the contradiction between old European laws and contemporary European influence affect abortion practice? Since abortion is legal in some Caribbean countries and not in others, do island populations migrate between islands to access services unavailable at home? The Caribbean Initiative⁵ was organized by two researchers, one based in Puerto Rico and the other in France, to address those questions and their implications for understanding Caribbean abortion realities in historical cross-border perspective. This working paper elaborates a regional case study within that larger ongoing Initiative.

³ Two major investigations and several interim studies provide this data. See: Azize-Vargas, Yamila & Avilés, Luis Alberto, May 1997. Abortion in Puerto Rico: The Limits of a Colonial Legality. *Reproductive Health Matters*, 9: 56-65; Azize-Vargas, Yamila & Henshaw, Stanley. Abortion in Puerto Rico: Rates, reasons, and characteristics of abortion clients. Presentation at the 130th Annual Meeting of APHA (American Public Health Association), November 11, 2002; Azize-Vargas, Yamila. *Abortion in Puerto Rico: A Comprehensive Overview*. Ford Foundation, 2002.

⁴ The above research reports do not distinguish immigrant women living in Puerto Rico (18% of sample of 541 women in the most recent study) from women coming from abroad specifically for abortions. Known for excellent hospital facilities and medical expertise, Puerto Rico is a Caribbean health care resource not only for abortion but also for advanced treatment and diagnosis such as cardiovascular surgery or pediatric oncology. (Taina Rosa. "Healing near home". *Caribbean Business*. Thursday January 9, 2003, pages 18,20,22). Historically, before legalization of abortion by the US Supreme Court, women from the United States depended upon Puerto Rican practitioners for safe abortion. A *San Juan Weekend* was for women from the US during the sixties what going to London was for the French before the *Loi Veil* or for the Irish to this day (Marchand-Arias, Rosa. Clandestine legal: El aborto en Puerto Rico de 1937 a 1970. *Puerto Rico Health Science Journal*. Vol 17, no. 1, 1998:15-26).

⁵ The Caribbean Initiative on Abortion and Contraception is coordinated jointly from the University of Puerto Rico (Yamila Azize-Vargas) and the University of Picardie Jules Verne, Amiens, France (Gail Pheterson).

Research Framework

Objectives

1. Document abortion laws in diverse non-independent and independent Caribbean countries.
2. Examine the relation between abortion laws (*de jure*) and their applications (*de facto*).
3. Analyze the continuing influence of colonial law on Caribbean abortion policy and practice.
4. Document the migration patterns of Caribbean populations for the purpose of securing abortion services.
5. Design an adequate methodology for gathering the above information in criminalized as well as legalized contexts.

Hypotheses

1. The liberalization of abortion laws in France, Great Britain, the Netherlands, and the United States favors safe abortion practices in (former) colonies of the Caribbean, even when local criminal laws remain.
2. When safe abortion exists despite legal prohibitions, access to services and quality care are compromised by high costs, social taboos and practitioner isolation.
3. Migration patterns among women and their health care providers work to network abortion information and services.
4. Existing information about abortion in the Caribbean is unreliable, partial, and biased due to the exclusion of non-independent countries from international documents, a lack of information on safe abortion in criminalized contexts, and ignorance about inter-island abortion service networks.

Phase One: Towards a New Research Methodology

Selecting research sites and populations comprised a first major phase of the investigation. Due to the complexity of the political context, existing documents about local situations could not be taken at face value. Since the methodology shapes the research project and distinguishes it from existing studies, the parameters are elaborated here in detail. This section is divided into four themes: (1) Selecting research sites (2) Mapping the Caribbean (3) Tracing an island network of abortion services (4) Choosing informants.

Selecting Research Sites

The following initial criteria were set for selection of research sites: (1) A small number of islands to render the study feasible (2) Countries governed at present or in the tangible past by diverse colonial equations so as to allow comparisons between islands and between various metropolitan influences (3) Countries situated in close geographical proximity so as to maximize the likelihood of migration, also for health care (4) Representation of abortion legislation ranging from strict prohibitions to liberal authorizations (5) A lack of prior information about the country or the nexus of countries so as to contribute to Caribbean Studies.

The investigation centered not only on a small number of islands, but also on islands with small populations. This facilitated more complete analyses of individual countries and a more accessible understanding of inter-island interactions. As for assuring a diversity of colonial equations, we took the following basic formulas into account: (1) Formal integration with the Metropole, as with the French Overseas Departments (2) Non-independence from European or US government but negotiated or imposed self-governance of internal affairs, as with the Overseas Territories of Great Britain and the Netherlands Antilles (3) Independence, as with the majority of former British colonies of the *West Indies*, all of which are presently members of the Commonwealth of Nations.⁶

We decided to focus on the British, Dutch, French and independent formerly British Caribbean, leaving aside the United States possessions of Puerto Rico and the US Virgin Islands, and the long-time independent countries of Haiti, Dominican Republic and Cuba. Puerto Rico was not included due prior knowledge, but it would serve as an analytic marker and institutional base for our study. Haiti and the Dominican Republic were excluded

⁶ The designation *Commonwealth* will refer throughout this paper to the *Commonwealth of Nations*: a Federation of 50 sovereign States formerly colonized under the British Empire. This alliance, “more moral than juridical” (*Petit Le Robert*, 1994: 490) should be distinguished from the *Commonwealth associated with the United States*, namely Puerto Rico.

because they don't fit the above colonial formulas; their health care system is basically detached from US or European influence, as is that of Cuba. However, Haitians and Dominicans were found to be large immigrant populations throughout the region. Caribbean countries on the South American and Central American continent would not be included due to the island-focused nature of the research.

Mapping the Caribbean

Caribbean countries are generally classified within the following categories: (1)Latin America (United Nations classifies South and Central America and the Caribbean as three sub-divisions to Latin America; WHO reports Caribbean abortion statistics under Latin America, as does the Alan Guttmacher Institute) (2)Latin America and the Caribbean, (The Center for Reproductive Rights uses this category) (3)An appendix to France or Great Britain or the United States listing statistics on their Overseas Territories or Departments (DOM-TOM for France) (4)Selected conglomerates of Caribbean countries such as the English-speaking Caribbean, Commonwealth Caribbean or the Netherlands Antilles (5)Individual country classification, wherein those countries with less than 300,000 persons are excluded.⁷

The above classification systems distort abortion realities in the Caribbean. Most countries are absent altogether from international documents due to their non-independent status or their relatively small populations. And when there is representation, one country is often taken to represent the whole Caribbean, thus leveling extreme regional differences in law and practice.. Two influential examples demonstrate.

In a reference publication on *Women of the World: Laws and Policies Affecting Their Reproductive Lives in Latin America and the Caribbean*, the Center for Reproductive Law and Policy investigates abortion facts in nine countries, eight in South and Central American and one in the Caribbean.⁸ Jamaica is used to represent the Caribbean. Abortion is *prima facie* illegal in Jamaica, although the government officially allows pregnancy terminations at public health facilities if the pregnancy puts women's physical or mental health at risk. According to the report, the prohibition is strictly applied so that legal abortion is largely

⁷ For example, estimates of unsafe abortion in subregional categories of the World Health Organization are derived only for countries with a population of 300,000 or more. See WHO Division of Reproductive Health. *Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data. Third Edition* (WHO/RHT/MSM/97.16). Geneva, Switzerland. World Health Organization, 1998.

⁸ International Program of the Center for Reproductive Law and Policy. New York: 1997. Note that the Center for Reproductive Law and Policy (CRLP) has since changed its name to the Center for Reproductive Rights (CRR).

inaccessible and complications arising from unsafe abortion remain one of the leading causes of maternal mortality. In another reference guide on *Clandestine Abortion: A Latin American Reality* (of which the Caribbean is considered a part), published by the Alan Guttmacher Institute, the introduction states that abortion is punished by law, except for strict medical reasons, in the the whole region except Cuba.⁹ The first example is misleading; the second inaccurate. Abortion is officially legal without restriction as to reason not only in Cuba, but also in Guyana, Puerto Rico, the US Virgin Islands, the Departments of Guadeloupe, Martinique, Guiana and, on socioeconomic grounds, Barbados, bringing the total Caribbean population living under liberal abortion laws to approximately 16,500,000.¹⁰ Abortion realities for those populations are completely erased by classifying the region according to one “representative” country (Jamaica) or in contrast to one “exceptional” country (Cuba).

Regional averages of abortion data gathered in diverse Caribbean countries are no more enlightening. The World Health Organization reports a mortality ratio from unsafe abortion at 74 women per 100,000 live birth deliveries for Jamaica and 9 per 100,000 for Cuba. It reports a ratio of 1 for Puerto Rico and a blank space for missing information on Haiti. It gives an overall mortality ratio of 71 per 100,000 live births for unsafe abortion in the Caribbean, considerably above the 57 world total.¹¹ What does the overall ratio tell us? The Caribbean includes countries with the riskiest practices in the world and others with the safest. Statistical averages of abortion complication ratios that combine lowest and highest figures are difficult to interpret, even were complete reliable information available.

How can we map the Caribbean to avoid the distortions of massive continental categories, peripheral colonial appendixes, exclusion due to size or status, and incomprehensible or incomplete statistics? How can we reveal Caribbean specificities, diversities, safety nets and danger zones? The present investigation is an attempt to design and apply a Caribbean-appropriate regional methodology. By tracing the movements of local populations on one sub-set of islands, we can try to map the Caribbean according to policies, practices and influences truly operative in the region. The subject of abortion is particularly illuminating in this regard.

⁹ The Alan Guttmacher Institute. *Aborto Clandestino: Una Realidad Latinoamericana*. New York and Washington: AGI, 1994:5.

¹⁰ Of course, those most concerned are women of fertility age, but the laws are relevant to all sectors of society, including health professionals, educators, government officials, religious leaders and women’s male partners and family members. Population data is drawn from *The World Factbook 2002*, www.cia.gov/cia/publications/fact.

