Published in final edited form as:

Med Anthropol. 2019 ; 38(2): 152–166. doi:10.1080/01459740.2018.1496333.

METRICS OF SURVIVAL: POST-ABORTION CARE AND REPRODUCTIVE RIGHTS IN SENEGAL

Siri Suh, PhD, MPH [Assistant Professor]

Department of Sociology, Brandeis University

Abstract

Drawing on ethnographic fieldwork conducted in Senegal between 2010 and 2011, I demonstrate how health professionals have deployed indicators such as number of women and abortion type treated in government hospitals to demonstrate commitment to global mandates on reproductive rights. These indicators obscure discrimination against women suspected of illegal abortion as health workers negotiate obstetric treatment with the abortion law. By measuring hospitals' capacity to keep women with abortion complications alive, post-abortion care indicators have normalized survival as a state of reproductive well-being.

Keywords

Senegal; abortion; ethnography; hospital metrics; reproductive governance; reproductive rights

On April 26, 2012, a case of illegal abortion appeared in the Society section of *L'Observateur*, a popular Senegalese newspaper. N. Kanté, a 19-year-old secondary school student, had purchased pills from a traditional healer in Guédiawaye, Senegal, who assured her the medication would “trigger” her menstrual period. A week later, after returning to school in a different region, Ms. Kanté swallowed two pills. When she began to experience severe abdominal pain, her aunt rushed her to a district hospital, where she “aborted” and received medical treatment. While Ms. Kanté was recovering, her physician alerted the police to a case of “clandestine induced abortion.” Police officers arrested Ms. Kanté at the hospital, and took her to the station, where she “admitted the facts.” she had paid the healer 30,000 CFA (approximately \$50 USD), her parents were unaware of the pregnancy, and the man who impregnated her had traveled to Mali. She received a three-month prison sentence (L'Observateur 2012).

Ms. Kanté's experience raises important questions not only about the kind of care to which Senegalese women are entitled in government hospitals, but also how this care is operationalized and evaluated within global forms of reproductive governance (Morgan and Roberts 2012) that have defined reproductive health as a matter of human rights since the 1994 United Nations International Conference of Population and Development (ICPD) (CRR and UNFPA 2013). As a signatory to the ICPD's Programme of Action, the

Senegalese government provides post-abortion care (PAC), or emergency treatment for complications of abortion, in public hospitals, despite the penal code's complete prohibition on induced abortion. Ms. Kanté would be counted in hospital statistics on the number of women treated with life-saving obstetric care. Ultimately, her case would be tallied into national statistics deployed by the government to demonstrate compliance with the ICPD's rights-based mandate to reduce maternal mortality. These statistics, however, obscure how Ms. Kanté's physician violated her right to confidential medical treatment by divulging her information to the police. Although she survived her injuries, PAC functioned as a gateway to Ms. Kanté's arrest and imprisonment.

In this article, I explore how the transnational politics of measuring compliance with the ICPD's mandate of reproductive rights have unfolded within Senegal's PAC program. Drawing on an ethnography of this program conducted between 2010 and 2011, I offer three contributions to scholarship on global reproductive governance. First, I interrogate meanings and practices related to two indicators of PAC: the total number of women treated and the type of abortion experienced by the patient. By tracing the construction of these indicators through clinical care in hospitals and research projects conducted in collaboration with international non-governmental organizations (NGOs), I illustrate how they generate selective interpretations of the kinds of women seeking care in government hospitals and of the intervention's public health impact. While PAC indicators demonstrate ICPD compliance by counting the number of women who survived abortion complications, they obscure clinical, textual, and organizational practices that discriminate against women who are suspected of illegal abortion.

Second, I illustrate how PAC indicators, by conveying the cost-effectiveness of the intervention within a global health landscape that increasingly prioritizes statistical measures of impact, come to define, and ultimately limit, the kinds of obstetric care to which women are entitled. By measuring hospitals' capacity to keep women alive, PAC metrics show that the intervention "works" (Adams 2013: 57). These indicators not only normalize survival of abortion complications as a state of reproductive well-being for women, but also "displace" (Adams 2013: 71) or "foreclose" (Wendland 2016: 74) opportunities for abortion law reform, which has been associated with declines in abortion related mortality in high, middle and low income countries (Sedgh et al. 2012). With nearly 62 percent of all global abortion-related mortality occurring in sub-Saharan Africa (WHO 2011), it is imperative to grapple with the extent to which human rights discourses are commensurable with a global model of reproductive health care that not only extends medical and legal surveillance over women, but also limits its definition of reproductive well-being to survival rather than the prevention of suffering.

