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Accounting for abortion: accomplishing transnational reproductive governance through post-abortion care in Senegal

Siri Suh, PhD, MPH

Assistant Professor, Gender, Women and Sexuality Studies and Institute for Global Studies,
University of Minnesota

Abstract

Reproductive governance operates through calculating demographic statistics that offer selective truths about reproductive events, bodies, and subjectivities. Post-abortion care, a global reproductive health intervention, represents a transnational reproductive regime that establishes motherhood as women's primary legitimate reproductive status. Drawing on ethnographic fieldwork conducted in Senegal between 2010 and 2011, I illustrate how post-abortion care accomplishes reproductive governance in a context where abortion is prohibited altogether and the United States is the primary bilateral donor of population aid. Reproductive governance unfolds in two sites—hospital gynecological wards and the national health information system—through the mobilization and interpretation of post-abortion care data. Health workers police the boundaries of appropriate sexuality by searching women's bodies and behavior for signs of illegal abortion. They minimize police intervention in the hospital by classifying most post-abortion care cases as miscarriage. Health authorities deploy this account of post-abortion care to align the intervention with national and global maternal health policies that valorize motherhood and reject safe abortion. Although post-abortion care offers life-saving care to women with complications of illegal abortion, it institutionalizes abortion stigma through the surveillance of women's bodies and the masking of induced abortion within and beyond the hospital. Post-abortion care reinforces reproductive inequities by withholding safe, affordable obstetric care from women until after they have resorted to unsafe abortion.

Introduction

On March 13, 2009, police officers arrived at a district hospital in urban Senegal two hours after receiving an anonymous tip that a woman had been admitted with complications of a suspected illegal abortion. They questioned 20-year-old Aissatou Coly (a pseudonym) in her hospital bed. On March 24, 2009, the attending physician released a report stating that an ultrasound procedure had revealed a non-evolutive pregnancy of 18 weeks and 6 days and an absence of amniotic fluid, thereby concluding that Ms. Coly had terminated a pregnancy. Two days later, Aissatou confessed to the police that she had ingested a mixture of papaya tree leaves, coffee, and Paracetamol to terminate an unwanted pregnancy. On April 3, 2009, the regional tribunal sentenced her to six months in prison.

In 2011, health workers at a tertiary hospital in urban Senegal questioned Fatou Ndiaye (a pseudonym) after she presented with heavy bleeding. Fatou explained that she had taken some medication to relieve a headache after a disagreement with her husband. After nearly two months of not seeing her period, she began to bleed profusely and experienced severe abdominal pain. When she sought help at a clinic in a neighboring health district three days later, the nurse referred her to the hospital. Health workers were skeptical of Fatou's story and continued to question, or, to use their words, 'interrogate' her during treatment. Fatou insisted she had taken the medication on previous occasions to relieve headaches. Had she known she was pregnant, she would have sought care sooner. She did not know her husband's whereabouts as she had not seen him since their argument several days earlier. Although health workers suspected that Fatou had illegally terminated pregnancy, they marked her in the hospital record as a case of 'incomplete abortion' and released her a few days later. In other words, Fatou Ndiaye appeared in the hospital record simply as a case of miscarriage.

Both Aissatou Coly and Fatou Ndiaye received treatment through Senegal's national program for 'les soins après avortement' or post-abortion care, which entails emergency care for abortion complications and contraceptive services to delay the woman's next pregnancy. Introduced to the Senegalese health system in the late 1990s with support from the United States Agency for International Development (USAID), post-abortion care is now available in health facilities throughout the country. Due to her arrest and prosecution by criminal justice authorities in 2009, Aissatou Coly's case appears in court records archived at the regional tribunal. In contrast, I directly observed the clinical and administrative management of Fatou Ndiaye's case at a large hospital in 2011. My research suggests that Fatou Ndiaye's experience, rather than that of Aissatou Coly, more accurately illustrates how the national post-abortion care program handles suspected illegal abortion. In other words, most women who receive post-abortion care for complications of suspected illegal abortion in Senegalese hospitals remain undetected by the police because they are processed as cases of miscarriage. Regardless of the circumstances under which these women left the hospital—one in police custody, the other by herself—their cases offer important insight into the production and circulation of post-abortion care data within and beyond the hospital and the contributions of these metrics to national and global systems of regulating reproductive bodies and practices.

Laws and professional regulations regarding the clinical, legal, and administrative management of reproductive practices such as abortion and contraception reveal a great deal about the ways in which the state attempts to regulate the reproductive bodies and identities of its citizens. Scholars have referred to such attempts as 'reproductive governance' (Morgan & Roberts, 2012). While reproductive governance takes many legal, clinical, and discursive forms, it is often accomplished and enforced through the production and deployment of demographic statistics that permit the state to monitor reproductive matters such as birth rates, maternal mortality, and abortion. Although China, India, and Romania may epitomize numeric reproductive governance at its most extreme during the mid to late twentieth century (Connelly, 2006; Greenhalgh, 2008; Kligman, 1998), governments throughout the global North and South, including Cuba, Nigeria, South Africa, Russia, the United States, and Zimbabwe (Andaya, 2014; Klausen, 2016; Petchesky, 1990; Rivkin-Fish, 2005;

Robinson, 2012; West, 1994) have actively linked the surveillance of demographic data to broader social, political, and economic goals.