¹¹ WHO. *Unsafe Abortion, Ob.cit.*, p. 4.

Tracing an island network of abortion services

Communities in small countries with fluid borders, economic disparities and diverse service provisions create their own informal international health care systems, also – perhaps especially - for abortion. If such dynamics exist in the Caribbean, as there is reason to believe, then those systems may offer an invisible supply of safe abortion services.

There is no ready-made map of an inter-island abortion service network. In order to trace such a network, we needed to delineate a certain sub-region of the Caribbean and then conduct the research in steps according to data gathered in the field. Islands east of Puerto Rico and north of Guadeloupe were chosen since they fit the research criteria and link the study geographically and politically to its coordinating bases in Puerto Rico and France. Within this northeast area of the Caribbean there are British, Dutch and US territories, a French Overseas Department as well as several recently independent nations of the Commonwealth.

The first research visit was made to Saint Martin (French Antilles) and Sint Maarten (Netherlands Antilles), two small countries sharing one island. Preliminary interviews with physicians immediately revealed a high degree of mobility of populations between the French and the Dutch side of the island; this mobility was not shared by professionals, most of whom had no contact on the other side of the island and little specific information about cross-border abortion practices. Whereas English – and Spanish – were widely spoken by local women on both sides of the island, professionals on the French side were predominantly French-speaking¹² and professionals on the Dutch side bi-lingual in Dutch and English. Professionals knew that women crossed the French-Dutch border according to their medical insurance possibilities and health care preferences; they knew because their patients told them so. These same professionals identified two other nearby small islands from which and to which women travelled for abortion services unavailable at home: Anguilla and St. Kitts-Nevis. A first round of interviews on those islands led to yet another island, both a referral source and a regional base for Family Planning coordination: Antigua-Barbuda.

After a series of interviews in Antigua, we decided to retrace our steps for more in-depth studies of those countries already visited and of their interactions with each other and with European metropolitan centers. This small network of countries was surely not

¹² Most spoke French in their personal and professional circles, although their medical practice obliged them to learn at least a minimum of English for working with the local population.

exclusive, as evidenced by a highly diverse Caribbean migrant presence¹³, but it offered the characteristics necessary to test our research hypotheses.

The inquiry was, thus, defined as a five country regional case study including Anguilla (British, population 13,254), Antigua-Barbuda (a two island state, independent since 1981, population 68,722), St. Kitts-Nevis (also a two island state, independent since 1983, population 38,958), Saint Martin (commune of the French Antillian Department of Guadeloupe, Saint Martin population 31,397; total French Antillian population 821,136) and Sint Maarten (island government of the Kingdom of the Netherlands Antilles, Sint Maarten population 30,597; total Netherlands Antilles population 213,900).¹⁴ The two-country island of Saint Martin and Sint Maarten and the two-island country Antigua-Barbuda are major transit and migration centers of the entire Caribbean region.

Not counting unregistered migrants or the high number of tourists on the islands at any one time, the total population of the five identified islands is about 196,000 persons. The circulation of unregistered migrants during any one year might so much as double that population, increasing the size to the 300,000 criteria of inclusion in global reports.¹⁵ And, if one draws the line from any one of those countries to their political partners or allies within the Caribbean, the network extends to other British and Dutch territories, other French Overseas departments and to the closely associated English-speaking Commonwealth countries of the region.

Choosing Informants

The main source of information was in-depth interviews with service providers. In addition, legislation texts, international documents and a host of secondary sources were consulted. Abortion statistics on the Caribbean in general and on the five research sites in particular are scarce and hardly reliable. They are almost entirely based on government data; limited information on unsafe abortion might be available from Emergency Room records, but surely effective safe abortions performed illegally were invisible. Since our interest was the

¹³ People of over 80 nationalities have been documented to live on the island of Saint Martin-Sint Maarten according to census data of the island government of Sint Maarten.

¹⁴ Census data for Anguilla, Antigua and Barbuda, and St.Kitts and Nevis are drawn from the *The World Factbook 2005*: www.cia.gov/cia/publications/fact. For Sint Maarten (census 2001): www.central-bureau-of-statistics.an. For Saint-Martin (census 2002): www.saint-martin-online.com/fr. Total figures for the Netherlands Antilles and French Antilles are country by country composite figures from the above sources.

¹⁵ No exact figures are available. According to local authorities, this circulation is significant on Antigua, St. Martin and Sint Maarten.

entire system of abortion provision, not only the casualties of that system, we needed a qualitative method capable of giving a fuller account of local practices, including the parameters of successful pregnancy terminations in criminalized contexts.

There are two main parties involved in most abortions: those who perform or supervise them and those who undergo them. A good deal of research has been conducted about the women who have abortions.¹⁶ Results invariably show that women of every social group terminate pregnancies whatever their age, origin, marital status, contraceptive history, or relationship satisfaction. Although there are a wide range of abortion rates in the world depending on complex conditions, an annual global estimate of 32 to 46 abortions per 1,000 women of reproductive age, adding up to between 36 and 53 million induced abortions worldwide per year,¹⁷ testifies that abortion is a common experience and need of women. There is no reason to expect deviation from this norm in the Caribbean. However, whereas abortion-seeking is unexceptional for women, abortion-providing distinguishes physicians from their colleagues in much of the world. Especially in criminalized contexts, doctors' decisions to offer services despite legal and social sanctions beg scientific investigation and analysis. Only those who provide routine abortions know details of the practice and its environment. They are the best informants of what actually happens since they are the operators of the system. This focus on practitioners places our study in one category of abortion research recognized by the World Health Organization, namely: *PRS=Provider Study*.¹⁸

Phase Two: Review of Current Abortion Laws

Abortion laws on the five research islands reflect the colonial history and current political status of each country. As a Commune of the Overseas Department of Guadeloupe, Saint Martin is governed by the letter of current French law. As an island government under the administration of Curaçao, Sint Maarten is part of the Kingdom of the Netherlands Antilles; laws are set by the Netherlands for foreign policy and set in the Antilles for most other matters, including health legislation. Antigua-Barbuda and St. Kitts-Nevis, both

¹⁶ In France, the most extensive recent study was conducted by the INSERM: Bajos, Nathalie, Ferrand, Michèle et l'Equipe GINÉ. *De la contraception à l'avortement. Sociologie des grossesses non prévues. Collection Questions en santé publique*. Paris : Inserm : 2002.

¹⁷S.K.Henshaw, "Induced abortion: A world review, 1990". *International Family Planning Perspectives*, 16 (199), 59-65.

¹⁸ Unsafe Abortion, *Op. cit.*:17.

independent, are self-governing. As former British colonies, they both operate against a background of old English common laws, some of which have been reconsidered and changed, others of which have been retained. As members of the Commonwealth, certain judicial decisions taken elsewhere in the world, notably England, may be applied. Anguilla, an Overseas Territory of Great Britain, is largely autonomous in fixing its own laws, exceptions being foreign policy and certain exigencies of the British Council.

The following key excerpts and minimum explanations sketch current abortion laws in each country:

Saint Martin (French Antilles): After a first provisional law in 1975, called Law Simone Veil, the French law on Voluntary Termination of Pregnancy, adopted in 1979 and amended thereafter several times, currently reads that:

A pregnant woman whose condition places her in a situation of distress may make a request to a physician for the termination of her pregnancy. The termination may be performed only before the end of the twelfth week of pregnancy.

A voluntary termination of pregnancy may be performed only by a physician.

The procedure may be carried out only in a public hospital establishment or in a private hospital establishment conforming to the provisions...

After pharmacological abortion was introduced in 1988, the law was amended to ensure that women could legally self-administer abortifacient drugs, although in the presence of a physician at an authorized hospital facility. Other reforms abolished the parental consent requirement for minors and the residency requirement for foreigners.¹⁹ At the time of this research, no abortions were allowed outside the hospital; shortly thereafter, in 2004, an amendment was passed to permit general practitioners with hospital affiliations to provide pharmacological abortion until 49 days LMP using a fixed protocol of mifepristone (RU486) and misoprostol (Cytotec).

Sint Maarten (Netherlands Antilles): Abortion law in Sint Maarten is patterned after the 1886 Dutch common law which was incorporated in the penal code of the Netherlands overseas colonies in

¹⁹ See especially : loi n° 75-17 du 17 janvier 1975, *Journal Officiel* du 18 janvier 1975, p. 739 ; loi n° 79-1204 du 31 décembre 1979, *Journal Officiel* n° 1 du 1^{er} janvier 1980, p. 3 ; loi n° 2001-588 du 4 juillet 2001 relative à l'interruption volontaire de grossesse et à la contraception (1), *Journal Officiel* n° 156 du 7 juillet 2001.

1918. Abortion per se is never allowed, although general criminal law principles of “necessity” would permit the act if required to save the life of a pregnant woman.²⁰ Aside from that overriding justification, the penal code specifies penalties of three to fifteen years imprisonment for a woman or any other person who causes the expulsion or death of the “fruit of her womb”, depending upon whether the woman herself or another person commits the act, whether the act is intentional, whether the woman consents, or whether she dies. A century later in 1981 that antiquated law was radically revised in the Netherlands into one of the most liberal in Europe, but the reform was not adopted in the Caribbean. The old common law still on the books in the former Dutch colonies – including the Netherlands Antilles, Aruba and Surinam - reads as follows (my translation from the Dutch):

Article 308

The woman who intentionally causes the expulsion or the death of her fruit <vrucht> or allows another to do so, will be punished with imprisonment of a maximum three years.

Article 309

He who intentionally causes the expulsion or the death of the fruit of a women without her permission will be punished with imprisonment of a maximum of 12 years. If the woman dies as a result, he will be punished with imprisonment of a maximum of fifteen years.

