Criminalization of Women Accessing Abortion and Enforced Mobility within the European Union and the United Kingdom

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ABSTRACT

The article explores the impact of criminalization and restricted abortion access in Poland, Italy, and parts of the United Kingdom. We look at the ways in which the partial and extensive criminalization of abortion in the European Union and in the United Kingdom forces women to travel to access abortion care. At the core of our considerations is the interconnection of issues pertaining to criminalization and movement with citizenship, bodily integrity and autonomy, and the nation-state. By tracing these connections through an analysis of existing laws and scholarship, our concern here is to ask what discursive, narrative and theoretical resources feminist scholars might draw on and help co-produce in framing the interstices of criminalization of abortion and enforced mobility.

KEYWORDS: Abortion; enforced mobility; EU; nation-state; reproduction; women

INTRODUCTION

Currently, no country in the EU effectively decriminalizes abortion, with varying degrees of acceptance for legal induced abortion grounds (Antoine, 2019; Berer, 2017; CECHR, 2018; COE, nd; Singh et al., 2018; World Health Organization, 2017). At present Malta is the only European Union state where abortion is fully outlawed with penalties between 18 months and three years of imprisonment (Center for Reproductive Rights, 2017; FRA, 2017; World Health Organization, 2018). Grounds for legal induced abortion remain severely limited in Poland, Cyprus, Finland, and in some countries and territories subject to UK laws (CRR, 2017; World Health Organization, 2018). However, even where restrictions may only be placed on the stage of pregnancy by which abortion is available, the complex legal and socio-political situation often creates a precarious situation for women seeking to access abortion care (Erdman, 2017; Fabbrini, 2011; Guillaume & Rossier, 2018). Indeed, in most countries, some form of penalties attached to abortion exists in the legal framework. Specific laws and their applications within EU member states and within their constituting nations variously produce a "chilling effect" on the possibility of obtaining a legal abortion (ECHR, 2019; Erdman, 2014, 2017). A further confounding element is a possibility, granted by law in 21 countries of the EU, for medical practitioners to invoke "conscientious objection" (CO) to performing an abortion (Heino et al., 2013). The existence of such a clause creates a further disadvantage for women based on their place of residence, socio- economic status, and income (Heino et al., 2013).

Partial and extensive criminalization of abortion in various parts of the EU forces pregnant people to travel to access abortion care to states or constituting nations in which induced

abortion is legal and/or available. Termed variously "medical tourism" (Gilmartin & White, 2011), "abortion tourism" (Bloomer & O'Dowd, 2014; cf. Guillaume & Rossier, 2018) and, perhaps most accurately "reproductive exile" (Kasstan & Crook, 2018), this movement is enforced by the criminal justice systems of member states. Those unable to meet the demands of enforced travel attempt to procure abortions medically by illicitly buying "abortion pills" online (Berer, 2017; Guillaume & Rossier, 2018), often risking lengthy prison sentences. At the same time, the interplay between local and supranational (EU) laws has the potential to create tensions and - serendipitously for those affected - "inconsistencies within the domestic legal systems of those states which restrict abortion rights" (Fabbrini, 2011, p. 2). What we mean here, is how the rights to freedom of movement and freedom of access to services have been invoked and used as "leverage" in arguments against attempts to curtail travel for abortion care (Fabbrini, 2011; Human Rights Committee Secretariat, 2016). This contribution seeks to map out the consequences of partial and extensive criminalization of abortion in selected parts of the European Union and the United Kingdom, formerly an EU country and now in the process of separating itself ("Brexit"). The aim is to instigate a discussion on (un)intended consequences of criminal laws which write themselves on the bodies of women-citizens.[1] We are not looking at one specific group of women or different groups of women - rather, our approach at this stage in our collaborative endeavour is to mark out the territory from an insider/outsider vantage point, within which we suggest a roadmap for future research directions. While the framework proposed provides a glance at the variegated landscapes where female bodies are criminalized, this contribution addresses current legal responses to women's reproductive rights in diverse settings. Putting forward a critical understanding of reproductive rights for women, we glance at the United Kingdom, Poland, and Italy to offer a panoramic view of how current abortion laws criminalize and undermine women's bodily autonomy. The concluding section returns to discourses that lead to abortion being posited as a threat to the life of society and challenges a strand in current theoretical writings on reproduction, which thus far tended to focus more on questions of subjectivity rather than the collective social identity that defines birth, reproductive rights, and citizenship for women.

CRIMINALIZING THE EMBODIED CITIZEN

The *de jure* and *de facto* criminalization of abortion across the EU and in the United Kingdom writes itself into a broader picture of heightened scrutiny, weaponized welfare oversight, and out- right criminalization of women's bodies, and specifically pregnant bodies worldwide (Bloomer et al., 2019; Goodwin, 2017; OHCHR, 2017). While the principle of autonomy remains the basis of most conceptualizations of citizenship and has been deemed crucial for a feminist understanding of citizenship (Lister, 1997a, 1997b), under restrictive legislation on abortion, this autonomy is severely curtailed on the most basic, bodily level. Even though the law provides one of the primary tools for conceptualizing, promoting, and guarding women's autonomy, it also remains the chief arena in which the political tensions between demographic priorities and reproductive choices play out (cf. Freedman & Isaacs, 1993). Under the supranational regime of the European Union, a further tension exists