I argue that post-abortion care merits further attention as a form of reproductive governance in Senegal, and in particular as a mechanism for the production of statistical representations of the kinds of abortions that take place in the population, are treated in hospitals, and come to stand in for the kinds of women who deserve obstetric services from the state. Using ethnography, I identify two sites—hospital gynecological wards and the national health information system—in which multiple forms of reproductive governance unfold through the mobilization and interpretation of post-abortion care data. Health workers police the boundaries of appropriate sexuality by rigorously searching women's bodies and behavior for signs of illegal abortion. They maintain professional jurisdiction over obstetric care by recording most hospitalized abortions as cases of miscarriage rather than induced abortion. The sanitized account of post-abortion care produced in hospitals, circulated throughout the health information system, and deployed by national health policymakers and international reproductive health non-governmental organizations (NGOs) and donor agencies engenders a reproductive subject—an expectant mother experiencing the miscarriage of a desired pregnancy—that resonates with global health programs such as the Safe Motherhood Initiative that have not only valorized the vulnerability of motherhood, but also privileged it as the primary reproductive identity worthy of investment by governments, aid donors, and other stakeholders (AbouZahr, 2003; Rance, 1997; Storeng & Behague, 2016).

The reproductive meanings and practices obscured by post-abortion care metrics are equally critical to the clinical, textual, and discursive production of the expectant mother worthy of protection from obstetric death. Post-abortion care masks the classed, racialized, and gendered dimensions of reproductive health care in Senegal. It withholds safe obstetric care from women until after they have resorted to unsafe abortion to terminate unwanted pregnancies. Since wealthy and expatriate women may obtain safe, albeit clandestine, abortion services from health providers in the private sector, post-abortion care may represent one of few affordable options for survival among low-income women who have procured illegal abortions. For women fortunate enough to reach the hospital, post-abortion care saves lives, but exacts a non-monetary, yet equally costly price in the form of harassment and humiliation when health workers suspect that they have procured an illegal abortion. In this sense, post-abortion care enacts not only reproductive governance, but also what scholars have understood as 'stratified reproduction' (Almeling, 2015; Ginsburg & Rapp, 1995), in which the reproductive bodies of middle class, white women in the global North are privileged over the bodies of non-white, low-income women in the global South.

Currently implemented in nearly fifty countries, with over half of these programs located in sub-Saharan Africa (PAC-Consortium, 2012), post-abortion care should be considered a transnational form of reproductive governance. At a time when nearly half of global abortion-related mortality takes place in sub-Saharan Africa (Kassebaum, Bertozzi-Villa, & Coggeshall, 2014), its persistence as a solution to the problem of unsafe abortion in national and global policy frameworks raises important questions about the gendered, classed, and racialized logics that shape the kinds of reproductive care to which women in the global South are entitled. Post-abortion care emerged from multiple global reproductive regimes,

including population control, Safe Motherhood, and the more recent paradigm of reproductive health. By connecting the production of post-abortion care data in hospitals to the transnational governance of women's bodies in Senegal, I highlight lingering contradictions between the feminist model of reproductive health, the persistence of highly restrictive abortion laws throughout the African continent (Boyle, Longhofer, & Kim, 2015), and the USAID's refusal to finance abortion-related programs despite promoting fertility reduction through the prism of maternal and child health (Crane, 1994; Crane & Dusenberry, 2004; Dixon-Mueller, 1993; Morsy, 1995). Above all, I illustrate what these contradictions in reproductive governance mean in everyday practice for women, health workers, and health officials in a country that has received population assistance from the US since the 1980s (Acedo, 1995).

Background

In Senegal, as in much of sub-Saharan Africa, the practice of abortion violates the social significance of women's fertility and sexuality within the context of marriage (Bleek, 1981; Foley, 2007; Johnson-Hanks, 2002; Rossier, 2007). Women who seek or have procured abortion may experience discrimination, harassment, and physical violence (Shellenberg et al., 2011). The national penal code, a remnant of French colonial period, criminalizes abortion under any circumstance, including rape or incest. Despite these restrictions, women seek clandestine abortion from a variety of skilled and unskilled practitioners. Especially for unmarried women and girls, the health risks associated with clandestine abortion may pose less of a threat than openly acknowledging active sexuality through the act of seeking contraception at a health facility or pharmacy (Jaffré & Suh, 2016). Unsafe abortion, thus, occurs frequently and may lead to undesirable health and legal outcomes. Nearly 32% of women in Senegalese prisons have been convicted of illegal abortion or infanticide (Iaccino, 2014).

In developing countries like Senegal with restrictive abortion laws, various factors complicate the calculation of accurate metrics of abortion incidence and mortality. Vital registration systems cannot account for abortions that take place beyond the formal health sector. Women, families, and health professionals may be reluctant to report abortion-related services, complications or deaths (Gerdtz & Ahern, 2016; Westoff, 2008; WHO, 2011). Nevertheless, the Centre de Recherche pour le Développement (CRDH) and the Guttmacher Institute recently calculated the first national estimate of abortion incidence. At 16.9 abortions per 1000 women of reproductive age, abortion incidence in Senegal is lower than the regional estimate for West Africa (28 abortions per 1000 women) (Gilda Sedgh, Sylla, Philbin, Keogh, & Ndiaye, 2015) but greater than that of the US (14.6 abortions per 1000 women) (Jones & Jerman, 2017). Of the 51,500 abortions estimated to have occurred in 2012, over half (55%) experienced complications. Given that the study relied on estimates of abortion provided by respondents assumed to be knowledgeable about reproductive health, the authors acknowledge that abortion incidence may have been underestimated.

The Senegalese Ministry of Health (MOH) introduced post-abortion care in the late 1990s through a series of operations research projects with support from the USAID, the United Nations Fund for Population Activities (UNFPA), and NGOs such as the Population Council

(Thiam, Suh, & Moreira, 2006). While surgical uterine evacuation, including dilation and curettage (D&C) and manual vacuum aspiration (MVA), is restricted to tertiary and district hospitals, digital evacuation and family planning services are offered at all facility types, including community health clinics (Suh, 2015).