Article 310

He who intentionally causes the expulsion or the death of the fruit of a woman with her permission will be punished with imprisonment of a maximum of four years and six months. If the woman dies as a result, he will be punished with imprisonment of a maximum of six years.

Article 311

In the case that a doctor, midwife or pharmacist is an accomplice to the crime in article 308, or guilty or accomplice to one of the crimes in articles 309 and 310, the fixed sentences can be raised by one-third, and he can be dismissed from exercising the profession in which the crime was committed.

Antigua&Barbuda and ***St.Kitts&Nevis***: Most Commonwealth countries of the Caribbean have retained the prohibitory English abortion law of 1861 entitled the Offences against the Person Act. Notable exceptions are Barbados and Guyana, where liberal laws were enacted in

²⁰ Article 42 of the Netherlands Antilles criminal code reads: “*Not punishable is he who commits an act to which he was irresistibly driven*” (In original Dutch: *Niet strafbaar is hij die een feit beaat waartoe hij door overmacht is gedrongen*). The Supreme Court for the Netherlands, the Netherlands Antilles and Aruba developed under this notion of a ‘superior power’ the theory of ‘necessity’, which applies when a doctor terminates a pregnancy to save a woman’s life. Information and interpretation kindly supplied by specialist in Netherlands Antillian law, Professor Jan Reijntjes.

1983 and 1995 respectively.²¹ Antigua & Barbuda and St. Kitts & Nevis both still operate under the nineteenth century law. The British Abortion Act 1967, the Indian Medical Termination of Pregnancy Act 1971 and the Singapore Abortion Act 1974 were the earliest advanced abortion laws to set positive legal grounds for pregnancy termination in the Commonwealth. Those laws became models for consideration in other Commonwealth jurisdictions. But much of the Commonwealth has not gone beyond the Offences against the Person Act which prescribes that:

Every woman, who with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whoever, with intent to procure the miscarriage of any woman, whether or not she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and be convicted thereof, shall be liable to be imprisoned for any term not exceeding ten years, with or without hard labour.
(Section 58)

Furthermore:

Whoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor, and, being convicted thereof, shall be liable to be imprisoned for any term not exceeding two years, with or without hard labour. (Section 59)

Debates center on what constitutes a *lawful* versus *unlawful miscarriage*. Two judicial English decisions help clarify: the Infant Life (Preservation) Act 1929 and the case of *Rex v. Bourne* 1938. The Infant Life (Preservation) Act of 1929 allows one to “destroy the life of a child capable of being born alive” if proven that the act was “done in good faith for the purpose only of preserving the life of the mother”. That act was further clarified in the *Rex v. Bourne* 1938 case wherein a physician, Dr. Bourne, was acquitted for terminating a pregnancy of a woman on the ground that, if her pregnancy continued, she would become “a mental wreck”. According to Cook and Dickens²², the *Bourne* case reasons “that if preservation of the mother’s life justifies sacrificing the child’s life at the moment of birth, it also justifies such sacrifice at any earlier stage in the pregnancy. The case went further, however, in ruling that an early termination is lawful to preserve not only the fact of the

²¹ In Barbados: *Medical Termination of Pregnancy Act*, 1983; in Guyana: *Medical Termination of Pregnancy Bill*, 1995.

²² Cook, Rebecca J. & Dickens, Bernard M. Abortion Laws in Commonwealth Countries. *International Digest of Health Legislation*. 30 (3), 1979: 395-502. Citation, p. 402.

mother's life but also the quality of her life. The quality of life is described as health and includes both physical and mental aspects.”

The Bourne judgment has been cited and approved in appeal courts in the Commonwealth, and most Attorney Generals in the Commonwealth Caribbean have explicitly recognized its applicability (including St. Kitts and Nevis but not Antigua and Barbuda²³). However, there would first have to be a prosecution for the case to come formally into play as a line of defense. But even aside from Bourne, the prohibitive Act refers to activities *unlawfully* committed. Significantly, courts have recognized that the word *unlawful* implies the possibility for *lawful* abortions.²⁴

Anguilla (Overseas Territory of Great Britain): Although the British reformed their abortion law in 1967, they did not dictate whether or not their overseas (dependent) territories should adopt the revision. Anguilla chose not to do so, thus the old basic law remained in effect. Only in 2000 did the Anguilla government decide to modify the Offences Against the Person Act. The change was inspired by a British funded Caribbean Commonwealth law review project. Why such a review at this time? British citizenship would be extended to the people of Anguilla in 2002 (as well as to the people of other Overseas Dependent Territories); the condition for this extension was abolition of the death penalty and decriminalization of homosexual activity. The death penalty had already been abolished in Anguilla. But, religious leaders were vehemently opposed to decriminalizing homosexual activity of their own accord and preferred the alternative route whereby the British cabinet would ask Parliament to extend their law to Anguilla. And so it happened. Liberalization of abortion law was not a condition of citizenship, and no parallel extension occurred. However, abortion codes were included in the legal review, and a reform was adopted; according to some informants, that reform passed as a less abhorrent concession to pressures for change than would have been acceptance of homosexuality. Also, it appears that the new law left room for multiple interpretations, such that certain persons now consider abortion legal on the island while others consider it still illegal.

²³ See Cook, Rebecca J. & Dickens, Bernard M. *Issues in Reproductive Health Law in the Commonwealth*. London: Commonwealth Secretariat, 1986.

²⁴ *op.cit.*: 406.

According to the Attorney General of Anguilla²⁵, the new law is a “codification of the criminal law” but in no way a reversal. It incorporates aspects of both the Infant Life (Preservation) Act and the case of *Rex v. Bourne*. Under the clauses cited above as Section 58 of The Offence Against the Person Act, the new codification prescribes that:

(1) A person shall not be convicted of an offence...when a pregnancy is terminated in a hospital by a medical practitioner if 2 practitioners are of the opinion, formed in good faith—

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the physical health of the pregnant woman greater than if the pregnancy were terminated or grave injury of prolonged duration to the mental health of the pregnant woman; or

(b) that there is substantial risk that, if the child were born, it would suffer from such physical or mental abnormality as to be seriously handicapped.

(2) The reference to the opinion of 2 medical practitioners and to an approved hospital shall not apply to the termination of pregnancy by a registered medical practitioner in a case in which he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman. (Article 183, Criminal Code Anguilla, R.S.A.c.C140, p. 72, Part 15 : Abortion)

Phase Three: Defining Safe (Criminal) Abortion

The above laws criminalize certain or all pregnancy terminations. Our study examines the full range of abortion practices and, therefore, examines unlawful as well as lawful behavior. Significantly, the subjects of our research are primarily health professionals authorized to practice medicine by the State and qualified as safe practitioners. We will, therefore, be investigating the illegal practices of approved persons in approved facilities.

There is little precedent for studying safe abortion in criminalized contexts. Experts are aware that women anywhere in the world can obtain safe abortions if they have the means to travel, pay high fees or influence local physicians to serve them. Also women without means may have access to safe pregnancy terminations in criminalized contexts under euphemistic terms such as *menstrual regulation* or *abortion aftercare*,²⁶ or under dire conditions beyond their control such as life-threatening pregnancies, fetal deformity or pregnancies resulting from rape or incest. Physicians may, depending upon the specificities

²⁵ Personal communication from Attorney General Ronald Scipio, 5 August 2003.

²⁶ For one discussion of menstrual regulation, see: Begum FS, 1993. Saving lives with menstrual regulation. *Planned Parenthood Challenges*, 1:30-31. For experiences with “abortion aftercare”, see Greenslade FG et al, 1993. *Manual Vacuum Aspiration. A Summary of Clinical and Programmatic Experience Worldwide*. IPAS: Chapel Hill, North Carolina.

of local legislation, be authorized to perform abortions in those cases. Such exceptions aside, abortion is assumed to be unsafe when it is illegal, notably by the World Health Organization of the United Nations.

Safe criminal abortion is, thus, a juridicial, if not clinical, contradiction in terms. As noted earlier, abortion research in illegal contexts generally focuses on the complications of unsafe pregnancy terminations, thus providing data on mortality and morbidity. Protocols for effective, comfortable, safe and accessible care - typical research topics in legal contexts – are rarely, if ever, the focus of systematic investigation where laws forbid elective abortion. Officially, professionals authorized within a country must comply with state law, so they cannot legitimately perform illegal procedures, regardless of competence or technology. Government officials know that clinical risks sometimes exist also in legal contexts and they know that clinical competence may exist in criminalized contexts; however, whereas they have a responsibility to denounce unsafe practice in legal contexts, they have no responsibility – or right - to secure or reinforce “safe criminal practice”.

The logic is clear, if tragic. The UN, respectful of individual state law, does not draft safety guidelines for unauthorized acts. Such guidelines would essentially legitimize crime. At the 1994 United Nations International Conference on Population and Development in Cairo, governments agreed that :

“.....Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe.”²⁷

According to the above statement, only women who live under legalized abortion systems have a right to terminate a pregnancy safely. The international community of governments is not prepared to call for a decriminalization of safe practice. That same community estimates the world death toll from unsafe abortion at 80,000 women per year or more than 200 women daily.²⁸

What would be a clinical, rather than legal, definition of safe abortion? An inversion of the WHO definition of unsafe abortion gives us a guide. In *Global and Regional Estimates*

²⁷ Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York, United Nations. (No. 95.XIII.18).

