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Abstract
In lieu of an abstract, below is the first paragraph of the paper.

Every hour, approximately eight women around the world die as a result of complications from unsafe induced abortions. Almost half of those who survive are hospitalized due to complications including hemorrhage and sepsis. Roe v. Wade is becoming a faded memory from the past as U.S. states place further restrictions. Abortion is a worldwide issue that needs to be addressed now. Too many women are putting themselves at risk to obtain one of modern medicine's safest procedures. Not only should abortion be legalized on a global-level, but work should also be done to prevent the need of the procedure by increasing awareness and creating more sexual education programs.
Who Owns a Woman’s Body?
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Every hour, approximately eight women around the world die as a result of complications from unsafe induced abortions. Almost half of those who survive are hospitalized due to complications including hemorrhage and sepsis. Roe v. Wade is becoming a faded memory from the past as U.S. states place further restrictions. Abortion is a worldwide issue that needs to be addressed now. Too many women are putting themselves at risk to obtain one of modern medicine’s safest procedures. Not only should abortion be legalized on a global-level, but work should also be done to prevent the need of the procedure by increasing awareness and creating more sexual education programs.

Abortion terminates a pregnancy by removing the embryo or fetus from the uterus before twenty weeks gestation, the time during which the fetus grows (Grimes and Creinin 620). The time of pregnancy is measured from the first day of the last menstrual period, not the day of fertilization (“Our Bodies, Ourselves” 394). In the United States, about 85-90% of abortions take place in the first trimester (Houppert). While there are a variety of options, the two preferred ways are by medication or vacuum aspiration. Within the first nine weeks, the option of medical abortion is available. This consists of a combination of two drugs; mifepristone, commonly known as RU-486 which is taken orally, followed by misoprostol which can either be swallowed or inserted into the vaginal canal. Progesterone is a hormone that the fetus requires in order for a pregnancy to be maintained. Mifepristone blocks it, causing the embryo to detach from the lining of the uterus. The drug methotrexate, which halts the process of implantation, can be used as well. The second half of the treatment, misoprostol, is taken within two days after mifepristone. It causes the cervix to become soft and the uterus to cramp up, expelling the embryo in a process similar to that of a heavy period or miscarriage. This method is not only safe, but it is also 95-98% effective (“Our Bodies, Ourselves” 394-95).

Another option in first-trimester is vacuum aspiration, also called suction curettage. This involves the suctioning of uterine contents to remove them. A cannula, or thin tube, is connected to a source of suction, whether it be a handheld syringe or electric pump, and is inserted into the uterus. The size of the cannula depends on how pregnant the woman is, and the size ranges from the size of a small drinking straw to half an inch wide. The method carries a lower risk of injury and infection, with the risk of dying about 1 in 340,000, a chance that is lower than that of dying from an injection of penicillin (“Our Bodies, Ourselves” 398).

Abortions can take place in the second-trimester. Some methods can induce labor via drugs, known as induction abortion. There are more risks to abortions in the second-trimester, however they still carry very low complication rates (“Our Bodies, Ourselves” 401).

There are many costs associated with abortion. The fee varies depending on the provider and type of abortion. Cost is also affected by the length of pregnancy, since the price may rise each week after the first trimester. Anesthesia used in the procedure must be paid for as well. Women who are Rh negative require an injection of immune globulin to stay healthy (“I Want an Abortion”). Medications, blood, health personnel, supplies, equipment, and overnight stays are paid for by the patient. Indirect costs in unsafe abortion include:

the loss of productivity from abortion-related morbidity and mortality on women and household members; the effect on children’s health and education if their mother dies; the diversion of scarce medical resources for treatment of abortion complications; and secondary infertility, stigma, and other sociopsychological consequences (Grimes et al. 1914).

While only cash payment is available at certain clinics, other providers may offer more options. Some insurance companies will cover the
abortion to a certain extent. In every state, Medicaid covers the cost of abortion due to situations including incest, rape, or if the woman’s health is in peril, but only a select few states accept it in other predicaments (“I Want an Abortion”).