Although the global post-abortion care model calls for non-discriminatory, confidential care, harassment by health professionals of women suspected of illegally terminating pregnancy has been widely documented (d'Oliveira, Diniz, & Schraiber, 2002; Ipas, 2016; Suh, 2014). In Senegal, the penal code does not obligate medical providers to report illegal abortion. Additionally, the code of medical ethics requires health workers to protect patient confidentiality. A 2005 law entitles all citizens, regardless of age, gender, or marital status, to confidential reproductive health care. Despite these policies, newspaper accounts suggest that it is not uncommon for health workers to 'denounce' women to the police (Diedhiou, 2011a, 2011b; L'Observateur, 2011, 2012).

Theoretical Significance

Anthropologists Morgan and Roberts define reproductive governance as the 'mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and NGOs—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and practices (p. 243)' (Morgan & Roberts, 2012). Their definition draws on Foucault's concept of biopower as a form of governance, in which population management occurs through the surveillance and regulation of individual behavior by public health institutions and professions such as medicine, demography, and epidemiology (Foucault, 1978).

National laws and professional regulations regarding pregnancy, delivery, contraception, and abortion reflect the demographic aims and logics of the state. While Cuba's abortion policies are among the most liberal in Latin America, the government's concerns regarding declining fertility and its desire to maintain low rates of infant mortality have led to increasing medical surveillance of pregnant women (Andaya, 2014). Disagreements over family planning policies and programs may reflect competing demographic goals among various stakeholders. In Sudan, while the Sudan People's Liberation Army/Movement calls on women to reject fertility regulation measures to 'replace' those lost in the war, MOH officials and international donors portray family planning and maternal health programs as critical to the processes of peace-building, modernization, and development (Palmer & Storeng, 2016).

Policies that directly target or tacitly neglect the reproductive behaviors and needs of sub-populations are embedded within broader systems of class, gender, and racial inequality, giving rise to a devaluation of poor, black, and brown reproductive bodies that scholars have termed 'stratified reproduction' (Almeling, 2015; Ginsburg & Rapp, 1995). For example, sterilization laws in the US during the twentieth century disproportionately targeted women of color and low-income women (Roberts, 1997), while restrictions on abortion and contraception aimed to increase fertility among middle and upper class white women (Beisel

& Kay, 2004). During the apartheid regime in South Africa, fears of the ‘black peril’ fostered a tacit acceptance among policymakers of high rates of clandestine and unsafe abortion among black women despite a highly restrictive abortion law (Klausen, 2016).

Reproductive policies control behavior not only by regulating access to services, but also by establishing and assigning moral value to particular reproductive subjectivities such as ‘the unborn fetus.’ Reproductive governance operates through the forging of identities that reflect dominant reproductive goals and logics, which in turn are connected to the state’s political imaginary of the body politic (Ginsburg & Rapp, 1995; Morgan & Roberts, 2012). In the US, the simultaneous inclusion of preconception care—a constellation of services designed to prepare women for potential pregnancies—and rejection of abortion in the 2010 Affordable Care Act conveys the state’s desire to establish motherhood as the ideal reproductive status for women (Waggoner, 2013).

Critical to the enforcement of reproductive governance, and the emergence of subjectivities associated with particular reproductive regimes, is the ability to calculate demographic targets. States exercise reproductive governance through the representation of demographic statistics as objective, scientific facts about population and fertility (Adams, 2005; Greenhalgh, 2005). These statistics facilitate comparison, and thereby planning and implementation of population projects across local, regional, and global contexts. At the same time, demographic statistics offer a selective set of truths about population—such as ‘unmet contraceptive need,’ which measures the percentage of women who desire to limit or delay pregnancy but are not using modern contraception (Murphy, 2012)—that frequently obscure certain empirical realities of pregnancy, abortion, fertility, and contraception, and multiple factors related to age, gender, marital status, ethnicity, and socio-economic status that shape women’s reproductive choices and experiences (Mumtaz & Salway, 2009). Through the production of demographic information, these selective reproductive truths are ‘fetishized’ (Oni-Orisan, 2016) as markers of effective governance and population expertise, and subsequently rewarded (or punished) in a variety of ways by the state. In developing countries, governments face additional political pressures to demonstrate expertise and competence by aligning national indicators with demographic goals articulated by global health and development mandates such as the Millennium Development Goals (Oni-Orisan, 2016; Robinson, 2012; Wendland, 2016). In other words, the processes of collecting, evaluating, and disseminating population data are as critical to the act of governance as the reproductive phenomena signaled by the data themselves. Health experts manipulate national, regional, and hospital data to portray the population truths deemed appropriate or desirable by the state.

Various regimes of population governance have been enacted on a global scale since the mid-twentieth century. Through a variety of policies, technologies, and discourses, these regimes have constructed the reproductive bodies, identities, and practices of ahistorical ‘Third World’ populations (Mohanty, 1988) in opposition to the responsible and modern reproductive subjectivities of women and men in the global North. During the era of ‘population control,’ population experts in the global North, and the US in particular, identified women’s ‘explosive’ fertility—and the pathological gender relations of black and brown populations in the global South that fueled high fertility—as impediments to capitalist

forms of economic development. The location of responsibility for poverty in women's bodies and non-white cultural systems, rather than structural inequalities engendered by the processes of colonization and post-colonial, neoliberal economic reform, signals the racialized and gendered logics through which population control, as a technology of development and modernization, reinforced social, political, and economic hierarchies between the global North and South (McCann, 2016). To solve the socially constructed problems of 'overpopulation' and 'underdevelopment,' the US 'inundated' developing countries with physician-controlled contraceptive methods such as the IUD (Takeshita, 2012). The logics and technologies of population control, however, have not entirely been driven by experts from the global North. Governments throughout Asia and Latin America grappled with population questions long before agencies like the USAID crafted techno-scientific development agendas around the imperative of fertility regulation (Connelly, 2003).