²⁸ Unsafe Abortion, *Op. cit.*

of *Incidence of and Mortality Due to Unsafe Abortion*, WHO Division of Reproductive Health explains the definition of unsafe abortion used to tabulate data:

“Unsafe abortions are characterized by the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities. Although the legality or illegality of the services may not be the defining factor of their safety, for the purpose of these tabulations, unsafe abortion has been defined as an ‘abortion not provided through approved facilities and/or persons’. What constitutes ‘approved facilities and/or persons’ will vary according to the legal and medical standards of each country. The definition does not take into consideration differences in quality, services available or the other substantial differences between health systems.” (*Op. cit.*, p. 3)

Inverting the formula, we arrive at the following definition of safe abortion:

Safe abortions are characterized by adequacy of provider skills, proven techniques and sanitary facilities. Although the legality or illegality of the services may not be the defining factor of their safety..., safe abortion can be defined as an “abortion provided through approved facilities and/or persons”. What constitutes “approved facilities and/or persons” will vary according to the legal and medical standards of each country. The definition does not take into consideration differences in quality, services available or the other substantial differences between health systems.

For the purpose of the present study, we will use the above definition of “safe abortion”.

And, we define unsafe abortion “by the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities”, irrespective of the state’s position on abortion. We are concerned about unsafe abortions according to that definition, but our primary objective here is identifying the persons and settings most likely to provide good care, namely trained health workers in approved facilities.

Essentially we are shifting the focus from the concept of abortion (a *right* in some countries, a *crime* in others, a *surveilled liberty*²⁹ in others) to the practice of abortion by competent persons with adequate facilities at their disposal. This shift allows for an uncensored investigation of the safest available abortion practices, whatever the law. Once identified, those practices could then be enhanced and, hopefully, legitimized for the sake of women’s survival, health and autonomy.

²⁹ *Liberté surveillée* in French is a juridic term meaning *probation* in English. In relation to abortion, the French criminal code allows for pregnancies to be terminated “freely” under state surveillance according to strict penal guidelines.

Phase Four: Interviewing Health Professionals

A wide range of health care professionals were interviewed including gynecologists, family practitioners, nurse midwives, Family Planning workers, government health officials and pharmacists. Each person was asked to recommend other professionals until an inter-island network of service providers was traced. Repeat interviews were conducted when necessary for complementary information. We also met with directors of government women's affairs offices and grass roots groups. Special effort went into meeting migrant women. Most interviews were conducted individually, although women's organizations and health departments sometimes met us with two, three or, in one case, twenty interested parties.

Interview Guidelines

Interviews with physicians, the main informants for this report, focused on the following topics: (1)Professional background (2)Abortion law and policy (3)Setting and technique of abortion practice, including surgical and pharmacological methods (4)Risks and/or complications due to unsafe abortion, inadequate facilities or governmental restrictions (5)Special issues related to migrants and adolescents (6)Referrals within and across state lines. The subject of contraception, including sterilization, was also addressed, although abortion was the central theme. Interviews with non-physicians followed the same basic interview schedule with particular emphasis on the expertise of the interviewee. Only the data directly pertinent to our research hypotheses will be presented here.

Data Collection

Field work was conducted from October 2001 to August 2003. Interviewers began each conversation by introducing both the research and the future goal of regional cooperation for training, advocacy and exchange. The conversations were, thus, both inquiries and invitations for future collaboration. All interviews were conducted by two persons, both university professors living in countries with liberal abortion laws. Their professional credentials and residence in countries with legalized abortion, one Caribbean and one European, may have facilitated disclosure about abortion practices in criminalized contexts. The attitude of the interviewers was clearly favorable to safe, accessible abortion services for women. Together the interviewers were fluent in Dutch, English, French and Spanish so interviews could be held and pertinent local documents examined in any of those languages.

Most interviews were recorded with the permission of interviewees. If not recorded, responses were noted by hand. Eighty per cent of the doctors and most other health care professionals were comfortable with tape recordings once reassured of anonymity. No names will be used in this report in order to protect informants and the abortion services upon which women rely.

Research Sample

A total of twenty-six physicians were interviewed, one or more times, in the five island countries: twelve specialists in obstetrics and gynecology, eleven family practitioners and three physician government administrators. Sixteen of the twenty-six doctors practice abortions, seven only in a hospital setting, two both at the hospital and in a private office, and seven -only in private offices. Of the ten physicians who do not perform abortions, five have been trained to terminate pregnancies and have done so in the past. Five government hospitals and two private hospitals provide the institutional settings. Of the sixteen abortion providers, nine are specialists in obstetrics and gynecology and seven are family practitioners. These practitioners perform the vast majority of all abortions in the five country research sites. Only two are legally permitted to perform elective abortions. An additional five have the informal accord of local government authorities, despite criminal laws; certain of those authorities set policy guidelines and conduct periodic inspections of abortion facilities.

In addition to the doctors, we interviewed more than thirty other health professionals, advisors or government officials. Those included five Family Planning workers (three of whom are nurse midwives), seven government officials (including a Minister of Health and an Attorney General), five pharmacists, and seven women's groups (collective interviews). Approximately the same number of people in all the above categories, including doctors, were interviewed on each of the five islands. This report explicitly avoids specifying the number of abortion practitioners on each island or the location of illegal procedures when such information could be incriminating. Elective abortion is legal and available in only one of the five countries, French Saint Martin. Nonetheless, also in that legal context, abortions conducted outside fixed guidelines are illegal; and note that also in highly restrictive contexts, certain abortions considered medically necessary are legal. So some of the illegal procedures recounted here take place in a country with liberal abortion laws, and some of the legal procedures in countries with restrictive laws.

Background Profiles

All of the physicians interviewed in the Dutch Antillian country of Sint Maarten were born elsewhere, several in the Caribbean (from a British territory, French Department, Cuba and Surinam) and a few in Europe, mostly from the Netherlands. All of the physicians interviewed in the French Antillian island of Saint Martin were likewise born elsewhere, mostly in France or former French colonies; no one was born in the Caribbean. All but one of the physicians interviewed in Antigua were born in Antigua. All the physicians interviewed in St. Kitts were St. Kittians. All but one interviewed in Anguilla was Anguillan. Of the twenty-six physicians, about half were trained in Europe or North America at various universities or medical centers; the other half were trained in the Caribbean at the University of West Indies (campuses of Barbados and Jamaica). Most of the Caribbean-trained physicians did some or most of their post-graduate work in Europe or the United States. Of the French Europeans in Saint Martin, several have histories of clinical practice in other overseas territories, departments or former colonies. A few of the Europe-born physicians in Sint Marteen have been there for decades. Many of the Caribbeans had been away studying for long stretches of time before returning home to practice medicine; they maintain professional affiliations abroad and continue to attend international seminars and conferences. Several physicians have research as well as clinical experience. All enjoy high social status as specialists, family doctors, medical administrators, or government officials. Ages range evenly from early thirties to late seventies; more than half are Caribbeans from birth and heritage. Women represent one-fourth of the sample.³⁰ All of the non-physician health professionals cited here, except for the French Family Planning midwife, are Caribbean women with diplomas from the University of West Indies (majority) or various institutions in Great Britain.

THE INTERVIEWS

Law, Policy and Practice

Sint Marteen

Sint Maarten was the first research site. Since our network had yet to develop, we began with telephone calls to hospitals, physicians, Family Planning Centers, women's

³⁰ The masculine generic pronoun will be used to report all data from interviews with physicians regardless of the speaker's gender identity in order to guarantee anonymity.

organizations and government health departments. We made a first call to the Sint Maarten Hospital Medical Center and asked for the Service responsible for Pregnancy Terminations. The operator (who spoke English, not Dutch) was taken aback by the question, put us on hold for a long while, and returned to say that such a Service did not exist. After some prodding she put us on hold again, and eventually directed the call to the Emergency Room. From there, we were forwarded to the Obstetrics and Gynecology Department and spoke to a specialist who offered us an appointment. And so we proceeded to organize a preliminary round of interviews. Upon arrival in Sint Maarten, we started with a meeting at the Women's Desk, a government community center which was to become our central research base. The staff responded to our inquiries about abortion on the island as follows:

“Abortion is illegal in Sint Maarten...No, the law is not a problem. Women just go over to the French side of the island or, if they are too far along, they go to... <another island >. Abortion...like homosexuality...is a taboo here. No one talks about it....”

That afternoon at the government hospital the specialist we had spoken to on the phone contradicted the Women's Desk:

“The Netherlands Antilles have not drafted a specific law about abortion so Dutch law applies. But we are more conservative: we limit abortions to under 12 weeks, and personally I discourage them over 10 weeks. Also, we do not have RU486 in the Netherlands Antilles although it is allowed in the Netherlands.”

Was abortion legal or illegal in Sint Maarten? Was it practiced or not practiced? The Women's Desk said not, but the gynecologist obviously performed them in the government hospital and freely offered the names of other practicing physicians with whom we could talk. And so we did. One family doctor helped to clarify the confusion:

“Abortion is illegal, but tolerated. When Holland changed the law, the Dutch Antilles never put the new law into effect, but abortion is very tolerated....because physicians know the Dutch law.”

Another physician who performs daily office surgical abortions told how the central government of the Netherlands Antilles not only tolerates abortion, but also visits facilities to assure quality care:

“We have a verbal agreement with the Curaçao Ministry of Health. An inspector came to visit from Curaçao to make sure we are doing the procedure properly. I'd been really worried about their visit and then all they did was check my facility and ask about my technique. They know it is a needed service.”

Such systematic, albeit unofficial, government surveillance was verified by also another practitioner who both favors and suspects the legal ambiguity:

“Everyone knows it is done. It’s an institutionalized toleration system. Safe abortions are available, also by gynecologists at the hospital. Curaçao even controls it now. They supervise the protocol, you establish the rules. I do up to 12 weeks, others only to 8. An inspector comes periodically, asks me for my guidelines. The Health Department here is totally aware of the situation but they don’t acknowledge it. They like to keep the situation illegal because then they could catch you. If anything goes wrong, they could prosecute.....it’s a taboo situation...But no, I’m not for legalization, that would mean more controls, more delays. The system works fine the way it is.”