Third, I extend scholarship on global reproductive governance by illustrating multiple and at times contradictory subject positions that are produced through health workers' daily PAC practices. Although some women, like N. Kanté, are "denounced" by medical providers to the police, many others are disguised as cases of miscarriage in PAC registers. Through these textual practices, health workers portray the typical PAC patient as an expectant mother, a reproductive subject that resonates with global commitments to Safe Motherhood since the late 1980s (Storeng and Béhague 2014) while obscuring the desperation

experienced by women who resort to unsafe abortion procedures to delay motherhood. I demonstrate how health workers at the frontlines of obstetric care in government hospitals grapple with conflicting desires to competently differentiate between spontaneous and induced abortion and protect patients from criminalization. Observations in three hospitals illuminate the clinical and professional limitations of the global PAC model for health workers, given the precarious legal context in which they practice these services.

METRICS: MECHANISMS OF REPRODUCTIVE GOVERNANCE

Anthropologists Lynn Morgan and Elizabeth Roberts define reproductive governance as an “analytic tool for tracing the shifting political rationalities directed towards reproduction (2012: 241).” Governments, religious entities, and NGOs deploy laws, economic incentives, services, and at times, “direct coercion,” to “produce, monitor, and control” reproductive behaviors (241). These “mechanisms” (241) of reproductive governance represent “moral regimes” (242) that privilege some reproductive identities, behaviors, and practices over others.

In this article, I expand the concept of reproductive governance beyond individual countries or regions to account for reproductive regimes that operate globally. Since the mid-twentieth century, at least two moral regimes of population—that is, population paradigms that privilege a particular theory of the relationship between gender, fertility and socio-economic development—have guided the population interventions, technologies, and practices of influential multilateral actors such as the UN agencies, the World Bank, and bilateral agencies like the US Agency for International Development (USAID).

Starting in the mid-1950s, a population paradigm known as “population control” conceptualized high fertility as a significant impediment to economic growth in newly sovereign countries throughout the global South (Connelly 2008). Population experts identified low-cost contraception as the technological solution to this problem and subsequently invested in researching and distributing contraceptive (and in some cases, abortive) methods to these countries (Murphy 2012). At the 1994 ICPD in Cairo, the global health and development community replaced population control with a new paradigm known as “reproductive health,” which defined reproductive well-being as a human right. Reproductive health advocates argued that fostering women’s reproductive autonomy, rather than simply reducing fertility, was key to economic growth in the global South (Lane 1994)

I argue that a definition of *global* reproductive governance requires greater attention to multi- and bilateral organizations, philanthropic agencies, and NGOs contracted to implement maternal and reproductive health programs in developing countries. In 1984, for example, the US Mexico City Policy (also known as the Global Gag Rule) prohibited NGOs that received US family planning aid to conduct any abortion-related activities, including services, referral, and legal advocacy (Crane 1994). Through structural adjustment loans, global financial institutions have pressured some sub-Saharan African countries to adopt national population policies that aim to reduce fertility to promote economic growth (Robinson 2015).

Precisely because of the role of these organizations in enforcing global population regimes, we must pay closer attention to metrics as one of the mechanisms through which global reproductive governance unfolds, and through which certain reproductive behaviors, identities, and interventions are valued over others. Anthropologist Sally Merry (2016) argues that metrics enact governance through the negotiation and establishment of performance indicators according to which governments are evaluated. Global reproductive regimes are enforced through demographic targets articulated by global treaties on population and development such as the ICPD, the Millennium Development Goals (MDGs), and now, the 2015 Sustainable Development Goals (SDGs). For example, the ICPD (and the fifth MDG) called for a reduction of 1990 estimates of maternal mortality (in the form of a maternal mortality ratio) by 75 percent by 2015. A country's commitment to the ICPD's reproductive rights agenda is thus evaluated by its progress in reducing this ratio. Governments draw upon these global benchmarks to guide national planning and investment decisions, thereby demonstrating moral authority, technical expertise, and competence in caring for their citizens (Andaya 2014).

Estimated through statistical techniques, population metrics like the maternal mortality ratio (which measures the number of maternal deaths per 100,000 live births) are widely perceived as objective, apolitical facts that facilitate evidence-based decision-making about maternal and reproductive health. Metrics, however, are hardly neutral. Instead, they produce and are in turn produced by the very social, political, and economic relations that deploy them for the purposes of governing in the first place. According to Merry, "those who create indicators aspire to measure the world, but in practice, create the world they are measuring (2016: 21)." Numbers exercise power by framing how problems are understood, by determining who or what will be counted (and how) in the definition of problems, and by informing the decisions formulated to address these problems.

Of course, power relations shape *who* does the counting (Erikson 2012, Merry 2016). Since the emergence of the population control paradigm, population expertise has been concentrated among highly educated professionals in a variety of institutions in the global North, including population centers and schools of public health at universities, philanthropic foundations, and NGOs (Greenhalgh 1996). In their role as daily health care providers, medical workers generate data about the kinds of care offered and the kinds of patients treated that feed into regional and national health statistics. Medical providers act carefully to protect their personal and professional interests when furnishing health statistics to the state or other relevant authorities, at times manipulating the completion of forms to avoid disciplinary action following undesirable health outcomes (Jaffré 2012, Oni-Orisan 2016, Erikson 2012). Across the developing world, decades of neoliberal economic restructuring have amplified the influence of NGOs in health care provision (Packard 2016). While some scholars have emphasized the inconsistency of metrics compiled by NGOs (McKay 2018, Sullivan 2017), others argue that they gather exactly what they want to "see" (Biruk 2018: 20-21): neat numeric snapshots of populations that can be widely circulated, managed, and deployed for the purposes of planning "at a distance" (Erikson 2012: 372).