In 1987, a collection of NGOs and UN agencies established the Safe Motherhood Initiative (SMI) to bring attention to the global health problem of maternal mortality (AbouZahr, 2003). In contrast to population control, which emphasized the overabundant, irresponsible fertility of 'Third World women' (McCann, 2016; Murphy, 2012; Takeshita, 2012), the SMI gained political support through its representation of motherhood as vulnerable and selfless (Rance, 1997). Organizations like the Partnership for Maternal, Newborn, and Child Health have leveraged the affective and physical bonds between newborns and mothers into increased funding for maternal health (Storeng & Behague, 2016). The connection between Safe Motherhood and child survival has been increasingly salient in consolidating the SMI's political respectability in a global reproductive health landscape dominated by the anti-abortion policies of the US since the early 1980s (Crane & Dusenberry, 2004; Dixon-Mueller, 1993).

Following the 1994 International Conference on Population and Development (ICPD), 'reproductive health' replaced population control as the primary global reproductive regime. This approach called on governments to 'empower' women to exercise reproductive choice (Lane, 1994). Although hailed by some as a feminist victory in global population politics, critics warned that this approach not only failed to dismantle forms of inequality such as structural adjustment programs that restrict women's reproductive choices, but also disproportionately burdened women with the responsibility of making fertility decisions that benefit children, families, and the environment (Murphy, 2012; Petchesky, 1995; Sasser, 2016).

The global post-abortion care model draws on logics from all three reproductive regimes. Conceived by US reproductive rights NGOs in the early 1990s (Corbett & Turner, 2003; Greenslade, McKay, Wolf, & McLaurin, 1994), post-abortion care represented a compromise on abortion between conservative and feminist delegates to the 1994 ICPD. Although the ICPD's Platform of Action omitted safe abortion from the definition of reproductive health, it called on governments to provide quality post-abortion care services as a public health solution to unsafe abortion (Kulczycki, 1999). The integration of contraception with obstetric care offered an opportunity to increase modern contraceptive prevalence in countries with high fertility. During the late 1980s, the SMI identified unsafe

abortion as one of five primary direct causes of maternal mortality. In a global reproductive policy landscape increasingly hostile to abortion, post-abortion care thus linked the management of incomplete abortion, including family planning services, to the global enterprise of saving mothers and children. This paper offers Senegal's post-abortion care program as a case study of how persistent contradictions between these population regimes and their preferred reproductive identities reinforce reproductive health inequities for women in Senegal.

Research Methods

I drew on three primary sources of data while conducting an ethnography of Senegal's post-abortion care program between November 2010 and December 2011. First, I conducted 89 in-depth interviews with health workers from eight state health facilities; MOH officials; personnel from national and international NGOs and research agencies; law enforcement officials; members of legal and medical professional associations; feminist advocates; parliamentarians; and journalists. I used purposive and snowball sampling to select individuals according to gender, profession, and institutional background. Second, I directly observed post-abortion care services in three hospitals in three different regions of the country. At each hospital, I observed, with patient consent, obstetric treatment and contraceptive counseling. I reviewed post-abortion care registers in the maternity ward and annual reports of post-abortion care data. Third, I conducted an archival review of illegal abortion prosecuted between 1987 and 2010; publications on abortion and post-abortion care research conducted from the 1980s until 2011; and articles on illegal abortion in the national press.

Most in-depth interviews were conducted and audio-recorded in French at the respondent's place of work. At each hospital, I manually wrote field notes and later transcribed them into Word documents. I transferred post-abortion care data from hospital records into Excel and generated descriptive statistics. My fieldwork drew on grounded theory, in which categories of analysis emerge through the process of data collection and in turn generate new and empirically relevant strategies for obtaining data (Corbin & Strauss, 2008). Analysis involved triangulating multiple sources of data by reviewing field notes and transcripts; conducting open-ended and thematic coding of field texts; generating matrices comparing codes across health facilities and health workers; and developing analytical memos that explored theoretical connections between codes, events, and institutions (Bernard & Ryan, 2009).

As a feminist ethnographer, I recognize the ways in which my status as a foreigner, a woman, and a non-clinician may have influenced the research context (Davis & Craven, 2016; Nagar, 2014). In particular, I acknowledge that my presence may have influenced health workers in the study facilities to under- or over-report suspected or confirmed illegal abortions during my fieldwork. Post-abortion care data from various sources, however, suggest that this is unlikely. My review of post-abortion care data at the three study hospitals prior to my fieldwork in 2011 shows that health workers rarely recorded induced abortions. While I witnessed several cases in which health workers voiced suspicion that a patient had procured an illegal abortion, I did not observe an uptick in confirmed abortion cases in the

study hospitals during my fieldwork. Reports of post-abortion care operations research conducted in regional and district hospitals from the late 1990s into the mid-2000s show that spontaneous abortions accounted for the majority of hospitalized abortions (CEFOREP, 1998; EngenderHealth, 2003; Thiam et al., 2006).

The Production of Post-Abortion Care Data

The Gynecological Ward

Table 1 shows that between 2009 and 2010 in three study hospitals, health workers classified nearly all post-abortion care cases as spontaneous abortion or miscarriage. This is not entirely surprising, as women and health workers in countries with restrictive abortion laws are often reluctant to officially disclose abortion histories and services (Gerdt & Ahern, 2016; Westoff, 2008; WHO, 2011). My observations of post-abortion care, however, suggest that health workers do not passively accept women's reports of abortion and transfer them into hospital records. In this section, I demonstrate how the official account of post-abortion care—and the distinction between induced and spontaneous abortion in particular—emerges through a complex, contradictory process in which health practitioners simultaneously search their patients' bodies and behavior for gendered and classed signs of illegal abortion and obscure suspected cases of illegal abortion in the form of miscarriage in the record. Medical providers accomplish several forms of reproductive governance through this process. By assessing the likelihood that women have had an illegal abortion against normative expectations of women's sexuality and health care seeking practices, health workers police the boundaries of appropriate reproductive behavior. In a context where law enforcement officials aggressively investigate illegal abortion, the characterization of most cases as miscarriage consolidates professional jurisdiction over what happens in the gynecological ward.