[1] It is important to note that most laws regarding abortion remain specifically gendered; thus, while pregnancy and with it abortion care are issues of importance to transmasculine citizens, the specificity of the legal framework requires our attention to the category of 'women'

between internationally derived standards and nationally enforced laws, often steeped in customs and religions of individual nation-states (Nowicka, 2011). Women's bodily autonomy and reproductive autonomy remain curtailed and with them, as many activists vocally argue (Antoine, 2019; Penny, 2019), women's full citizenship rights (cf. Horgan & O'Connor, 2014; Lakhani & Horgan, 2015). Furthermore, it is not simply that reproductive autonomy would enable women "to take control over their reproductive lives by entrusting to them both the authority to make decisions about reproduction and the ability to make those decisions based on access to adequate information and suitable services" (Freedman & Isaacs, 1993, p. 19) but rather that "to force women to have children they do not wish to have is a form of violence against women" (Fried, 2016). We argue that the violence, enacted by the states, is also manifest in the expulsion that occurs when women have to travel in order to seek out abortion care, in what constitutes enforced migration. This migration, its criminalizing undercurrent, and the processes that cause it are not adequately captured through existing protocols, which tend to focus on discursively demarcated constructs of "migration" as a specific form of mobility (Gorodzeisky & Leykin, 2020).

OFFENSES AGAINST THE PERSON: THE MULTI-TERRITORIAL RIPPLES OF BRITISH-DERIVED LAWS

The complex picture of nation-state independent law-making on abortion is evident not only across, but often within individual states. Abortion in many of the territories currently dependent, associated with, or subsumed within the United Kingdom of Britain and Northern Ireland, and those formerly colonized by it,[2] has been marked by section 58 and 59 of the Offenses Against the Person Act 1861, which provided penalties for women seeking the termination of a pregnancy and those who would assist them. The adoption of the 1967 Abortion Act in 1968 has made abortion more of an acceptable feature of life in some parts of the United Kingdom (Aiken et al., 2019; Greenwood, 2001). The Act applies to England, Wales, and Scotland and now Northern Ireland. The change of law has affected the Crown Dependencies - Jersey, Guernsey and Isle of Man - in as far as their residents were able to travel to the UK under the Common Travel Area to procure an abortion (Hansard, 1990), until it became lawful locally (1997, 1997, and 2019, respectively). In the British Overseas Territory of Gibraltar, the only such Territory surrounded by EU countries, abortion is regulated by section 11 of the Crime Act and punishable by life imprisonment—a not-too-distant echo of the "penal servitude for life" of section 58. Northern Ireland's situation remains, at the time of writing, unclear and in flux. A cross-party amendment passed in July 2019, compelling the government to decriminalize abortion in Northern Ireland and align the laws with the rest of the UK, became law in October 2019. Resulting provision is expected from April 2020 but is as yet undecided.

Importantly, the Abortion Act 1967 does not provide the right for the woman to end her pregnancy simply because she wants to, but rather gives registered medical practitioners

[2] In the formerly colonised Republic of Ireland, this law was further supplemented by the 8th Amendment of the Constitution of the Republic of Ireland giving equal rights to 'the unborn' as to the pregnant woman, with far-reaching consequences predicated on its legal and medical interpretations. The repeal of 'the 8th' in May 2018 can be seen as both a finishing point and an opening of a new chapter, in ROI's long march to reproductive freedom.

(doctors) authority to decide whether there are medical grounds to support a woman's request for an abortion. section 1 of the Abortion Act made abortion legal when two doctors agreed in "good faith" - that is acting on the evidence presented to them or based on their own medical opinion - that pregnancy is less than twenty-four weeks[3] and evidence exists that the pregnancy would threaten the mother's life, her physical or mental health, or the unborn child would suffer "such physical or mental abnormalities as to be seriously handicapped," or that existing children would suffer harm. Significantly, the Abortion Act 1967 allows doctors to take into account the woman's "actual or reasonably foreseeable environment," that is her socio-economic conditions - a clause, which allows doctors to apply that element of the law with a significant amount of latitude. Arguably, if it had not been interpreted liberally by doctors who overwhelmingly proscribe to the view that it is damaging to the mental health of a woman to be forced to undergo a pregnancy against her will, the act would be unworkable in practice (Greenwood, 2001). This points to a risk, inherent in a law dependent on latitude in its application, and giving the ultimate decision, not to the woman, but an overseeing medical professional, as the same law could be used to restrict what is currently accessible (cf. Heino et al., 2013 and Italian case below).

The Act was, arguably, a product of its time, a result of concerns with reform and attempts to solve social problems through paternalistic welfare policies: a product of concerns over the effects of dangerous "back-street" abortions on the reproductive health of the nation and reverence to the medical authority which entrusted doctors as gatekeepers to a wide range of social and ethical decisions (BPAS, 2013; Greenwood, 2001; Sheldon, 2016). Such an attitude stands in stark contrast to current beliefs in which these choices belong to the patients (Sheldon, 2016). Purdy (2006) explains that a growing consensus respecting reproductive autonomy is the route to the ultimate advancement of women's welfare and Sheldon points out that women must be allowed to partake in the public domain on equivalent terms with men and that, "prima facie, control of one's own fertility is a fundamental prerequisite for such full participation" (Sheldon, 2016, p. 2).