Not all physicians are satisfied with the situation. Another doctor, also a Family Planning administrator, finds the arrangement volatile:

“I don’t do abortion, and there is no movement to legalize, but it should be legal. Law enforcement has never done anything about it so it has never become an issue. But one day something will happen and things will explode. I expect that something will happen to a patient and then: front page, prosecution, legal process.”

Others believe themselves and their colleagues to be totally sheltered from police action:

“The only person the police would never question is a doctor. No policeman can come here. Only the judge with an official letter is allowed to ask information about a patient.”

We interviewed a lawyer about the risks facing physicians who provide abortions. She questioned public authorities for us and reported the Public Prosecutor as saying:

“Abortion is a criminal offence in the Netherlands Antilles but prosecution is not a priority since it is difficult to know who is practicing”.

By the time we heard this, we had ourselves acquired a list of abortion practitioners, names given more freely by physicians than by government officials. Speaking once again to the Women’s Desk, we learned that the staff did, in fact, know abortions were practiced in Sint Maarten:

“Everyone knows who is doing them” <but> “we don’t talk about it, we can’t talk about it since it is illegal and we are a government agency”.

They did not, however, know that the Curaçao Health Ministry was inspecting the services. One staff member was indignant that off-island officials conducted checks of abortion facilities without informing them, the island government women’s center.

Despite the 1886 prohibitory Dutch Criminal Law still on the books, abortion services are currently provided both in hospital and private office settings in Sint Maarten and they are surveyed by the central health department of the Netherlands Antilles in Curaçao. Is this

« institutionalized toleration system », as one physician called it, equal in practice to a legal system? We asked two of the hospital gynecologists whether they set any conditions for a woman to terminate a pregnancy and, if so, what conditions. The gynecologist for whom “Dutch law applies” said:

“I try to discourage women from having an abortion unless they have heavy social reasons. If a woman has 6 or 7 or 8 children, okay, but if she has only 2 or 3 then I don’t do the abortion”.

Another ob-gyn specialist elaborated how women dealt with the limited access to abortion at the government hospital:

“Officially we cannot do it unless there’s a serious medical reason...So some women go to family physicians on the outside...and some go to the French side where it is legal, and often these days what you see more is that they use the Cytotec - these days physicians are giving out Cytotec...we are getting a lot of patients now with incomplete abortions...”

Asked if he was in favor of legalization, the same hospital physician declared:

“I think that a woman has a right to choose, and if you think women have a right to choose, then you better make it legal so that she can do it in a better way....”

“A better way” for this doctor refers to a better way than using Cytotec. Cytotec is the brand name of *misoprostol*, a synthetic analogue of prostaglandin E1 developed by G D Searle & Company in the 1970s for treatment of certain kinds of gastric and duodenal ulcers. It is currently approved and available for this indication in over 80 countries. Presently it is also routinely used to induce labor and to induce abortions up to 49 days pregnancy in combination with RU486 (mifepristone). Taken alone, the drug can induce complete – or incomplete – abortions, although less effectively and less comfortably than when preceded by RU486. Administered according to recommended protocols, complete abortions occur upwards of 80% for first and early second trimester pregnancies.³¹ For women without legal or payable or socially acceptable access to abortion services, it offers the possibility of a self-induced pregnancy termination or of legal aftercare for “miscarriage”. Widespread use of the drug for its abortifacient qualities was first documented in Brazil in the 1980s.³² Presently it is extensively used in many countries both by women on their own and under the medical supervision of doctors who don’t have access to RU486; those doctors may or may not

³¹ For a variety of excellent references on misoprostol, see the Special Issue “Medical Abortion”, *Journal of the American Medical Women’s Association*, 55 (3), Supplement 2000.

³² Costa, SH. & Vessey, MP, 1993. Misoprostol and illegal abortion in Rio de Janeiro, Brazil. *The Lancet*. Vol. 341. May 15, 1993, 1258-1261; Arilha M. & Barbosa RM. November 1993. Cytotec in Brazil: “At least it doesn’t kill.” *Reproductive Health Matters*, no. 2, 41-52.

themselves provide back-up aspiration for incomplete expulsions. The last speaker favored legalization of abortion in order to reduce the number of incomplete Cytotec abortions. As our investigation unfolds, we will see that Cytotec use has become a key indicator of the social, economic, clinical and (il)legal context of abortion in the Caribbean.

Crossing the Border to Saint Martin

People in Sint Maarten were very much aware that hospital abortion is legal and available just a walk away across the border in Saint Martin. But whereas professionals have little or no direct contact with their colleagues on the other side of the island, women go back and forth. A family doctor on the Dutch side explains women's medical choices economically:

“The Dutch and French side don't work together at all. Except the patients – they go to both. Whether the population goes to French or Dutch side depends on their insurance system. If they work on Dutch side they go to Dutch doctor even if they live on French side. The majority of the island works on the Dutch side but that doesn't mean the majority get Dutch care because the French side have much more liberal social laws and it is very well organized so they give also many people who don't work medical care. We on Dutch side have unemployed who can't get medical care. Plus, all undocumented people go to French side. And anybody who is pregnant will definitely go to French side - if they don't have the Dutch insurance- because either they get it free or it's cheaper.”

For those women who go to the hospital in Saint Martin, French abortion law and policy determine the service they will receive. On our first visit, the Chief of Obstetrics and Gynecology at the Centre Hospitalier explained the system in Saint Martin:

“The French law is very clear. All pregnancy terminations are done at the hospital. Our only deviation is allowing women to take the second medication, misoprostol, at home. It is justified by our lack of adequate hospital facilities for supervising the expulsion. Home expulsion is completely safe and efficient. Women are supposed to come back 5 days later for a sonogram but no one actually comes back unless they have a problem...and then we do an aspiration.. We are also flexible about reducing the delay for reflection...All eligible women get the pharmacological procedure - 30 to 40 percent - unless they come from off the island. Most prefer it, though some prefer early surgical because they know the pills are not so easy. All aspirations are performed electrically under general anesthesia. Local is better and it's totally legal but the nursing staff objects. They are used to general and they are very resistant to change.”

During a subsequent visit, a new Chief of Service gave some history:

“We have to respect the law. We can't do terminations after 14 weeks <12 weeks pregnancy = 14 weeks Last Menstrual Period> and never in private offices. There were problems before, forbidden practices, but they went after the doctors, the police did, and since that period,

there aren't many abortions in private... not as many as on the other side <Dutch side> though sometime we think that it could occur but not as much as before."

Neither specialist knew any of the physicians working on the Dutch side, although they did know where women could go off-island for 2nd trimester abortions:

"Over 14 weeks, we just say we cannot do it here, but in the English law they can do it later than in French law, so maybe in..., we're not sure, maybe they can go over..."

Women could and did "go over", and so would we, thus discovering that English law did not, in fact, apply to the independent neighboring island. The Saint Martin gynecologist freely offered us the name of the off-island practitioner, and it would be physicians elsewhere who eventually gave us the names of practitioners of illegal abortion in Saint Martin.

Abortion services at private offices were obviously transgressive of French law. In a certain sense, their acts were more transgressive than those on the Dutch side of the island because *"The French law <unlike applications of Netherlands Antilles law> is very clear"*. However, we soon learned that this transgression did not have the same meaning for the physician - nor perhaps for the government? - if the abortion was done surgically or pharmacologically. One physician, comfortable with being tape recorded, was vehemently against doing aspirations in private offices, but pleased to help women abort with Cytotec under careful supervision, even if it entailed getting the drugs under false pretences:

*"The RU, I would like that we could give it in the office, but never an aspiration in a private office, never, it is too dangerous....Cytotec? Yes, it is a problem because the box has 60 tablets...I give just 2 or 3 or 4, I don't want her to buy a box because I never know if she will give it to someone else, that's why it's me, I buy it at the pharmacy as if it is for me (laughter)....When the pregnancy is 10, 11, 12 weeks, it works very well. At 5, 6, or 7 weeks it's much better with the RUI tell them to put the Cytotec tablets in vaginally...morning, evening, morning, evening for two days, then they come back to me and check and usually they are done and then they don't have to go to the hospital."*³³

Another private practitioner was hesitant to receive us and refused to be taped. He performed routine aspirations in his office. Once reassured that we were interested in surveying safe abortion options provided by competent professionals regardless of the law, he "admitted" to his practice and showed us his instruments:

³³ At the time of this interview, the physician did not have access to mifepristone; one reason given for authorization of medical abortion in offices (see Laws) was to control and improve current practices by giving physicians with hospital affiliations authority to give an initial dose of RU486 before the misoprostol (personal communication).

“I do aspirations by electric suction here in my office, I’ve got the machine, it’s quick...I do only to 8 weeks. If they are further along, I send them to the hospital.”

A French nurse confided her horror and curiosity about such practices on the French as well as Dutch side of the island:

“There are a lot of dirty practices on the island, Dutch side, French side, illegal things are done, but they are so illegal one can’t talk about them...Abortions are done in private offices, French side too, and the rules, limits in weeks pregnant, aren’t always respected. There’s Cytotec, that’s for sure...I’ve been told, I have, that there’s the American method, you know in offices, the manuel method, local anesthesia – and everything, everything - you know like when you see those American films where the women are given abortions, you see them enter and do like this (she separates and raises her legs) and then they walk out ten minutes later....”

Whereas this nurse, among other French practitioners, was aghast at the idea of “la method ‘américaine’”, i.e. aspiration under local anesthesia in a private office, professionals on the Dutch side of the island were sometimes aghast at what they consider a French routine of unnecessary general anesthetic, unnecessary hospitalization and over-medication. Such cultural quarrels may remind Europeans of ongoing Continental rivalries.

A private abortion doctor in Sint Maarten criticized medical practice across the border:

“On the French side, they prescribe pills and there is no follow-up. Or, for aspirations, they give general anesthesia: Ridiculous!”