Health workers did not always explicitly mark spontaneous abortions as such in the register. They used a variety of terms to describe cases, not all of which differentiated between induced and spontaneous abortion. For example, health workers used the terms 'incomplete,' 'late,' 'fetal,' and 'hemorrhagic' to describe abortion. Some simply marked cases as 'abortion.' Others omitted abortion type completely. Variations in recording spontaneous abortion did not matter, health workers explained to me, since only cases explicitly marked as induced abortion were considered as such. Additionally, they only identified cases as induced abortion if the patient 'confessed' during treatment. In other words, even when providers suspected that a woman had illegally terminated pregnancy, the default strategy was to manage her as a case of spontaneous abortion. Since women rarely admitted to having an induced abortion, providers recorded most cases as miscarriage (Suh, 2014).

Certain physiological factors, such as cervical injuries or objects in the uterus or vagina, offered strong evidence that the patient had illegally terminated pregnancy. In the absence of such 'flagrant' signs, other bodily and behavioral markers assumed importance in raising the likelihood of illegal abortion. Here, I focus on a selection of indicators that elicited suspicion among health workers and prompted additional patient questioning. Known as 'pushing the interrogation,' this line of questioning addressed physical symptoms such as bleeding or pain; women's care seeking itineraries and the extent to which families appeared to be

involved; and socio-demographic information like marital status. Conditioned by providers' expectations of the circumstances under which women can legitimately engage in sexual activity and receive reproductive health care, these indicators facilitate the institutionalization of abortion stigma within clinical and administrative procedures of post-abortion care.

Health workers almost always considered the patient's marital status in their calculus of abortion type. Although a 2005 reproductive health law entitles all Senegalese citizens, regardless of marital status, to quality medical care, many Senegalese, including health providers, perceive married women who wish to space pregnancies as the most appropriate clients of reproductive health services (Foley, 2007). Pregnancy spacing, as a form of preserving maternal health, does not contradict normative expectations of female sexuality within marriage, in which motherhood is a natural and desirable outcome of conjugal relations (Kumar, Hessini, & Mitchell, 2009). Consequently, women with questionable sexual attachments, and in particular unmarried women and women with husbands who worked abroad, were most likely to be suspected of induced abortion. Providers believed that single women resorted to abortion to conceal evidence of premarital pregnancy. Women with migrant husbands who became pregnant as a result of an extramarital liaison might seek abortion to 'avoid divorce.' A midwife at Hospital 1 told me that inquiring after the woman's marital status was insufficient: 'We also ask where her husband is.' At Hospital 3, a physician asked a patient, who said her husband lived abroad, to detail the dates of her husband's last visit to establish the timeline of her pregnancy.

Since health workers had limited means of verifying a patient's reported marital status, they relied on other behavioral markers to signal relevant kinship ties. Family members frequently cared for hospitalized women by bringing food and changes of clothing and by paying for treatment and medication. Such investments in women's reproductive health demonstrated the social significance of women's fertility beyond the conjugal couple (Bledsoe, Banja, & Hill, 1998). Providers thus viewed with suspicion women like Fatou Ndiaye, who arrived alone and appeared disheveled throughout her hospital stay. They also suspected women who could not pay for treatment. At Hospital 3, the head midwife insisted on personally interrogating a woman who reported being divorced and could not cover her hospital bill.

Health workers investigated women's care seeking itineraries, experiences, and narratives. Women who arrived late at night might be suspected of attempting to discreetly seek treatment at a time when the hospital was less crowded. At Hospital 1, a physician instructed midwives to re-interrogate a single, 18-year-old woman who had arrived alone very early in the morning. Women who described their illness experience in ways that seemed 'incoherent' or incongruent with clinical exams also raised suspicion. Midwives at Hospital 1 re-interrogated a woman in her early thirties who self-identified as single, had an 11-year-old child, and had arrived alone with severe bleeding. They expressed uncertainty about whether her unmarried status was related to divorce or widowhood. Laughing skeptically, one of the midwives explained to me that the woman reported bleeding after she took medication to 'clean her stomach' because she felt ill. She denied knowing she was

pregnant. An ultrasound procedure appeared to contradict her account by revealing an inanimate fetus with an estimated gestational age of 17 weeks.

Health providers' expectations of appropriate reproductive behavior do not always reflect the reproductive and conjugal realities of Senegalese women. Despite health workers' concerns regarding patients' marital status, an estimated 15% of births among women aged 15 to 35 take place prior to the woman's first marriage (Guilbert & Marazyan, 2013). As marriage to men who work abroad becomes an increasingly attractive strategy for women to achieve financial security, long periods of separation between transnationally located spouses are not uncommon (Hannaford, 2014; Hannaford & Foley, 2015). In a context where a third of married women are in polygamous unions (ANSD, 2012), not all women live in the same household as their spouse (Duffy-Tumas, 2009). In both monogamous and polygamous marriages, shifts in women's status within the relationship may influence their perceptions of pregnancy desirability (Bledsoe, 2002). While health workers suspect women who offer 'incoherent' narratives of care seeking, women's health care itineraries involve multiple factors that determine their arrival at the hospital, including the influence of family members, the availability and cost of transportation and the onset and acknowledgment of physiological symptoms such as pain. In Senegal, as in other countries with high rates of obstetric mortality, women may seek obstetric care from non-biomedically trained practitioners before going to the hospital (CEFOREP, 1998; George, Iyer, & Sen, 2005). Women may be unwilling to disclose sensitive information to health workers who appear different in age, socio-economic status, religion, and ethnicity (Jaffré & Prual, 1994). This misalignment between medical providers' normative expectations of women's sexuality and fertility and the ways in which women navigate a complex terrain of reproductive strategies and choices illustrates how low-income and unmarried women are particularly vulnerable to abortion stigma during post-abortion care.