Thus, it has to be of serious concern that the criminal law, the most formidable and authoritarian of state powers, can coercively control a woman's bodily autonomy and that invocation of such law can result in prosecution, punishment and even incarceration. It is important to understand that the 1967 Abortion Act does not legalize abortion but creates a range of exceptions to the 1861 Offenses Against the Person (OAP) Act. Potential criminal offenses apply to medical professionals who perform abortions and to women if they carry out an abortion on themselves (Brannan et al., 2017). Campaigners and practitioners argue that the restrictions in the law do not reflect the numerous changes in medical and clinical practice and they subvert the fundamental legal principles of bodily integrity (Article 3. HRA 1998) (Sheldon, 2016). A growing body of practitioners and campaigners within the UK, which include the British Medical Association, the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwifes (RCM) claim the law is archaic and out of date (Howard, 2017). Most specifically, the use of the drugs mifepristone and misoprostol up to the tenth week means abortions do not need to be monitored in a clinical setting (Guillaume & Rossier, 2018; Howard, 2017). In 2018 it was announced that women in England (following on from Scotland and Wales) will be allowed to take the second of the

[3] In discrepancy with Infant Life (Preservation) Act 1929, which set the legal bounds for foetal viability and hence 'life' at 28 weeks.

two drugs in their own homes. Scotland became the first part of the UK to allow women to take the "abortion pill" in their own homes, after the Chief Medical Officer (CMO), working in consultation with women-led organizations, had written to all Scottish health boards, with the backing of ministers, indicating that misoprostol could be taken outside a clinical setting (Chief Medical Officer Scotland, 2017). Although abortion law was devolved to Scotland under the post-independence referendum Scotland Act 2016, the CMO was using powers available under the existing Abortion Act 1967. Within the rationale for such an important milestone was the acknowledgment that women from rural and remote parts of Scotland were forced to travel long distances. This removal of just one journey, a small aspect of legally enforced mobility, was seen as a way to allow women to avoid the distress and embarrassment of bleeding and pain during a journey back from the hospital and vastly improve the experience of over 100,000 women a year (Cockerell, 2018).

Self-administered abortions using pills—often procured over the internet—was the cheapest, most accessible solution for women in Northern Ireland, who faced discrimination and inequality through the denial of equal access to abortion (Bloomer & O'Dowd, 2014). Until the recent changes in October 2019, abortion in Northern Ireland remained regulated by the 1861 OAP Act statute and the Criminal Justice Act 1945 (Northern Ireland), due to long-standing political resistance against any extension of the 1967 Act to Northern Ireland (Thomson, 2016). Rape, incest and severe foetal abnormality were not grounds for an abortion in Northern Ireland. As a result, women were forced either to accept unwanted pregnancies, risk criminal prosecution by purchasing abortion medication online, or travel to clinics in Britain to receive the healthcare they need—until June 2017 the NHS did not cover the costs of these abortions (Guillaume & Rossier, 2018; Hoctor et al., 2017). Further, in a glaring illustration of the Northern Irish paradox of enforcing mobility, within weeks of the Supreme Court ruling that the NHS did not have to provide them since the law of the land in Northern Ireland mostly forbade them, the charges associated with accessing abortion care were waived in England, Wales and Scotland, and the NHS concession approved by Parliament. Lawmakers were happy to put women on the move.

Activists in Northern Ireland have previously challenged the particular criminalization of women procuring abortion using pills by writing open communication to the Northern Ireland Police Service, stating they had used or supplied these pills. These acts of civil disobedience high- lighted how unworkable the law is on this matter and challenged a change in the law by defying it (Lakhani & Horgan, 2015). Several well-publicized cases have brought the conflicted nature of NI legislation to the fore, among them a case of a 21-year-old woman, who in April 2016 was found guilty of having an abortion at 19 years old. The young woman was given a suspended prison sentence and her barrister stated that "had she lived in any other jurisdiction, in the UK, she would not have found herself before the court"—the young woman thus having been "victimized by the system" (McDonald, A., 2016; Mcdonald, H., 2016). Another is the case of a mother who in 2013 procured abortion pills online for her underage daughter (Lakhani & Horgan, 2015). After having accessed medical care for her deteriorating mental health, the young woman's medical records were shared with the Police. The 15-year-old was not prosecuted, but her mother faced two charges under the OAPA 1861 of unlawfully procuring poison (the abortion drugs) with intent to procure a miscarriage and supplying that poison to her daughter, facing a maximum sentence of 10 years. The day after the law changed on 23rd October 2019, she was formally acquitted at a Belfast Crown

Court (Carroll, 2019) This underscores an inequality suffered by women in Northern Ireland: if the young woman had been living in any other part of the UK, she could have accessed these pills freely on the NHS (Amnesty International UK, 2019). This also reveals the hypocrisy of UK politics, which allows the prosecuting of women within the UK, whilst promoting universal access to sexual and reproductive health rights as a goal through its Department for International Development (Marie Stopes International, 2018).

Over the years, in the build-up to the change in the law in 2019, the UK has faced intense criticism and censure for failing to protect women in Northern Ireland. In February 2018, the UN Committee on the Elimination of Discrimination against Women (CEDAW) said that the UK is responsible for "grave and systematic violations of women's rights in Northern Ireland" by constraining their access to abortion (OHCHR, 2018). In June 2018, the UK Supreme Court ruled that the law on abortion was incompatible with the right to respect for private and family life guaranteed by article 8 of the European Convention on Human Rights. Lord Mance stated the law is "untenable" and in need of "radical reconsideration" due to the "ongoing suffering" it causes (Supreme Court, 2018). In 2017 at least 861 women were forced to travel to England to access services that are legally available and readily accessible in all other parts of the UK (FPA, 2019). Lord Mance's description of the situation for women in Northern Ireland as "ongoing suffering" was not an understatement. There are multiple stories of the heartbreak and trauma caused to women and their families who faced unwanted or unviable pregnancies under the repressive regime (cf. Aiken et al., 2019; Horgan & O'Connor, 2014), which we can only hope is about to end. Despite the changes in the law, the actual nature of the provisions such as cut off dates, conscientious objection, and exclusion zones are yet to be established. However, the fact that women can now attend doctors' surgeries as patients and not as criminals is a radical, emancipatory and empowering change for women in Northern Ireland (Griffin, 2019).