A French family doctor practicing in St.Martin was virulent in his condemnation of Dutch practice, be it in Sint Maarten or in the Netherlands:

“Abortions on the Dutch side are not safe. General practitioners do them <aspirations> in private offices, simply not sterile enough, so there is a risk of infection, and they don’t use general anesthesia so it is very painful. The Dutch, they do it just for the money. It’s unsafe. <And in Europe, in the Netherlands?> Same thing, unsafe, just for the money...Before RU486, women would go to the Dutch side to avoid a hospital stay. Now with RU and better insurance, they pay nothing and they don’t have to stay in the hospital...”

Leaving clinical judgments to Curaçao health inspectors, and French-Dutch quarrels to Europeans, these words serve as a useful outline of alternative settings and protocols for safe abortion practice worldwide: hospital versus office setting, general versus local anesthesia, specialist versus general practitioner, surgical versus pharmacological method, private versus public payment.

Avoidance of hospitals is a theme that comes up again and again on every island, and it is given as a reason women prefer private office abortions, whatever the method, or self-administered Cytotec abortions. Hospitals are forboding, first of all, because they are often

too costly for women who do not have health insurance, the case for most migrants and all unemployed persons on the Dutch side of the island (there is universal health coverage on the French side). Secondly, the hospital is a public place and many women (according to interviews with service providers and women's groups) fear social exposure so they search for an alternative to the hospital either on the island or abroad. Lastly, many women want simply to avoid hospital admittance and general anesthesia. In Saint Martin, the only place in our study where RU486 is available, also the drug protocol requires one or more hospital consultations and a woman is eligible only if she is under 49 days pregnant. So many go to private physicians. If also the office procedure is too costly for them or if they want to avoid an aspiration, then they may opt to take Cytotec either under medical supervision or on their own...if they can get the drug. A French pharmacist explained:

“Women ask for Cytotec but I never give it without a prescription, it's very dangerous. I heard that many generalists give it out...Women try the Cytotec because it can be much easier...so well, it's worth a try, that way you avoid the hospital, you avoid general anesthesia”.

Physicians confirmed that the drug had changed the face of abortion care over the past few years; some consider it a positive development and some a health hazard. Whereas the practice was recounted by doctors on both the Dutch and the French side of the island, a number of providers of surgical abortion on the Dutch side object strongly to the technique, and attribute the practice exclusively to French practitioners. One doctor in Sint Maarten said: *I am against the giving of Cytotec...French people give it.* Another, also on the Dutch side, was more specific:

“I am strongly opposed, so much bleeding...women are not dying from it, but there are complications, risk of infections, risk of sterility.”

However, many physicians seemed comfortable with the Cytotec option. Borrowing an example from our next research site, a gynecologist who admitted that his abortion services are “*pricey*”, did not hesitate to advise women to try Cytotec:

“Women have come to me and said, ‘Doctor I want to have a termination but I cannot afford the 1400 dollars <Eastern Caribbean currency=560 US dollars>, what can I do?’ And I've said, ‘This is what you can do, you can go to the pharmacist, they can give you these tablets, and if you have any problem you come back and see me.’”

Back in Sint Maarten, even gynecologists who are wary of such practices tell that professional and scientific developments are moving toward greater acceptance of Cytotec use for a host of gynecological uses, including pregnancy termination:

“There was a conference in Washington D.C. of FIGO, the International Federation of Gynecologists and Obstetricians. They were talking a lot about Cytotec and there is some consensus more or less...I also read about using misoprostol alone to terminate pregnancies in an article of the Journal of Ob-Gyn...”

Certain physicians may have been inspired by professional meetings and journals, and according to some informants, pharmacists may have stimulated under-the-counter sale of the drug. However, most credit the drug’s arrival predominantly to resourceful migrant women. The majority of those migrants in Sint Maarten/Saint Martin are from the Dominican Republic or Haiti.

We decided to ask the Sint Maarten Women’s Desk to organize meetings for us with groups of Dominican and Haitian migrant women. Due to the delicacy – and illegality – of the issue, the most informative conversations were conducted later in private by a well-trusted Dominican nurse who told women she would convey their experience to us. We had wanted to meet the women ourselves but the nurse explained that they *“no quieren dar la cara”* <didn’t want to show their faces> in a conversation about abortion since it is illegal. She interviewed ten women who all had had from one to four self-administered Cytotec abortions. Undocumented women in Sint Maarten/Saint Martin usually bought the pills from women traders, often from Santo Domingo, and migrant residents with health insurance sometimes tried to get the drug from doctors. They each had been given precise recommendations about how many pills to take at what time intervals. One woman told the nurse how she had bled a lot for one day, another for two days, and both women said they had a lot of pain (*“sangró mucho”*...*“mucho dolor”*). Two other women told the nurse they feared sterility as a result of multiple Cytotec abortions:

“Two of the ten women, two of them were left practically sterile, according to what they say, because now they want to get pregnant but they can’t...They think it’s because of using the pill, because these were two women who have used it more than one or two times...”

Women’s experience with the drug is an extremely important subject for in-depth future investigation. Suffice it for now to say that there is evidence of a grass roots circuit of Cytotec “suitcase traders”.³⁴ The women interviewed explained that other abortion options were either too expensive or too visible, especially for undocumented migrants. A gynecologist reported that whereas a few years ago nearly all those using Cytotec were Dominican migrants, now *“everyone is using it, even teenager girls.”*

³⁴ Term used to refer to those who transport the drug in suitcases from island to island for underground sale (personal communication).

Anguilla , Antigua, St.Kitts³⁵

Doctors and other health professionals in Saint Martin and Sint Maarten make referrals off-island, and they receive referrals from abroad either via the women's grass roots grapevine or, more rarely, from professional colleagues. Those referrals are usually either for unavailable services, such as 2nd trimester abortions, or for anonymous services away from home. We followed the network according to the names offered and organized interviews in the independent Commonwealth nations of Antigua and St. Kitts and in the British Overseas Territory of Anguilla. Since those three countries have comparable juridic, religious and social environments, the interview findings will be presented together.

One Ob-Gyn specialist in Antigua described how law, religion and abortion practice co-exist in his country:

“Technically abortion is illegal in Antigua, but the law hasn't been a problem...We do know there are some laws on the books that state that if a woman's life is in jeopardy, then two doctors can recommend that she has a termination. That is what we basically work on. We <physicians> have gone to the government trying to seek legislation, and basically the government has backed off. They said, 'Look, it hasn't been a problem, what we do is turn a blind eye, but to legislate that abortion would be legal would cause too much problem with the Church.' This is a very Christian society.”

A St.Kitts specialist referred to those “laws on the books”:

“if ever charged with a crime <abortion> , you have the right to refer to British law, and you would be acquitted.”

He was referring to the Commonwealth precedent *Rex v Bourne* (see Laws) allowing abortion if otherwise the woman would become a *mental wreck*. On those islands still under British rule as Overseas Territories, such as Anguilla, the two-level legal apparatus was even more explicit, if not necessarily more certain in its application. One gynecologist who has worked on different islands explained:

“Basically there are two sets of laws. The dependent <British> territories have their own intrinsic laws that are passed by the government of the island. And then one can sort of operate under the mother country laws. So in order for me to do a termination of pregnancy, I have to do it under British law... As for the independent English-speaking Caribbean countries, well they too come out of the British inheritance. It's not legal in most of them, except Barbados and Guyana, but it's tolerated because nobody is going to prosecute a doctor...”

³⁵ From this point on, Antigua and St.Kitts will be discussed without reference to their partner islands, Barbuda and Nevis, because interviews were held exclusively on those parts of the two island states.

And if they did prosecute, apparently the doctor could fall back on the Bourne's case. Nonetheless, doctors hinted to us that they would not welcome such a scandal. Was British law a legal back-up or an ongoing immunity to criminal sanction? We admitted to a ob-gyn specialist in Anguilla that it was not clear to us when British law applied and when the Anguillan law applied. He replied frankly that: *"It is not clear to anyone."* To complicate things further, we learned that in the year 2000 Anguilla's island government had passed a more liberal abortion law. The Medical Director of the government hospital at the government hospital confirmed that: *"Yes, there is a new law here, but it is not being implemented."*

In principle, the new law should make access to abortion more supple. We decided to make an appointment with the Attorney General of the island government for clarification. He gave us some notion of the social and religious climate that may be clouding legal interpretations and impeding implementation of the recent reform:

"The change in law was not intended to open up abortion for women here. It was recognized that there are certain circumstances that may be dangerous for the mother...The culture of Anguilla would not permit abortion on demand. This is a Christian society. Laws from Great Britain are not our laws. They don't decide for us because we have a different society. We will not legalize the taking of a life."

Health workers on each island linked the retention of old abortion laws or non-implementation of new laws to Church opposition, and some felt it best to leave well enough alone. One health administrator of an NGO expressed his concern that political mobilization could jeopardize existing services:

"If we try to push this legalization business, we are just going to push the Church, the conservatives, the whole society, against us, and the safe abortions that are happening are going to stop...The Church knows about this...I'm not going to fuck up what works well here because our concern is the health of our women....Down the line, legal. Right now, safe. This is our highest moral principle..."

A nurse reiterated the same basic sentiment:

"Everyone pretends it's not happening. The church, they don't say anything about it because it isn't legal...no, it's not really legal but it's not done as a cloak-and-dagger thing, it's done more or less openly, and safely..."

She recounts the history of abortion practice on the island:

"They used to send people to prison. There was a time when there were all these back street abortionists. One lady told me she went to a fisherman! What does a fisherman know about human anatomy?! That's how desperate she was....People used to end up with sepsis, really sick, and when I say sick, I've seen times you had to stay outside the room the smell was so bad. You don't see that anymore. Doctors realized that people were dying - or becoming

infertile, and they decided, well it was inhumane to let people suffer like that...Now people go to the doctors and the doctors help them..."