Abortions have been performed for thousands of years. Even as the Constitution was being signed, abortions were not only common, they were advertised. During the end of the 19th century, laws were passed by states outlawing this procedure (“History of Abortion”). The government feared that immigrant children would soon outnumber the number of children produced by natural born citizens, so it wanted white U.S.-born women to reproduce, to keep foreign populations low (“Our Bodies, Ourselves” 407). In the 1800s, pregnancy and labor were risky and infant mortality rates were high. Due to a minimal number of hospitals, and unsanitary methods, all surgical procedures carried a large amount of risk. Women who sought out abortions often had to turn to illegal practitioners for help, which further increased the danger of the surgery. The American Medical Association was formed because doctors wanted the exclusive rights to practice medicine. This would prevent other practitioners such as apothecaries, homeopaths, and midwives who were not certified from “stealing” patients and taking their money. The AMA stated that not only was abortion unsafe, but that it was immoral as well.

Although many women were considered criminals and were injured in the process, the rate of abortion did not decline, with about 1.2 million performed each year. In 1973, the case of Roe v. Wade was brought to the Supreme Court. The case ended with the Court’s ruling that Americans have the right to privacy. This included that women have the right to decide whether or not to have children and to allow a woman and her doctor to make reproductive decisions without state interference. Upon hearing this, many who opposed abortion were outraged. They demonstrated in front of clinics that offered abortion and gave those trying to enter a hard time by blocking the entrance or by harassment. Protesters turned to violence as time went on, and some clinics were bombed. Women and abortion providers were attacked and murdered (“History of Abortion”). Efforts to overturn the decision of the Supreme Court failed wretchedly (Kissling and Michelman). Later in 1992, the Supreme Court ruled in Planned Parenthood v. Casey that the states could restrict the availability of abortions such as how first trimester abortions were performed (“History of Abortion”). This conclusion gave more power to states, and as laws tightened, abortion rates decreased (see fig. 1). Abortions also fell due to the invention of the morning-after pill (Houppert).

![Abortion Rates Graph](https://fisherpub.sjfc.edu/ur/vol10/iss1/7)
In April of 2007, the Supreme Court ruled in a 5-to-4 decision declaring that “partial birth” abortions are illegal. Physicians are no longer able to practice the procedure of “dilation and extraction” (Houppert). This method, also referred to as D&E, removes the placental and fetal tissue from the uterus by a combination of instruments and suction. It is similar to that of a vacuum aspiration. D&E was the most common method of second-trimester abortion (“Our Bodies, Ourselves” 401). The Court now makes exceptions for the life, rather than the health, of the mother. The National Abortion Federation president and CEO, Vicky Saporta, said, “This is an invitation for states to pass further restrictions on abortion. Most troubling, it undermines the core principles of Roe v. Wade by not putting women’s health first.” The ban impacts teenagers and older women the most (Houppert). The rate of abortion is continuing to fall; there have been 25% fewer abortions than there were in 1990. However, no one can prove the cause of this decline. This is good news, no matter how one views abortion (Gibbs).

The decline in abortion can also be accredited to a newly developed drug known as the morning-after pill, more commonly referred to as Plan B. The pill contains a high dose of a hormone called progestin or uses a combination of estrogen and progestin, both of which are commonly found in birth control pills. If taken within seventy-two hours after unprotected sex or contraceptive failure, it can prevent pregnancy safely by stopping ovulation or preventing fertilization. The FDA credits the morning after pill as being 80% effective. Plan B is not an abortion pill, rather it is a drug designed to prevent pregnancy (“Morning-After Pill”).

In August of 2006, Plan B was approved by the Food and Drug Administration for over-the-counter sale to women who are age eighteen and older upon proof of age. While this is good news for many, this law does not cover adolescents, the age group that would benefit the most from its access. Some argue that allowing teenagers over-the-counter access could result in a more rapid spread of sexually transmitted diseases. Young people in particular may not comprehend the serious consequences of unsafe sex and may fail to plan ahead. The availability of Plan B may aid young adults by sparing them the high costs of carrying a pregnancy to term and preventing them from dropping out of school to live a life in poverty.

The “proper use” of the morning-after pill has been debated. However, little evidence exists that suggests that an easier access to Plan B increases precarious sexual behavior. In fact, a study published in Journal of Adolescent Health stated that condom use does not decrease with increased availability of emergency contraception. While Plan B is available to teenagers with a prescription, the law restriction should be revised to allow them equal opportunity to acquire the medication without a note from their pediatrician. Teenagers may not have a “Plan B” when making decisions about sexual activity, so it is not just the availability of the morning-after pill that is important; rather, a comprehensive sex education program should be a primary focus (Frantz 4-5).