LIMITING LEGAL ABORTION CARE, CRIMINALIZING SUPPORT, AND FETAL RIGHTS IN POLAND

Polish law on abortion in its current form has garnered public attention since 2016 due to repeated attempts to limit the existing restrictive provisions (Chrzczonowicz, 2017; FEDERA, 2018a; Hoctor et al., 2017; Hugson, 2018; Korolczuk, 2016), which stem from the 1993 Act on Family Planning, Protection of the Human Foetus and Conditions of Acceptability of Abortion (JoL 1993, item 17 pos. 78). Currently, under the 1993 Act, legal access to induced abortion is limited to situations where the pregnancy poses a threat to the life or health of a pregnant woman, where prenatal tests or other medical indicators suggest a high probability of severe and irreversible impairment of the foetus or an incurable disease threatening its life, or when there is a reasonable suspicion that the pregnancy arose as a result of a prohibited act, such as incest, rape, and statutory rape. Unless the pregnancy poses an immediate threat to the woman's life, the first grounds must be attested by a doctor other than the one who terminates the pregnancy. The same rule applies to the second grounds. In both, termination is available until the foetus is able to live independently outside the body of a pregnant woman. Most controversially, the third ground for legal abortion, available up to 12 weeks from conception, has to be attested by the public prosecutor's office.

The 1993 law the current basis of repression is often denoted a "compromise" between the religious fundamentalism of certain sections of the Roman Catholic Church in Poland and the country's progressive and left-leaning parties. But as Desperak (2003) observes, due to the discourse incited around the Act, reproductive rights and reproductive health have become politicized issues, and the Act itself can be read as an ideologized (and further ideologizing) instrument aimed at controlling women's bodies. The previously applicable law of 1956, which allowed for abortion due to "difficult living conditions" but left unspecified the determinants of such hardship and resulted in a liberal application of the law, was thus presented in political debate as a remnant of a "Soviet-inspired" mentality (Desperak, 2003; Korolczuk, 2016; Nowicka, 2011). There is no space here to discuss the full implications of the abortion laws as post/colonial legacies, which in itself is a detailed and extensive topic, but it is important to note this layer within the discursive practices around abortion laws and notions of "nationhood," where national identity - and with-it citizenship - may be forged as an alignment or difference with a significant other's attitudes (cf. Fletcher, 2001). The Polish political and legal landscape on abortion is therefore shaped by a combination of pro-natalist, religious and nationalist sentiments, resulting in a complex socio-legal discursive arena, where abortion is marked as a "foreign" concept.

Beyond limiting grounds for legal abortion, Poland also criminalizes terminations outside of these exceptions. The Act of June 6, 1997 - the Penal Code (Journal of Laws of 2017, item 2204, amended) Art 152 § 1 criminalizes providing a termination with a woman's consent and stipulates "deprivation of liberty for up to 3 years" as a sanction. The same penalty is provided by §2 for offering or being persuaded to offer assistance to a woman in terminating a pregnancy outside the exceptions. The penalties for both reach up to 8 years for a foetus which "has reached the ability to live independently outside the body of a pregnant woman" (§ 3). Should a woman die as a result of an unlawfully procured abortion, the penalties range from 1 to 12 years imprisonment (Art. 154). Special provisions are made by Article 153 to the use of violence and coercion to influence a woman to terminate the pregnancy, and to terminations without a woman's consent. According to annual reports the number of prosecuted "abortion crimes" ranges between several dozen to several hundred per year; most cases involving the violation of art 152.2 of the Penal Code, concerning the provision of assistance to a woman in terminating a pregnancy, or persuading her to do so. Furthermore, in 1997, responding to an attempt to liberalize the 1993 Act, the Constitutional Tribunal ruled that The Constitution of the Republic of Poland in art. 38 posits "legal protection of human life," extending it to the category of "unborn child." As Janine P. Holc states, this decision problematically "situates 'unborn' citizens as privileged markers of the health of both democratic processes and the integrity of the nation" (Holc, 2004, p. 758). Discursively, this situates women advocating for abortion rights as "enemies" of the nation, state, and democracy, and aids to justify the expulsion of those seeking abortion care.

Polish law also stipulates a conscientious objection (CO) clause, under the art. 39 of the 1996 Act on the profession of doctor and dentist, which states that "a doctor may refrain from performing medical services inconsistent with their conscience (…) but is obliged to indicate an attainable way of obtaining the provision from another doctor or medical unit, and to justify and record this fact in the patient's medical documentation." In a joint letter from pro-choice organizations addressed to the Human Rights Committee Secretariat, the authors state that "the stark effects of the restrictive legal framework" which "combine to generate a punitive

and stigmatizing environment" and have "a chilling effect for medical professionals," are further compounded by "a lack of effective regulation of conscience-based refusals of care" (Human Rights Committee Secretariat, 2016, pp. 2, 4). The authors of the letter also pointed to judgments of the European Court of Human Rights issued in three seminal cases against Poland which were a result of Poland's failure to guarantee in practice women's access to legal abortion services.[4] To further confound the picture, Desperak (2003, p. 197) notes that emergency contraception (EC) has also been branded as a tool for "early termination" within the national debates on abortion. Indeed, in one study, a high proportion of young women (68.3%) regarded EC as a means of early termination of pregnancy (Olszewski et al., 2007). Thus, despite its legality under EU provisions, the use of EC is reportedly increasingly blocked by CO doctors and pharmacists and monitored by law enforcement, a further layer of state-condoned disavowal of women's reproductive autonomy.