We asked providers to tell when and why they began performing abortion despite the criminal laws and the heavy social and religious judgment. A former Chief of Ob-Gyn in St.Kitts pointed proudly to one of the many diplomas behind his desk:

"Look at this date. I finished my residency in Obstetrics and Gynecology in New York City on July 1st, 1970. Does that say something to you ?? - - - It was the date New York State legalized abortion."

And he recounted at great length the training, experience and commitment he developed during those formative years, and his subsequent provision of abortion services for women from his and neighboring islands.

A family doctor on another island told how he had been doing abortions for many many years, first D&Cs and now aspirations. He recalled the horror of Emergency Room "*S&S: Slip and Slide*", the term residents of the University of West Indies Medical School had used to refer to the bloody floors associated with abortion complications. He expressed pride in his clinical talents and ongoing office practice of early 1st trimester abortion; he also expressed dismay at the increase in Cytotec use:

"When I was a resident, I was so good and quick <at doing abortions>, they said I was a natural...Abortion is safer than walking across the street...I used to do up to 6 a day, but now it's cut in half due to all the Cytotec...Immigrant pharmacists fromsell the tablets individually, they mark the price way up...We know because there are lots of incomplete abortions showing up at the Emergency Room...The gynecologists at the hospital sent around a Circular to all the pharmacists telling them to stop selling it."

At our request, he later sent us a copy of that circular entitled "Indiscriminate Use of Cytotec" and signed by the three gynecologists of the government hospital:

"We wish to express our concern about the indiscriminate use of Cytotec by some pharmacists and general practitioners to induce abortions. It seems that there is no awareness of the dangers of Cytotec as patients are being prescribed large doses of the Cytotec orally and/or vaginally repeatedly until some form of bleeding occurs to a greater or lesser degree. They are then being told to report to the Casualty Department when the abortion is occurring. We have long been seeing patients at the Casualty Department with several undissolved tablets still in the vagina, some patients still having a live fetus seen on ultrasound scan. In some cases bleeding is so severe as to require emergency blood transfusion with attendant risks.The wanton use of Cytotec in the outpatient setting is a very dangerous practice. It is inviting disaster to suggest to these desperate women that they use those large doses of Cytotec to 'help' them out of a situation and then send them on their merry way with no responsibility being taken for the possible sequences of events. As health providers we need to take care that our actions are helping and not hindering life preservation. Please be guided accordingly."

Despite the language of contemporary abortion debates, the term “life preservation” obviously refers here to preservation of the woman’s life. As for Cytotec, the statement is careful to denounce specifically “*indiscriminate use*”, “*wanton use*”, “*large doses*”, “*late use*” (implied by reference to a “*live fetus*”), and “*no responsibility*”. It is unclear whether discriminate use, careful use, small appropriate doses, limitation to early pregnancies, and professionally responsible use would make the practice acceptable. In fact, on a subsequent visit to the island we asked one of the signature gynecologists that very question, and he confirmed that the problem was not Cytotec abortions per se, but lack of supervision. A family doctor who routinely prescribes the drug for pregnancy terminations explained his decision to take responsibility:

“My first two years of practice, I refused to do it, and then they used to go right and left and come in with complications, and I said, Let me help them under my supervision...I had done research on Cytotec...so I had all the information...I have a small suction machine for the 20 to 30 percent <who don’t get a complete expulsion>, I don’t want them to bleed bleed bleed, I use either manual or electric for small suction just to finish.”

Unlike the French physician who practices pharmacological but not surgical abortion, this physician provided the surgical back-up himself. We asked whether he would do a suction curettage for a woman who preferred having a direct aspiration rather than waiting out a chemically-induced expulsion:

“I don’t do it. They want it, but I say you have to go to the gynecologist....oh, sometimes they insist so much, I do it, usually I just do suction to finish, you realize that after 3 or 4 days of taking Cytotec, you take the suction and push it like this, easy, but if you do it right away, painful...I don’t want to do much surgery anyway, this is just one aspect of my practice...I am a family practitioner...”

When questioned about whether the criminal prohibition concerned him, he responded with the force of professional and scientific authority:

“We are medical professionals. We have the French Canadian Medical Association...it’s a medical thing....(opens his top drawer and pulls out a scientific article with the misoprostol protocol he follows published in a journal of the University of Montreal).³⁶ You see, the medical profession respects us. It is not something done in the jungle.”

³⁶ *Le Cahiers de Formation Médical Continu. Obstétrique-Gynécologie.* Université de Montréal. 16 mai 2001. The protocol was based on a series of studies of Bulgahol, A., Carbonell, L. *et. al.*

Circumventing the Law in Criminalized Contexts

All of the above speakers expressed professional pride in their medical ethic and standard of care. Thirteen of the sixteen abortion practitioners we interviewed in the five countries work within highly restrictive legal contexts. When asked how they deal with criminal laws, practitioners invoked various support systems: For some it was the precedent of European law; for others the unofficial toleration of the State, the Church or the Health Department; for others confidence in their clinical protocol, dedication to reducing health risks, or trust in scientific methods:

“You have the right to refer to British law.”

“The government turns a blind eye.”

“We have a verbal agreement with the Health Department”.

“The Church knows about this.”

“The medical profession respects us...We have the French Canadian Medical Association...”

“I read an article in the Journal of Ob-Gyn...”

“<Women> used to <get> complications...I said: ‘Let me help them under my supervision’.”

“It was inhumane to let people suffer.”

Such responses reflect these doctors’ sensitivity to women’s needs as well as their link to international networks of scholars and service providers. Their practice is, nonetheless, influenced by criminal prohibitions of abortion. Despite the medical and moral legitimacy of their work, they are transgressing or skirting the letter of the law. Many feel obliged to take clinical and/or administrative precautions against exposure and some express dismay at the technical compromises imposed upon them by restrictive policies. Some take precautions not as much to protect themselves as to protect the privacy of their patients. We turn now to a brief look at some of those compromises and precautions.

Over-Treatment and Under-Treatment to Accommodate the Law

Especially the physicians who work in government hospitals bemoan the systematic performance of unnecessary D&Cs for early abortions and abortion aftercare. One gynecologist explained how he performs aspirations at the private hospital, where he has a certain degree of freedom, but is obliged to do D&Cs for the same indications at the government hospital because simpler procedures are associated with illegal pregnancy termination:

“At the government hospital we do a D&C because we don’t have the instruments to do aspirations so basically we have to give them general anesthesia and use a curettage to curette the uterus...Since it’s a government hospital and terminations should not be done, they wouldn’t order the instruments... for electric or manual aspirations...Most patients go

to the government hospital because the doctor's fee, the anesthesiologist's fee, all of those the patient doesn't have to pay at the government hospital."

On another island functioning under the same laws, a gynecologist was able to supply the hospital with Manual Vacuum Aspiration (MVA) instruments since he was aware of indications other than elective abortion, such as endometrial biopsies and legal treatment of incomplete abortions or miscarriages. However, the first time he proceeded to use the MVA in the Emergency Room, he was stopped by vigilant nurses:

"I took out the instruments and started to prepare, but the nurses got agitated and called the hospital administrator who immediately ordered me to admit the woman to the Operating Theater for a D&C...All hospital pregnancy terminations in the hospital are done by D&C...they are not considered abortions but the MVA was considered an abortion."

If certain doctors are obliged to over-treat women with D&Cs when a simpler, safer and less expensive (if less profitable) alternative is available, others may feel obliged to under-treat women. Once again, a different language implies both a different concept and a different procedure.

For early pregnancy terminations, physicians sometime avoid the prohibitory word "abortion" by calling their intervention – be it pharmacological or surgical – "menstrual regulation". Better known in other parts of the world³⁷, the procedure is used by at least one general practitioner in Sint Maarten:

"If you don't do a pregnancy test and you do a suction, it's not a suction for abortion, it's menstrual regulation. Same thing with Cytotec, it's not an abortion, it's menstrual regulation...The doctor gives women the drug to take home and tells them: 'See how it goes, come back in a week.' If it doesn't work and the woman does not get her period, then she is referred to the gynecologist with a note saying: 'We gave Cytotec and it didn't work, can you help?' ...But usually it works, and maybe it was really not an abortion at all, just a <regulation of> hormonal imbalance."

And if it was just a hormonal imbalance, then the procedure was probably unnecessary. Or, if there was an ectopic pregnancy or more advanced pregnancy than anticipated, then the procedure could carry unnecessary risks. Those are the risks of a prohibitory system that forces doctors to circumvent the law. Sometimes such procedural and linguistic circumventions foster a certain complicity between women and their doctors, and sometimes they entail euphemistic reporting of diagnoses and treatments on official documents.

³⁷ Bangladesh, where abortion is strongly restricted by prohibitory law, is perhaps the best documented example of legal systematic "menstrual regulation" to "establish non-pregnancy for women at risk of being pregnant." (See Begum, *op.cit.*).

Euphemistic Terms and Diagnoses: “Late periods”, “miscarriages”, “stomach aches”...

Referring to abortion as the bringing on of menstruation rather than the termination of pregnancy, a gynecologist in private practice shares knowingly the neutral language of his patients:

“Women ask for something to bring on their period. I have drugs <tamoxifen and misoprostol> to ‘bring on their period’, and don’t even mention abortion or pregnancy termination.”

Once again, we see a physician’s relative ease with a drug protocol. This particular protocol of tamoxifen followed four days later by Cytotec was suggested to the above specialist by a family doctor who read about it in the *New England Journal of Medicine*.³⁸ In an interview with the family doctor, we learned that for him supervising drug-induced pregnancy terminations was not actually “doing abortions”:

“I don’t do abortions...only medication.”