Despite the rigorous interrogation process, health workers rarely recorded cases as induced abortion. Medical providers explained that most women did not admit to procuring an illegal abortion. Furthermore, without signs of unsafe abortion, such as cervical injuries, the difference between spontaneous and induced abortion during the first trimester of pregnancy was not always clear. Such dimensions of obstetric care provision in a context with restrictive abortion laws are not unique to Senegal. Nevertheless, my research suggests that health providers' record-keeping practices constitute a form of reproductive governance that aims to maintain professional jurisdiction over post-abortion care. Health providers perceived strict boundaries between the professional duties of medical workers and law enforcement officers in the management of abortion complications. A nurse at Hospital 2 aptly illustrated these professional divisions when I asked him how medical providers handled suspected cases of illegal abortion:

We are not the police. It's not up to us to manage delinquents. Our main concern is health. It's up to the criminal justice authorities to see if it's a case of induced abortion. When the patient comes, we have to treat her, and the rest is not our problem. We wear white coats, not uniforms.

Some providers indicated that they deliberately disguised suspected cases of induced abortion as miscarriage to avoid police intervention. A midwife at Hospital 2 explained:

Sometimes the midwife will say it's a spontaneous abortion when it's an induced abortion. There are implications for the provider if the case is pursued by the police. It's rare for the provider to write induced abortion because you have to prove it and you can't let the patient go after treatment. It's just easier to write spontaneous abortion.

When law enforcement officials become aware of a case of illegal abortion, they expect health workers to cooperate in a variety of ways. In the case of Aissatou Coly in 2009, the police requisitioned a medical report of induced abortion from the attending physician. At the time of my fieldwork at Hospital 2, the head midwife had been called to serve as an expert witness in a case of illegal abortion under prosecution. She complained that such activities not only disrupted her personal and professional schedules, but also affected her pocketbook as she did not receive compensation for transportation costs between her home and the court house.

A physician at Hospital 1 illustrated the tensions between health workers' desires to maintain professional autonomy and their clinical and record-keeping practices:

We know that most of them lie. But if she says it's spontaneous, you can't write induced, you have to write spontaneous. We record what the patient tells us. We write the words of the patient. We are not police. We don't do investigations.

Although health providers distinguished their role in the management of abortion from that of law enforcement officials, the techniques of surveillance deployed by the process of 'I'interrogation' in some ways resemble the tactics employed by police officers in the investigation of illegal abortion. I argue that the lingering threat of a police-initiated inquiry in response to an anonymous tip-off, as in the case of Aissatou Coly, compels providers to search their patients' bodies and behavior for signs of induced abortion. A midwife at Hospital 1 explained:

Some of my colleagues were called to the police station in a case of suspected induced abortion. The police asked them questions. Finally they saw it was a case of spontaneous abortion. The patient doesn't always tell you. You always have to know what you're doing, otherwise you're not covered. You have to do complete exams and in-depth interrogations.

These observations suggest that even if providers do not always record induced abortion, they must demonstrate due diligence in their attempts to determine abortion type. In a context where health workers are expected to provide quality obstetric care regardless of the kind of abortion a woman has experienced but the MOH offers few guidelines on how to process possible or probable cases of illegal abortion, the interrogation represents a self-protective mechanism against charges of complicity in a prohibited act.

The Health Information System

Patient data do not remain in hospitals, but are instead transmitted across multiple levels of the health system and aggregated into national health indicators. In developing countries, external actors such as NGOs, donor agencies, and pharmaceutical companies participate in the transnational production of patient data through the conduct of clinical research projects

at state hospitals (McKay, 2012). In this section, I explore how the institutional account of abortion illustrated in Table 1, which arises out of social and professional interactions between health workers, patients, and law enforcement officials, is deployed and interpreted by MOH officials and NGO personnel in ways that portray post-abortion care as an intervention that primarily treats expectant mothers with complications of miscarriage.

Senior midwives at the three study hospitals compiled quarterly reports of post-abortion care services for hospital administration, which in turn developed annual reports for the MOH. Although health workers recorded abortion type in the post-abortion care register, these distinctions largely disappeared in hospital reports of obstetric care. My review of annual post-abortion care data between 2004 and 2010 found that disaggregated data on abortion type were available only between 2005 and 2006 in one hospital. Annual statistics generally covered the total number of post-abortion care cases treated and the proportion treated by MVA.

MOH officials explained that the legal context of abortion complicated their capacity to collect abortion data from hospitals. First, the illegality of abortion discouraged women from disclosing such procedures to health workers, thereby contributing to systematic underreporting of induced abortion. Additionally, health workers themselves were reluctant to note abortion type because of the possibility of police intervention. A regional health official explained:

We know induced abortion exists, but we can't document it. We can't even say, I saw in such and such facility, that there were so many abortions, because you're giving information that merits investigation.

The ethic of the global post-abortion care model, however, is supposed to render irrelevant the distinction between induced and spontaneous abortion. A national MOH official told me: 'We are not interested in the type of abortion, because we are not here to crack down on women.' What mattered, and what merited calculation, was the capacity of health facilities to treat women with MVA. The MOH thus prioritized data on the total number of abortions treated, the proportion treated with MVA, and the proportion of patients receiving contraceptive services. Such data offered insight not only into the intervention's impact on women's reproductive health, but also areas requiring additional improvement in training, equipment, and infrastructure.

A similar logic is observable in clinical and operations research on post-abortion care from the late 1990s until the late 2000s. Although a small number of these studies reported abortion type, investigators primarily focused on process indicators of the intervention itself. Examples of reported findings include declines in the cost of treatment and the duration of hospitalization, levels of satisfaction related to MVA use among midwives, and the proportion of patients treated with MVA. The largest operations research project, conducted in five regions of Senegal between 2003 and 2006, measured the number of practitioners trained, the proportion of facilities with a provider trained in post-abortion care, and the proportion of facilities with adequate infrastructure for post-abortion care (Thiam et al., 2006).