Between 2016 and 2018, proposals to ban and fully criminalize terminations, or to severely limit women's access to abortion were submitted to the Polish Parliament by citizen's initiatives (Sejm, 2017a, 2017b, 2018) and are in various ways proceeded in the Polish Parliament (FEDERA, 2018b). The 2016 "Stop Abortion" project seeks to instate a total ban on abortions and introduce criminal sanctions for the pregnant woman. Ostensibly rejected by parliament after "Black Protests" and pressure from the EU (Korolczuk, 2016; Nawojski, Pluta, & Zielinska, 2018), it has been sent to parliamentary committees using a legislative loophole.[5] Submitted soon after the 2017 "Halt Abortions" project by the Pro-Life Federation similarly seeks to ban abortions but without criminalizing women. It proposes to instate a ban on the right to abortion in the case of a high probability of a serious and irreversible impairment of the foetus or an incurable disease threatening its life. Its submission coincided with a challenge in the Constitutional Tribunal on the right to abortion in the case of irreversible impairments based on the "right to life" (Trybunal Konstytucyjny, 2017: K 13/17). While a pro-choice coalition "Save Women" submitted a counter project backed by 440,000 signatures, this was rejected by the Parliament in January 2018; the "Halt Abortion" project proceeded to parliamentary committees (FEDERA, 2018a). This demonstrates a consistent dedication on the part of lawmakers to maintaining the status quo, which forces women to seek abortion care outside legal bounds, either by traveling abroad or by avoiding the national healthcare system and going "underground" (Chełstowska, 2011).

Tracing the discursive changes that occurred alongside - and as an effect of - changes in the law and through the systematic campaigns by anti-choice organizations, Desperak (2003) notes the difficulty of framing abortion as a women's right. This, she agrees with Graff (2014), is due to the "disappearance of women" from the language used not only in official debate but also in popular media, including most women's magazines when discussing abortion. The radicalization of public discourse around abortion also means that women's organizations have for many years shied away from addressing the issue of legal abortion care, focusing instead on the availability of legally sanctioned "exceptions" (Desperak, 2003; Graff, 2014; Zuk & Zuk, 2017). Because of criminal sanctions placed on "assistance" even this form of intervention may be curtailed. In mid- 2018, several women's organizations in

[4] R.R. v. Poland, No. 27617/04 Eur. Ct. H.R., paras. 159-160 (2011); P. and S. v. Poland, No. 57375/0 Eur. Ct. H.R. (2012); Tysiac̨ v. Poland, No. 5410/03 Eur. Ct. H.R. (2007).

[5] In November 2016, Polish government approved a regulation offering pregnant women carrying a seriously disabled or unviable foetus a one-time payment of approx. e1,000 to carry the pregnancy to term.

Poland were informed of reports made to the authorities by anti-choice organizations stipulating the possibility of crime being committed under article 152 of Penal Code, with information women's organizations publish about ways in which women can access legal abortions within and outside the country presented as "evidence" (FEDERA, 2018b).

It is important to note that there is currently no criminal sanction for the woman accessing abortion. This situation opens up the possibility to travel abroad to access abortion care. But the criminalization of assistance places women seeking to travel in a highly precarious situation. While official figures remain around 500–600 legal abortions a year, it is estimated that Polish women terminate around 150,000 pregnancies every year, and according to one CBOS study around 5.8 million Polish women have had an abortion (Swiechowicz, 2014, TVN24, 2014). Two separate simulation models for abortion rates in Poland suggest a realistic rate of between 30 and 185 thousand abortions annually (Ossowski, 2008). A proportion of these happens in the "abortion underground" in Poland—some through access to private providers, including medical professionals who are not trained obstetricians (Wojciechowski, 2016). Others through access and use of medication with known abortive properties, often purchased illegally online (Zuk & Zuk, 2017).

Increasingly both women and goods cross the boundaries of nation-states within the EU for the purposes of termination of pregnancy. Polish women typically travel to hospitals and clinics in countries where abortion is more freely available, primarily to nearby countries like Germany, Austria, Slovakia, and in rare cases in Lithuania, but they may also travel to the Netherlands, where abortion under "unbearable" circumstances is available until the 22nd week, and less frequently to the UK (Gerdts et al., 2016). According to press reports, many clinics employ consultants who speak Polish (Swiechowicz, 2014) and some offer transport to and from the clinic; the lines of transit falling on routes that in the 1990s served trans-border traders and smugglers (cf. Gwiazdzinska-Goraj & Jezierska-Thole, 2013; Poweska, 2016). But with the costs of abortion with the transfer, the "problem" of abortion disproportionately affects poor women. As Krystyna Kacpura of the Federation for Women and Family Planning states "access to abortion depends on the depth of the wallets and resourcefulness of women" (Zuk & Zuk, 2017).