Next to such colloquial language, doctors consider carefully what to record on official medical charts. One specialist always notes the absence of fetal heartbeat as a legal precaution:

“The law is the Offences Against the Person Act. If there is no heartbeat, there is no person. ...I’m not worried about the law. Nobody can tell the fetus was alive. I always record that there was no fetal heartbeat, nurses can’t know if there was...On the operating list I write RPC – removal of Retained Products of Conception – so it looks like a miscarriage.”

In fact, the Offences Against the Person Act (see Laws) does not refer to “persons” or “heartbeats”, but precisely to “miscarriages”. Nonetheless, miscarriage is commonly given as a diagnosis since it technically refers to a spontaneous rather than an induced abortion in contemporary language. Sometimes doctors adjust their language to facilitate reimbursement of costs for women. A doctor explained:

“Insurance companies cover “miscarriage” but not “incomplete abortion”. The company will call the doctor to go over the form - and they refuse coverage if the woman can’t show she was being followed by a physician for a pregnancy prior to the miscarriage.”

And sometimes doctors are pressured to camouflage abortions by women who fear Church sanctions:

³⁸ Currently researchers do not recommend using tamoxifen before administration of misoprostol.

“Patients beg us not to write the truth on medical charts. If their church finds out they had an abortion, they’ll be expelled from the church. There is no privacy in the hospital, there is no privacy anywhere on the island, not even at the bank... So once I tell a woman she’s pregnant, I don’t see her again, she will go to St. Martin...French or Dutch side.”

Indeed, cautious language is not always effective. Often the euphemism is a public secret.

One hospital physician gave an example:

“When you say ‘abdominal pain’ in the Emergency Room, everyone knows what it is...and many people have a relative or sister of a friend who works at the hospital...”

A family doctor who recently arrived on one of the islands told how he was referring to the gynecologist for “*pregnancy termination*” until a colleague told him to “*Just write down stomach pain.*”

Such linguistic circumvention of legal as well as social condemnation makes it difficult to come by reliable statistics on abortion in Caribbean criminalized contexts. The regional director of a Caribbean Association of Health Professionals admitted that the lack of data made it difficult to give visibility to safe practices:

“No, we don’t have data on the Caribbean, it is difficult to get data in countries where abortion is illegal. Right? But we have strong reason to believe that abortions are extensive in...and we have huge reason to believe that the huge majority are done in doctor’s offices according to WHO standards. So, although abortion is illegal, it’s happening all the time, it’s safeWe don’t raise the question <about abortion practice> at a national level because we have not had a case in years that was botched because it was done unsafely by a non-medical non-professional with unsanitary instruments...”

According to this regional director, the conviction that most abortions are done safely within established standards erases the abortion issue from the national agenda.

Research Conclusions

We have come full circle. For the World Health Organization, the fact that abortion is criminal implies that it is unsafe, and for the state with criminal laws, the fact that abortion is safe means that it can just as well remain criminal. We heard more than once from abortion providers in the five countries studied that “*the law is not a problem*” because abortion is “*done under medical supervision*” and “*it is at least relatively safe*” or “*quite safe*”, even “*safer than walking across the street*”. Although some health professionals were outspoken in advocating liberalization of abortion laws, most accepted the current situation as medically satisfactory: “*Down the line, legal. Right now, safe.*” Those practicing in French Saint Martin, likewise, accepted the limits of legal services, despite evidence of criminal practices outside the hospital and reliance upon illegal 2nd trimester abortion services off-island.

The objective of this study has been to document abortion law, policy and practice on one set of Caribbean islands. We began with four main hypotheses designed to illuminate the influence of past colonial relations with Europe, current problems related to criminal laws, interactions between islands and inadequacies in knowledge about abortion in the region. An initial exploration of international health documents, legal instruments and a model study of abortion in Puerto Rico helped set the stage for a grass roots methodology of data collection. Interviews predominantly with health professionals were conducted within a framework of unconventional assumptions and non-assumptions: We assumed that politically diverse islands in geographic proximity could be studied as one cross-border health care system. We did not assume that laws would match practices.

Using our initial hypotheses as a guide, the findings can be summarized as follows: Firstly, we can indeed conclude for our research sites that the liberalization of abortion laws in France, Great Britain, the Netherlands, and the United States has favored safe abortion practices in (former) colonies of the Caribbean in that licensed health professionals are providing services in those countries irrespective of the law. This process has occurred through a combination of legal, educational and professional influences. On a legal level, abortion is authorized in some countries by direct extension of Metropolitan laws, as with Puerto Rico and Saint Martin; for others, European law can be officially invoked to supersede Caribbean law, as with Commonwealth countries, or unofficially invoked as a source of medical legitimacy, as with the Netherlands Antilles. The one country in our research that actually liberalized its own legislation, Anguilla, has yet to implement the reform. On an educational level, exposure to European or North American medical practice has been decisive for physicians who have had basic and/or advanced medical training in Metropolitan centers where elective abortion is legal. Also some of those trained at the University of West Indies studied in Barbados within a legal abortion framework. Beyond their education, many doctors belong to Northern professional associations and subscribe to scientific journals published in countries with legal abortion. All of the above influences give Caribbean abortion practitioners, also in criminalized contexts, a certain professional as well as ethical credibility.

According to our definition of safe abortion, a reformulation of WHO guidelines, most pregnancy terminations in the five country research sites are safe in that they are performed, supervised and/or followed-up in “approved facilities” by “approved persons”. We can attribute that fact predominantly to the ongoing (colonial) relations between the region and Northern countries with legalized abortion, something that distinguishes the Caribbean from

South and Central America. However, our research also demonstrates that criminal laws hinder access to services and quality care, a verification of the second hypothesis. The most striking illustration of this finding is the wide and apparently growing use of Cytotec, both independently by women who self-induce abortion and under medical supervision by office practitioners who help women abort outside the hospitals. Whereas Cytotec does not kill³⁹, it is not the most effective method for terminating pregnancies. When taken according to recommended protocols, it does offer many women a safe way to avoid the costs and penalties of illegal services. Nonetheless, even if successful for the “huge majority”, a minority of women who rely upon the drug routinely end up in hospital Emergency Rooms with incomplete abortions and they are regularly over-treated with D&Cs. Such a routine system of emergency care, often involving major discomfort and risk for women, is a sign of the dysfunction of the criminal system. Another sign is the routine misrepresentation of abortion-related interventions on medical charts, an impediment to reliable documentation, physician accountability and clinical research.

On a social level, the stigma glued to criminal activity reinforces the isolation of practitioners and the isolation of women seeking abortion services. Most of the providers we interviewed are well-trained, but they are eager for further exchange, ongoing training and new strategies for improving abortion practices in their country. Local anesthesia regimens, manual vacuum aspiration, alternative pharmacological regimens, and reliable protocols for abortion aftercare were topics of particular pertinence.⁴⁰ Significantly, although primary care abortion practitioners are well-qualified, the same is not necessarily true for emergency room attendants and hospital nurses who are often rewarded for blocking, rather than facilitating, quality treatment.

Women’s isolation brings us to our third hypothesis about migration and abortion. Whereas the migration of doctors for education and professional association gives them greater legitimacy should they decide to practice abortion illegally, the migration of women for employment or health services leaves them fearful to “show their face” when talking about abortion because it – and they – are illegal. So women have organized their own

³⁹ This formulation is borrowed from: Arilha, M. & Barbosa, R. M., “Cytotec in Brazil: “At least it doesn’t kill””, cf. *supra*, note 30.

⁴⁰ For a brief description of some of educational and training activities organized by the *Caribbean Initiative* after completion of this investigation, see <www.saludpromujer.org> and the postscript of Pheterson, G. and Azize, Y. “Abortion practice in the Northeast Caribbean: “Just put down stomach pain”. *Reproductive Health Matters*. November, 2005.

underground health care system by passing on information to one another about services within feasible geographic reach. This network serves not only migrants, but also resident women in search of available, payable, anonymous, safe services. Women from Sint Maarten sometimes go to Saint Martin for abortions due to French universal medical insurance. Women from Saint Martin go to Sint Maarten if they prefer an office aspiration or if their employment health insurance covers them “over there”. Women from Anguilla travel by boat for 20 minutes to Saint Martin or Sint Maarten for an afternoon anonymous service. Women from Antigua might go to the nearby island country with a provider of 2nd trimester abortions since it is closer, thus less expensive and less time-consuming, than traveling for a legal 2nd trimester procedure in Barbados or Puerto Rico. And migrant women might simply await a suitcase trader for a supply of Cytotec, an alternative they have now shared with resident women. The lines are open, but clandestine. There are no counselors or established referral services or institutional support if something goes wrong.

Within the small island region of our study, women know health professionals across state lines but the professionals themselves rarely know their foreign colleagues. The professionals are networked within political borders, namely within the orbit of British, Dutch or French (former) colonial rule or across the ocean to the “Mother Country”. Those historical affiliations offer fewer advantages to the general population than to doctors, especially to segments of the population without the resources for long-distance travel or advanced education abroad. But it is exactly the health care strategies of those populations that was the indirect focus of this investigation by way of their doctors. We have seen that doctors get training, legitimacy and legal back-up from European and US hegemony, all of which women use without themselves gaining institutional access to information, legitimacy or legal practice. Of course, abortion is not a daily activity for women as it is for their physicians. The two positions are asymmetric, but both are uneasy. There is need for information about the impact of restrictive policies on both abortion seekers and abortion providers. At present, such information is lacking for the Caribbean region, a finding in line with our last hypothesis. Without reliable information, there is little chance of mobilizing resources to nurture the quality and dignity of service.

Surely this one investigation has not sufficed to deconstruct and reconstruct a data base and sociological interpretation of abortion in the entire Caribbean region. We have, however, demonstrated the existence of safe abortion in criminalized contexts. Of course, basic health care should be legal, and abortion services are basic to women. This study has shown that those services can be found, provided and networked even before laws change.

Such conscientious transgression of official prohibitions is testimony to the alliance between women and health professionals against legalized injustice.