Abortions are among the safest procedures in modern medicine. The fatality rate today is less than one death per 100,000 abortions, however the earlier the abortion, the safer it usually is (Grimes and Creinin 623). Complications are rare, but still occur. Some symptoms include heavy bleeding, pain, fever, and signs of continuing pregnancy such as bloating, breast tenderness, or nausea (“Our Bodies, Ourselves” 405). Other complications include acute hematometra (the uterine cavity fills with blood and clots), hemorrhage, and infection. Antibiotics, such as doxycycline, can help prevent the risk of infection. A woman’s
reproductive cavity is not harmed via induced abortion. Abortion does not increase the frequencies of infertility, premature birth, ectopic abortion, spontaneous abortion, or other adverse pregnancy outcomes. A woman’s emotional health is not harmed as well, and “postabortion trauma syndrome” does not exist. In fact, the most common reaction after an abortion is relief. Abortion does not raise a woman’s risk for cancer, either. Both the World Health Organization (WHO) and the National Cancer Institute agree that there is no reliable evidence that proves a link between abortion and breast cancer (Grimes and Creinin 624).

There are three main perspectives on this topic: those who oppose it, others who support abortion rights, and finally people who respect differences between the two groups. Pro-lifers believe that human life starts at the moment of conception. They insist that caring societies expand their unborn fetuses into the “human community” (Kissling and Michelman). Those in opposition do not want abortion to be legalized at all and believe that by eliminating the legal availability, abortion will no longer exist (Arons and Saperstein). They believe that human life starts at the moment of conception, therefore making aborting pregnancies murder. Limitations could require women who are pregnant to have parental consent or consent of her husband before having an abortion, ban on partial-birth abortion, outlaw public facilities or public funds from performing abortions, and prevent the sale of drugs that would offer a non-surgical approach to abortion (“Abortion: Discussion Guides”).

Some are adamant on increasing the cost of the procedure with unnecessary clinic regulations. They impose waiting periods so that it is more difficult to obtain an abortion, especially since the only window of access takes place now during the first trimester. Due to pro-choice supporters, public funding is banned and biased counseling is provided. Another goal is to decrease the number of available clinics and doctors. These limitations put access of safe abortion beyond the reach of a large part of the population, particularly the rural, the young, and the poor (Arons and Saperstein). As Dr. Gomperts stated, “Even if you are against abortion you might face a moment where your situation is ‘different.’ My work is about ensuring there is a fundamental respect that a woman can make that decision for herself at that point in her life” (Ferry).

On the flip side, there are many people who support abortion rights. They feel a woman has a right to choose, whatever the circumstance, and that access to safe abortion services should be provided as an equal opportunity for all women. This would mean insurance companies including abortion in the services offered and motivating pharmacies to distribute drugs that terminate pregnancy. They are not encouraging women in hopes that the rate of abortion increases. Rather, they would like to see more sex education and easier access to affordable birth control so that abortions can be avoided all together (“Abortion: Discussion Guides”).

The third view compromises between the two groups, such as passing laws that would only make abortion legal in the first trimester and informing women of the alternatives such as adoption (“Abortion: Discussion Guides”).

Unfortunately, there is a pandemic of unsafe abortions in the world, making it one of the most ignored sexual and reproductive health problems worldwide today. In 1995, it was estimated that about 26 million legal and 20 million illegal abortions took place each year throughout the world. The United States has one of the highest international abortion rates (see fig. 2). The country with the most legal abortions is Vietnam, while the least are in India and South Africa. Both of these nations have some of the strictest abortion laws in the world.

Ninety-seven percent of unsafe abortions take place in developing nations, usually among women who are ages 20-29 years old. WHO estimates that if this trend continues, women in developing countries will each have an average of one unsafe abortion before they reach age 45. Women around the world seek abortions for various reasons, such as a lack of education, poverty, a need to postpone childbearing, rape, incest, risks to health, and a poor relationship with the husband or partner. More often, poor access to contraceptives or contraceptive failure is the cause. Unsafe induced abortion puts women at a much greater
risk. Those who survive often experience other complications such as sepsis, peritonitis, hemorrhage, and injury to the vagina, cervix, and abdominal organs (Grimes et al. 1910).