Restricted mobility and state oversight affect women accessing abortion care and services, but increasingly also medication for medical abortions. Starting in January 2018 users of forums regarding legal access to contraception, emergency contraception (EC) and legal abortion began sharing experiences which point to an intensification of control over postal deliveries, reporting being questioned by the police (despite current laws permitting personal imports of up to five packets of EC pills) and being threatened with prosecution. In response, and as an act of open defiance, activist organizations restaged pill-carrying drone flying exercises, crossing the river Oder from Germany into Polish territory. These examples point to the possibilities which supranational regulations open up (Fabbrini, 2011). Certainly, EU accession in 2004 and becoming part of the Schengen zone in 2007 have affected Polish women's access to abortion. The rights to freedom of movement and freedom of access to services have become welcome enabling factors, used as arguments against attempts to curtail travel for abortion care (Human Rights Committee Secretariat, 2016). The lack of border checks also remains an important factor enabling women to access abortion care in neighbouring countries. However, in the current climate of increased border securitization and the pro- posed introduction of random medical testing, this freedom seems precarious. It

nevertheless permits some liberal lawmakers to not address the issue by "outsourcing" it abroad.

LEGAL BUT INACCESSIBLE: ABORTION IN ITALY

The Italian abortion law (Law 22 May 1978, n. 194, On the social protection of motherhood and the voluntary termination of pregnancy, Gazzetta Ufficiale n. 140, 22 May 1978) reveals all the symptoms of ineffectiveness described in the previous cases. Popularly known as "Law 194," it leaves the decision regarding the permissibility of termination of pregnancy in the hands of the medical profession and allows doctors to opt-out of providing abortion on the grounds of con- science. In the forty years of its existence, the application of the law by doctors whose consciences continue to be affected by the Roman Catholic Church and its considerable political power has made it less available than the law on paper would suppose (Hanafin, 2007; Caruso, 2020) forcing women to move in search of non-objecting practitioners. As is the case in Poland, the prevailing law is the result of a "compromise" between the two dominant parties at the time of its introduction—the Christian Democrats and the Communist Party—signalled in the first article of the law by the reference to the protection of "human life from inception" and "social value of maternity," whilst also highlighting the state's role in guaranteeing "responsible procreation." This discursive pattern reveals a tension within the law itself between (female) citizen's bodily autonomy and Italy's patriarchal values (Hanafin, 2007). It is further exacerbated by Article 37 of the Italian constitution, which reiterates the primacy of the maternal role for women (Andall, 1994). Despite attempts by the feminist movement in Italy to secure a more woman-centric and self-sufficient model for abortion care at its inception (Caruso, 2020; Hanafin, 2007), current provisions under Law 194 and right to CO are severely restricted in practice. As a result, women are forced to travel to access abortion care—this enforced movement occurs both within the country's regions or between them, and abroad (Gerdts et al., 2016).

While Law 194 permits "interruption" of pregnancy during the first 90 days on a "voluntary" (or better "volitional" basis, Article 4), this must be predicated on health, economic, family or personal reasons (Caruso, 2020; Chavkin et al., 2017). Under Article 6, terminations up to 24 weeks gestation are only permissible in cases of serious danger to a woman's life or when foetal abnormalities pose a risk to her physical and mental health (Caruso, 2020; Chavkin et al., 2017). The pregnancy, and the woman's physical and mental health, need to be assessed by a physician. Importantly the woman may choose the provider and the facility, but the decision is in the physician's hands. Women under 18 years of age may additionally require the permission of their legal guardian or parent, or a judicial decree (Article 12). The doctor may declare the need for abortion "urgent," which grants the woman access to termination without delay. More typically they will be bound by Article 5 to note the woman's stated reasons for termination, issuing a document, which attests that the woman is pregnant and "invites her to reflect for seven days" (Caruso, 2020) creating the first push to move around and find a supportive practitioner. This document is a certificate confirming the woman's qualification for the procedure, which is free for women who have the state healthcare system *tessera sanatoria* insurance card; women without the card are required to cover the cost of the procedure (Edwards, 2018). While the services are publicly funded, the law limits the provision to accredited centres and/or public hospitals and introduces administrative sanctions (fines) for women who seek self-funded abortions from private providers (Articles

8, 9). The latter also covers self-management of abortion with the use of abortifacients and pills. The introduction of procedural steps effectively curtails many women's ability to access abortion care within the legal limits. As a result, women seeking an abortion after 12 weeks might be forced to travel abroad for care—including the UK (Gerdts et al., 2016). Those who do not have the means, increasingly resort to illegal, potentially risky abortions. A legislative decree de-penalizing secret and illegal abortion was introduced in 2016 in response to activist interventions. At the same time, however, the Cabinet of Ministers increased the financial penalty for those to up to e10,000.

Several of the law's provisions for legally permissible abortion make the law unworkable and reflect what Andall (1994, p. 244) terms an "ideological attachment to a specific vision of women's appropriate role." In the legal arena, patriarchal familialism was one of the pillars of Italian fascism (Andall, 1994; Caruso, 2020; Hanafin, 2007). Several authors note that the symbolic legal construction of women as reproducers of the nation reflects how little has changed in the relationship between the state and its women-citizens in Italy's post-war period. Right-leaning groups have consistently attempted to challenge Law 194, for the first time in 1981 when the Right to Life Movement was formed and collected enough signatures to propose a referendum repealing the abortion act (Andall, 1994; Hanafin, 2007). Of those voting, 68% were against the motion.[6] Despite this clear confirmation of popular support, successive challenges ensued, most notably on the back of legislation on bioethics with the Christian Democratic government pro- posing the introduction of Catholic counsellors to abortion clinics (Andall, 1994). Their role was to specifically counsel women against abortions, over and beyond the currently required "options counselling." The stated purpose of the counsel (Article 5) is to make women aware of available welfare strategies, with the father of the *concepito* (the conceived) involved at the woman's per- mission. This fits with the broader opposition toward women's self-determination and the familialism of Italian law, where the good of the family is valued over and above that of its individual members (Andall, 1994). An understandable wish to avoid these confrontations would again require travel.