Reproductive health experts diverted attention from abortion type because of policymakers' concerns that post-abortion care, and specifically the availability of MVA syringes, would facilitate illegal abortion in state hospitals:

There was a big decision maker who said that as long as he occupied his position there would not be any post-abortion care, because as far as he was concerned, it was the same thing as induced abortion (National MOH official)

At first, even the concept of incomplete abortion posed enormous problems, because legal experts said it's an incomplete abortion, therefore you are terminating the abortion (Demographer, national NGO)

To address these anxieties, health experts actively separated post-abortion care from induced abortion by focusing on measures of the intervention itself. These indicators not only demonstrated the impact of post-abortion care, but also that it could be feasibly implemented in state hospitals without devolving into a de facto form of induced abortion:

You see the elements of operations research, with respect to the length of hospitalization and cost for patients, the satisfaction of clients and personnel. When presented with all this information, the decision makers could not make any objections. We had to show them that their fear was unfounded because we're looking at abortions that have already happened (National MOH official).

Most importantly, these measurement techniques produced a new lexicon to describe the object of clinical action—'complications of incomplete abortion'—that did not distinguish between induced and spontaneous abortion. For example, the term post-abortion care does not appear in the title of the final report of the first pilot project: 'Introduction of emergency obstetric care and family planning for patients presenting with complications of incomplete abortion' (CEFOREP, 1998). A regional health official's remarks about post-abortion care reveal how health experts have firmly ensconced the intervention within the national Safe Motherhood strategy by connecting the vocabulary of 'abortion complications' to the reduction of maternal mortality:

Safe Motherhood will reduce maternal mortality. We rely on strategies like spacing births, prenatal care, safe delivery, free Caesareans, and post-natal care. And of course, the treatment of abortion complications. So post-abortion care is a component among the others.

Interpretative logics connecting post-abortion care to Safe Motherhood facilitate a particular representation of the kinds of complications being treated in hospitals, and in turn the kinds of patients seeking care. If post-abortion care entails treatment of complications of miscarriage, then the women in need of treatment are expectant mothers. A member of Senegal's World Health Organization bureau stated matter-of-factly: 'There are induced clandestine abortions, but at the level of the public system, it's spontaneous abortion that accounts for most cases.' Put differently, the typical post-abortion care patient has become an expectant mother with complications of miscarriage. Hospital accounts of post-abortion care successfully stand in not only for the kinds of abortions that are regularly treated in government hospitals, but also the kinds of women entitled to receive obstetric care.

Political Implications of Post-Abortion Care

Within a broader geopolitical and transnational context of reproductive governance, this account of what post-abortion care does and who it aims to treat is highly pragmatic. Post-abortion care is the only abortion-related intervention supported by the USAID, the largest donor of global maternal and reproductive health aid (Hsu, Berman, & Mills, 2013). Although the fifth Millennium Development Goal calls for reducing maternal mortality, only in 2006 did it incorporate a sub-target for achieving universal access to reproductive health (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006), in which there is no mention of abortion. Post-abortion care resonates with global health policy frameworks that prioritize maternal over women's health and have long rejected safe abortion from reproductive health care. By aligning post-abortion care with Safe Motherhood, the MOH demonstrates compliance with global mandates to reduce maternal mortality and secures USAID resources to strengthen emergency obstetric care and family planning services.

International reproductive health and rights NGOs that collaborate with the MOH varied in their interpretations of the national post-abortion care strategy. For some NGOs, post-abortion care stalled political advocacy to revise a restrictive abortion law that made unsafe abortion inevitable. A health professional from a reproductive health NGO argued:

I would say that it has helped maybe to make treatment easy for complications of unsafe abortion because people have been trained and equipment has been procured here and there. So maybe severe morbidity has been reduced to some extent. However, it has also blinded countries. It has blinded countries because people think that now that they are providing post-abortion care, they don't need to do anything more.

From this perspective, post-abortion care breeds political complacency regarding women's reproductive health. Although the intervention may save women's lives, it does not confront a legal framework that criminalizes induced abortion and compels women to resort to clandestine and frequently unsafe procedures.

Other NGOs recognized the constraints the MOH faced with respect to post-abortion care programming in an arena where many, but not all, NGOs receive USAID funding that explicitly prohibits abortion-related services and activities through US policies like the 1973 Helms Amendment and the 1984 Mexico City Policy. A health professional from an international NGO explained:

A lot of the potential partners actually receive funds from USAID. And so, as you know, USAID has strict guidelines on what work can be done and what work cannot be done. And so it was difficult when you have a majority of the players that are working in reproductive health receive funds from USAID trying to collaborate with another organization that doesn't receive funds from USAID. I think a lot of it was...not fear based, but they were protecting their programs and the work that they do. Of course, with the majority of the funds coming from USAID they had to be mindful of that... I think governments are cautious.

Post-abortion care permits the MOH and its NGO partners to use USAID funding to implement and coordinate reproductive health services and programs like family planning

and emergency obstetric care, that can prevent mortality from unsafe abortion, without explicitly addressing induced abortion. Difficulties between partners may arise, however, when NGOs that are not bound by USAID funding desire to move beyond the public health mandate of post-abortion care and engage in abortion activities unauthorized by USAID funding.