Legal abortions per 1,000 women aged 15-44, by country, 1995 and 1996

Vietnam* - 478
Romania* - 177
Cuba - 168.4
Russia* - 78
Kazakhstan - 77.2
China* - 43.9
United States - 22.9
Australia - 22.2
England and Wales - 15.6
Canada - 15.5
Italy* - 11.4
Germany - 7.6
India* - 2.7
South Africa* - 2.7


Fig. 2. International abortion rates.

There are some very damaging methods that have been used by women in attempt of abortion both in the United States and worldwide. Some oral treatments include: turpentine, laundry bleach, acid, tea made of livestock manure, toxic solutions, and detergent solutions. In an attempt to remove the embryo or fetus from the uterus, a variety of foreign objects including wires, knitting needles, coat hangers, ballpoint pens, bicycle spokes, chicken bones, or sharp curettes have been placed through the cervix into the uterine cavity. Women have also tried to lift heavy weights or have jumped from the tops of roofs and stairs to create trauma to abort the fetus. Women think that vigorous punching of the lower abdomen will end the pregnancy, but often the uterus bursts, and it’s the woman’s life that is ended instead. Each year, about 220,000 children around the world will lose their mother in an abortion-related death (Grimes et al. 1911).

A global study conducted by a collaboration of scientists from the World Health Organization in Geneva and the Guttmacher Institute in New York, a group that actively supports reproductive rights, concluded that abortion rates are comparable in nations where abortion is both legal or illegal (Rosenthal). Presently, abortion is prohibited in seventy-two nations. In some countries, women who have an illegal abortion are prosecuted and jailed (Grimes et al. 1912). In Nicaragua, abortion is a crime thatpunishes both the woman and her doctor, even in cases of incest or rape. Pregnant women who suffer from maladies such as kidney failure have perished because their conditions were not treated in order not to interrupt the pregnancy. Freedom of religion is a basic right, however the government should not let the church interfere with the state and violate women’s rights to health and life (Lattig and Heimburger). Those who have a miscarriage or stillbirth are accused of infanticide and are put in prison as well (Grimes et al. 1913).

Legal access to abortion has caused an improvement in reproductive and sexual health, but it has not necessarily increased demand so governments do not need to worry that the health-care institutions will be burdened with additional costs. Legalizing abortion does not automatically mean that women will have access to safe services; governments need to be more specific with their laws. Women often have poor knowledge of their legal rights, so they are more susceptible to poor care and financial exploitation. Minors may not seek care because there are laws about sexual intercourse before legal age. Many barriers stand in the way of a safe abortion besides the law (Grimes et al. 1913). The Bush administration’s multi-billion dollar campaign against HIV/AIDS prohibited the use of American money to promote or provide abortion as a method of family planning in Africa. Women who reside in nations where abortion is illegal are subjected to hardships and cruelty that violate their basic human rights (Rosenthal).
Rebecca Gomperts, an abortion doctor and activist became inspired after meeting a teenage girl in South America. The girl was eighteen years old and had responsibility of her three younger brothers and sisters. Her mother had passed away due to complications of an illegal abortion of a fifth child she simply could not support. Gomperts devised a plan, and founded Women on Waves (Wow), a Dutch organization that sails on an “abortion ship” to nations where abortion is still illegal. Women are taken to international waters where an abortion can be provided safely. Her ship’s cargo contains IUDs, the morning-after pill, RU-486, and condoms, with a total crew of six women and two men. So far she has sailed to Ireland, Portugal, and Poland, with plans to travel to South America or Africa in the future.

“It’s such a waste of life,” Gomperts states. “As a doctor, I look at the abortion issue from a health perspective and the fact is that an early abortion is safer than giving birth. That is not meant to promote abortion because if women want to have children it is a risk they are naturally willing to take. However, if they don’t want them they should not be forced to take that risk” (Ferry).