Another push to travel in search of abortion care occurs internally, between the country's regions, and applies equally to women seeking terminations and to doctors willing to provide it. Article 9 of Law 194 provides a clause allowing medical personnel conscientious objection through a declaration made to the provincial medical officer, which can be submitted and cancelled at any time (Caruso, 2020). As a result, gynaecologists, but also nurses, anaesthetists and other assistants, can refuse to provide legally sanctioned abortion care, unless the immediate termination is needed in order to save the woman's life (Chavkin et al., 2017; Ministero della Salute, 2018; Torrisi, 2017). The annual reports by the Italian Ministry of Health (Ministero della Salute) on Law 194 indicate CO has been declared by just over 70% of the country's gynaecologists, with as many as 93% in Molise, and around 80% in Sicily and Rome and the surrounding Lazio region. Nevertheless, the Ministry is at pains to stress that for the women 92.1% of terminations took place "in the region of residence" (Ministero della Salute, 2018). This does not account for travel times for rural women, a measure postulated by researchers in the medical field as a better qualifier of access barriers than distance (Barr-Walker et al., 2019). The seemingly low mobility of women also hides

[6] Simultaneously, the Radical Party was able to put forward a referendum expanding the law to private providers and improving provision for minors; this was defeated with 88% voting against the motion (Andall 1994).

the reported pressures on the medical professionals, who not only experience discrimination, increased workloads, and limited career trajectories but may also face relocation—leading some to record CO to avoid uprooting (Chavkin et al., 2017, De Zordo 2018). Finally, with many public hospitals affiliated with the RCC, even non-objectors may find it impossible to provide adequate care (Pianigiani, 2016; Tamma, 2018). Italy's case of enforced mobility is thus brought about through its laws on CO.

It has been argued that the law exhibits all the problems inherent in attempting to transform women's legal position without a transformation in the symbolic position of women (Hanafin, 2007). Just as forty years ago, the efforts of the women's movement still concentrate on women's self-determination and ability to access to safe abortion care. With medical abortion an out- patient procedure in only 5 of the country's 20 regions and still managed by hospitals (Edwards, 2018), chances of any swift changes are low. Enforced travel for women results in shame and stigmatization, posing also a risk to health and presenting a financial burden. Marginalized women - those living in poverty, uninsured, migrants and asylum-seekers - or those simply too ill to travel are often forced to turn to clandestine and potentially dangerous methods. Social Rights Committee of the Council of Europe agreed with the complaint brought forward by Italy's biggest union CGIL (Italian General Confederation of Labour) in 2016, stating that as a result of wide- spread conscientious objection limiting access to safe abortion services women's rights were being violated by Italy (Reuters, 2016). Hanafin (2007, p. 1) cites Haraway (1990), arguing that the Italian case illustrates how "reproductive politics is at the heart of questions about citizenship, liberty, family, and nation." Questions around citizenship emerge through the valorisation of rights of foetuses over those of women, liberty is put in question by the denial of self-determination, the family is proscribed through the law's explicit references to the heteropatriarchal model, and national values are equated with those of the RCC, as reflected in the constitution. At the level of provision of abortion care, this is demonstrated by the balancing act of CO within a public healthcare system. As argued by Chavkin, Swerdlow and Fifield (2017) "legally permissible CO to legally sanctioned health care" reveals the tensions within societies committed to delivering democratically agreed national healthcare services between the interests of women-citizens seeking abortion care, the willing providers, the objectors and the political powers that bind them. The current law has been ineffective in changing the symbolic position of women and obscures their exploitation as intended reproducers of the nation (Caruso, 2020; Irigaray, 1985) or forces them to travel to assert their self-determination.

MAPPING CONNECTIONS AND ENGAGING IN ACTIVISM

Across the contexts described here, different laws curtailing access to or criminalizing abortion directly or indirectly, remain in place as women are forced to seek "ways around" them in order to access abortion care. Human rights bodies have repeatedly held that restrictive abortion laws violate women's and girls' rights to life, health, privacy, non-discrimination and freedom from torture and other ill-treatment (Chavkin et al., 2017). Similarly, withholding and denial of abortion- related information to women also violate our fundamental human rights. Yet it seems some states care little for the autonomy of their women-citizens, and little perhaps for their health, as they are satisfied to effectively "outsource" abortion care to contexts outside their jurisdiction, by privatizing and exterritorializing its reality. By addressing contexts and meanings pertaining to the