Despite perceptions among some NGO personnel that post-abortion care 'isn't enough,' Senegalese health officials have advocated for abortion law reform. High level MOH officials described their attempts to include permission for abortion in the case of rape or incest in the 2005 reproductive health law. The bill included protections for health workers who provide post-abortion care and contraceptive services to teenagers and married women without spousal or parental consent. When members of the National Assembly threatened to reject the bill because of the abortion provisions, health officials backed down to preserve access to contraceptives and post-abortion care. A health official illustrated the political minefield of abortion advocacy when he explained:

In Senegal, I'm not sure that we're ready to adopt a law that will authorize abortion generally. When you want to discuss this with, let's say a woman who is involved in women's movements, in private she will be in favor of this, but if she has to say this with a microphone, on the screen, and defend abortion upon request, you will never see this. When you take the case of a deputy, or a senator in private, he will always tell you yes, but it's difficult for him to accept even what I'm telling you here. When we elaborated the law on reproductive health in 2005, there were these aspects of rape. It was the women parliamentarians themselves who told us to remove that, and that if we don't remove it, they will vote against that law. This is to say that things are not ready for a legalization of abortion in Senegal. I think there's fundamental work that has to be done...but it will take time.

These experiences suggest that in addition to global policy and funding frameworks that isolate abortion from reproductive health programs, Senegalese health authorities face significant political resistance to abortion law reform from local and national actors. The very introduction of post-abortion care to the health system signaled a major accomplishment in an environment where stakeholders, some within the MOH itself, believed that the intervention constituted a de facto form of medicalized abortion. The portrayal of post-abortion care as an intervention for the medical management of miscarriage represents a highly pragmatic approach to addressing complications of unsafe abortion in a context where vocal abortion advocacy might jeopardize support from local, national, and global stakeholders.

Discussion

Measurement techniques at multiple levels of the Senegalese health system support national and global narratives that emphasize the virtue and vulnerability of motherhood. By marking nearly all patients, even those suspected of illegal abortion, as cases of miscarriage in the record, health workers generate an account of obstetric practice that erases induced abortion from the hospital. Routine data collection by the MOH and operations research projects reproduce the invisibility of induced abortion within the health system by measuring

hospitals' capacity to treat complications of unspecified abortions. Together, these techniques portray post-abortion care as an intervention that primarily treats miscarriage, a reproductive outcome experienced by women who would otherwise have become mothers.

The contradiction between this account of post-abortion care and recent epidemiological estimates that at least 59% of hospitalized abortions may be related to induced abortion (Sedgh et al., 2015) illustrates how the management of abortion data accomplishes reproductive governance among various stakeholders. Health workers shore up professional control over reproduction through the surveillance of women's bodies and behaviors and through record-keeping practices that minimize police intervention at the hospital. Although the focus on treating abortion complications may stall feminist advocacy efforts to revise the abortion law, this public health approach permits health officials to reassure local and national stakeholders that post-abortion care is not equivalent to de facto medicalized abortion in government hospitals. By portraying the intervention as a Safe Motherhood issue, health authorities demonstrate compliance with global mandates that privilege maternal health. The production and deployment of post-abortion care data constitute an important performance of maternal mortality reduction that has been rewarded by national and global policy stakeholders. In addition to its incorporation into national maternal health protocols, Senegal's post-abortion care program is widely recognized as a model for the West African region by various international donors and NGOs (Dieng, Diadhiou, Diop, & Faye, 2008). Post-abortion care, thus, represents highly pragmatic reproductive governance in a context where abortion is altogether prohibited and the USAID is the primary donor of population aid.

The pragmatism of post-abortion care as a transnationally negotiated reproductive regime that privileges motherhood as women's primary reproductive identity is hardly unique to Senegal. In Burkina Faso, where health authorities face similar political hostility to induced abortion, post-abortion care facilitates the management of unsafe abortion as a public health matter without having to enter the quagmire of abortion law reform. Reproductive health NGOs recognize that post-abortion care may represent the first of many steps in a long-term approach to revising the law (Storeng & Ouattara, 2014). In Bolivia, physicians carefully refer to MVA technology as the 'saving women' device to maintain the political respectability of post-abortion care in a country with restrictive abortion laws. Such discursive strategies simultaneously reinforce professional expertise in obstetric care and align post-abortion care practices in hospitals with national and global Safe Motherhood policies (Rance, 2005).

My research illustrates how post-abortion care data, and the reproductive identities they come to represent, co-constitute transnational processes and performances of reproductive governance in Senegal. Without a doubt, one of the most critical accomplishments of post-abortion care is the intervention's capacity to provide life-saving care to women with complications of unsafe abortion with minimal detection by the police.

Demographic data, however, offer selective truths about reproduction with real consequences for women's bodies. If the lives and bodies of all women—not just mothers—matter, an alternative accounting of post-abortion care's accomplishments as a reproductive

regime is necessary. Post-abortion care represents a stratified system of reproductive care in which women with social and economic capital can discreetly obtain safe, albeit clandestine, abortions, but low-income women are only entitled to affordable obstetric care—in the form of miscarriage management—after they have resorted to unsafe procedures. The withholding of care perhaps serves to punish women who have transgressed the boundaries of motherhood by seeking induced abortion. Post-abortion care, the product of a global reproductive health policy framework hostile to abortion, threatens women's reproductive health well before they reach the hospital—if they reach the hospital at all—and encounter health workers' discriminatory interrogation practices. Continued investment in post-abortion care by global and national policymakers, despite evidence from around the world showing that legal access to safe abortion reduces obstetric mortality (Sedgh et al., 2016) and that post-abortion care is less cost-effective for health systems than offering safe abortion (Henshaw et al., 2008; Parmar et al., 2015; Singh & Maddow-Zimet, 2015; Vlassoff et al., 2014), suggests a troubling devaluation of women's reproductive bodies and identities beyond the role of motherhood. While post-abortion care may accomplish pragmatic forms of transnational reproductive governance, it fails to achieve reproductive justice for women.

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Table 1:

Type of abortion treated at three hospitals, 2009–2010

		Total Abortions Treated	Spontaneous Abortions	Induced Abortions
Year	Hospital	N	N	N
2009	Hospital 1	403	400	3
	Hospital 2	443	442	1
	Hospital 3	1467	1460	7
2010	Hospital 1	361	360	1
	Hospital 2	389	387	2
	Hospital 3	1091	1087	4