The United States has the highest teen-pregnancy rate in the world: nearly double that of England and Canada and eight times as high as Japan and the Netherlands (Gibbs). Today, unclear restrictions including the involvement of parents, waiting periods, and biased counseling are in place by different states. Women are not required to involve their spouses in the process, however. The first Hyde Amendment was adopted by Congress in 1976 which prohibited federal Medicaid funds from going towards abortions for women who received low income. This amendment was revised the following year (“History of Abortion”). A legal and safe abortion may be obtained if the fetus is terminally deformed as well (Gibbs). In 1994, the FACE Act (Freedom of Access to Clinic Entrances) was passed after Dr. David Gunn was murdered. The use of threats, force, or obstructions towards those receiving or giving help involving a woman’s reproductive health was prohibited. President Bush placed a federal ban on abortion procedures, regarding partial birth abortion, in 2003, but it was blocked immediately by the National Abortion Federation, and did not go into law (“History of Abortion”). Abortion is not only a medical procedure; it is strongly linked to women’s status and political power, along with the population objectives of society (“Our Bodies, Ourselves” 411).

Abortion can and should be prevented. Each year, 80 million women become pregnant unintentionally; 60% of these pregnancies are aborted. Most women seeking an abortion did not use any form of contraceptive, and those who did, sought abortion less frequently (see fig. 3). While no contraception method except for abstinence is 100% safe, increased availability can reduce the need for an abortion (Grimes et al. 1908-15). It was found by a Guttmacher study in 2006 that in the United States about 14% of the decline in pregnancy between 1995 and 2002 was due to teenagers practicing abstinence or having sex less often. However, 86% was credited to an increase in contraceptive use by sexual active teens. The abortion rate among teenagers has, in fact, decreased the most compared to other age groups (Gibbs). In Eastern Europe, when contraceptive availability increased following the fall of Communism, abortion rates fell by 50% (Rosenthal).
Fig. 3. Contraceptive use of abortion patients

According to a study supported by the Danish National Board of Health, results concluded that the lack of knowledge of contraceptives by women is indeed linked to the choice of abortion. This was seen more frequently among immigrant women whose familiarity with methods to prevent pregnancy was poorer than others in the study. It was also shown that the woman’s partner influenced her decision by having a negative attitude towards contraception, therefore none was used, which led to the choice of abortion. Problems with contraceptive methods contributed to the women’s choice of abortion as well (Rasch et al. 5).

Contraceptive ability is just one step towards eliminating the need for abortion. More accessible sex education, including pamphlets, websites, videos, and classes can prevent unwanted pregnancies and help to eliminate the demand to terminate them. Information should also include medically accurate information about contraception and abstinence (Arons and Saperstein). Insurance coverage on a wider range of family planning, along with more public funding, and better access to the morning-after pill could also lead to a decline. Another method should be to promote programs that work to prevent sexual abuse and domestic violence (Arons and Saperstein). Programs could be developed to ensure pregnant women that they have the means to raise a child in a healthy and safe environment should she choose to do so. Women who are of low-socioeconomic status, young, and/or illiterate would benefit with opportunities to complete education and develop career skills, access to health care, housing, services for disabled children, childcare, and other critical supports. There should be a fight to end the reasons for abortion, not against the women themselves.

Women are entitled to make their own decisions regarding when and if they should have children. Taking the right of abortion away also makes sexual freedom impossible and prevents women from participating fully in society. Women should not be forced to stay pregnant against their will (“Our Bodies, Ourselves” 389). Whatever the reason, women will always seek abortion, and legally, they should be allowed to. While life may begin at conception, at the same time, life may be endangered or coming to a halt for the mother once she finds out she is pregnant. Some girls become pregnant at an early age, and having the baby could not only put them in serious physical danger, but it could also put them at risk of being shunned in society. The pregnancy may be a result of an abusive relationship or a rape, and a woman should not be forced to remain pregnant and be burdened with traumatizing memories. A mother may not be able to provide for her baby financially or emotionally, and adoption may not be an option considered. According to Frances Kissling and Kate Michelman, “Our vigorous defense of the right to choose needs to be accompanied by greater openness regarding the real conflict between life and choice, between rights and responsibility.” No one’s circumstances are the same, and people must choose the most responsible option given a situation. The government of any country should not have any right to outlaw a procedure that can save a woman’s life or make her a healthier person. Women own their bodies; the law does not.

Works Cited


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