criminalization of abortion we challenge the way in which reproduction is theorized - the reproductive discourse about women "without women" (Arendt, 1958). Laws regulating abortion outline intimate aspects of "private" life as matters of intense public regulatory interest and represent, preferably marital, (hetero)sex as an activity involving the production of citizens (Caruso, 2020; Nawojski et al., 2018). The underlying legal argument remains that regulation of private conduct becomes necessary to preserve the character of public life (Nawojski et al., 2018). This is to say that abortion does not simply threaten the unborn; it threatens unborn populations (cf. Siegel, 1992). Arguments against abortion represent family and state in traditional, homologous relation to each other, where they are both interdependent institutions (Caruso, 2020; Desperak, 2003; Graff, 2014). Furthermore, the widespread claim that life begins at conception provides a persuasive basis for criminalizing abortion, as one of many arguments that identify the reproductive process as the basis of social life (Desperak, 2003). Such rhetoric has been employed against abortion for a long time (Siegel, 1992) and used to put forward the argument that regulating the physical act of reproduction is necessary to guarantee and safeguard the reproduction of the social order. Consequently, as we see in the cases described above, subjects who are involved in the act of abortion are subjected to enforced mobility. Rather than an individual issue, abortion becomes a "blemish" on the body politic (Siegel, 1992).

This exclusion/expulsion materializes in the criminalization of abortion and the enforced mobility it produces. The mobility necessary to access abortion care becomes a double (triple?) transgression: of laws criminalizing abortion and of boundaries of national belonging and allegiance to a reproductive future. By the same token, through enforced mobility, the states involved in the expulsion of their citizens 'absolve themselves' from the responsibility for the act of abortion. Although recourse to international instruments and human rights laws has proven successful in some cases (Bloomer et al., 2019), it is also important to note that sometimes supranational affordances - such as the EU freedom of movement - may also present hindrances to localized change. While "freedom of movement" allows women to retain shreds of dignity and autonomy, it allows states to outsource reproductive services. One potential response is the insistence of intra-state and cross-border parity, as was the case for the "Now for NI" campaign (BPAS, 2015). Coordinated transnational actions and activism, establishing connections with grassroots movements, facilitated by digital organizing have allowed for acts of solidarity that allow each campaign to reach further than it ever has, as exemplified by the resonance of the Polish Black Protest initiated in September 2016. Cullen and Korolczuk (2019) and Bloomer et al. (2019, p. 89) argue that transnational, digitally enabled, feminist activism allows us to "witness the global nature of control of women's reproductive lives and often the similar forms it takes [and] provides a global solidarity movement" whilst remaining situated in local contexts.

As activists seek to engage in various forms of action, we uphold that as scholars, we need to embrace and support activism. Feminists and other critical theorists have long held that the construction of knowledge is a political process and Italian feminist thinkers have woven a useful reworking of theory/praxis relationship (Hanafin, 2007), proposing an un-thinking/un-doing of the dominant power structures and traditional politics (Caruso, 2020). As demonstrated most recently, in the cases of Ireland and Poland, academic considerations of abortion could support activist groups by using the political process of knowledge-making to gather evidence to inform and enrich activism (cf de Londras & Enright, 2018; Korolczuk,

2016) and evidence ways that travel to access abortion care creates risks to women's health, generates costs and presents logistical problems (Bloomer et al., 2019). Beyond that, the haunting prospect of a movement that never ends, and of a pain that cannot find an outlet can, and has been, used as a powerful tool to dismantle the laws or to oppose restrictions. Highlighting the pain of being banished abroad to deal with a crisis pregnancy, became a key feature of the campaign to repeal the 8th Amendment in the Republic of Ireland and abortion reform in Northern Ireland, and remains the focus of current Polish campaigning. Those stories—mobilized in challenging restrictive laws—also travel; shared between national contexts, they turn private tragedies into accounts of state-enforced violence and injustice. In The Republic of Ireland and Northern Ireland, campaign efforts involved many people going public with their abortion stories, including those from the group TMFR (Termination for Medical Reasons) and those sharing their stories anonymously as part of the multi-platform "In Her Shoes" campaign. In Poland, the story of using pills and then seeking abortion abroad recounted by the singer Natalia Przybysz galvanized public opinion.

Beyond humanizing peoples' experiences and revealing the injustice of the law, telling stories of the unsafe situations and risks pregnant women endure when procuring an abortion abroad or using pills and being afraid to seek medical help in discomfort or distress, helped to highlight the head- line that criminalization was bad for women's health, dangerous to women's lives and amounts to state-sanctioned violence against women. But such testimonies also highlighted how those within borders as asylum seekers had to endure enforced immobility when faced with crisis pregnancies, an issue warranting a separate paper. The activism allowed for the emergence of arguments around access to EC and to medical abortion under WHO "Model List of Essential Medication" (cf Bloomer et al., 2019). Most significantly, effective campaigning built its strength not on allegiance to a nation-state, but on disrupting this allegiance, by standing on the side of those break- ing the law. Polish activists have, for example, defiantly flown drones with pills from Germany, mobilizing resistance and visualizing the movement and posed on the cover of a women's glossy in T-shirts stating, "Abortion is OK."

Women do and will risk everything when faced with an unwanted pregnancy - criminalization is neither effective nor is it just. One of the main contributions of women's organizing focused on re-telling of stories and challenging of enforced mobility has been the dismantling of abortion stigma, which marked women accessing abortion care as failing to attain "the ideal of 'womanhood'" (Kumar, 2009 in Bloomer et al., 2019, p. 56). In all the contexts discussed, campaigners reminded the public that it was highly likely they knew a woman who had an abortion and that she was likely to be their mother, sister, or friend. Such public attempts to resist the stigma aim to wrestle the discourse around abortion back into women's control. We include our voices in that anti-stigma momentum, as well as our critique of states who wish to distort and criminalize the reality of abortion. This is the path we must stay on.

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