The complexities of health and of health care provision drop out as they move up the chain of authority and are manipulated by decision-makers to portray certain facts (Merry 2016).

Reductions in the maternal mortality ratio can be deployed as evidence of good maternal health governance, even in a country like Malawi where an estimated 75 percent of deaths are not included in vital registration systems (Wendland 2016). Numbers thus exercise power in their capacity to convey demographically or epidemiologically convenient “truths” (Adams 2005: 82). Indeed, what numbers “perform” (Erikson 2012: 373) may be more politically useful than the accuracy of the numbers themselves. In her study of global health governance in Tanzania, anthropologist Noelle Sullivan shows how even statistically imperfect data allow government health authorities and NGOs to demonstrate accountability to donors who wish to see “numbers” that “go up” (2017: 200). When donors are satisfied that their funding is contributing to improved health outcomes, funding contracts are renewed and people remain employed (Erikson 2012).

MONITORING REPRODUCTIVE RIGHTS THROUGH PAC INDICATORS

The global PAC model was developed during the early 1990s by a collection of reproductive health NGOs to reduce mortality and morbidity from unsafe abortion in countries with restrictive abortion laws. This model linked emergency treatment for complications of spontaneous or induced abortion to contraceptive counseling and method provision and other reproductive health services. Additionally, it called for replacing dilation and curettage (D&C) with safer, more effective uterine evacuation methods like Manual Vacuum Aspiration (MVA) that could be used by non-physicians at lower levels of the health system (Greenslade et al. 1994, Corbett and Turner 2003).

PAC represented a technological and programmatic innovation for reducing maternal mortality during a longstanding impasse among global health policymakers since the 1984 Mexico City Policy on the political legitimacy of abortion. It also offered a timely opportunity to generate abortion-related metrics in countries with restrictive abortion laws. Although PAC services could estimate neither abortion incidence nor the contribution of unsafe abortion to maternal mortality and morbidity (Bullough et al., 2005, Gerdtz, Vohra, and Ahern 2013), they could generate metrics that illustrated the cost-effectiveness of a “harm reduction” approach to unsafe abortion (Erdman 2011). Maternal health experts have argued that process indicators of access to, availability, and quality of services are more useful than the maternal mortality ratio in identifying specific areas of maternal health care in need of strengthening (Storeng and Béhague 2017). Through PAC, health authorities could generate statistical data on the number of women receiving treatment; the proportion treated with more effective technologies like Manual Vacuum Aspiration (MVA) (and more recently, Misoprostol); and the proportion receiving family planning services during or after treatment. Additionally, they could evaluate the extent to which PAC reduced the length of women’s hospital stays and the amount women paid for services (Huber et al. 2016).

In 1994, the PAC model was integrated into Section 8.25 on women’s health and safe motherhood of the ICPD Programme of Action as a harm reduction approach that, while neutral on the legal or moral dimensions of abortion, aimed to prevent death and disability from unsafe abortion (Erdman 2011). PAC represented an uneasy compromise on abortion between the feminist architects of the ICPD Programme of Action who understood abortion as a reproductive right and delegates from the Vatican who categorically rejected abortion as

a form of murder (Kulczycki 1999). Section 8.25 advises governments and NGOs to “strengthen their commitment to women’s health” by ensuring access to treatment for abortion complications regardless of the legal status of abortion (UNFPA 1994).

PAC thus belongs to the collection of maternal and reproductive health services identified by the ICPD (and subsequently the 1995 Beijing Women’s Conference, the MDGs, and the SDGs) as markers of commitment to the principle of reproductive rights (Corbett and Turner 2003, Curtis 2007). PAC is the only abortion-related health intervention that is compatible with the Mexico City Policy, reinstated in 2017 by President Trump (Barot 2017). Between 1994 and 2001, the US spent up to 20 million dollars on PAC policy and advocacy, training, research, and service delivery in 40 countries (Curtis 2007). PAC has been implemented in nearly 50 countries worldwide, with nearly half of those programs in sub-Saharan Africa (PAC-Consortium 2012).

I argue that PAC indicators have enacted global reproductive governance by framing the intervention as the best possible evidence-based solution to the global problem of unsafe abortion. PAC metrics “create the world they measure” (Merry 2016: 21) by demonstrating the government’s compliance with the anti-abortion policies and discourses of the US and the ICPD’s reproductive rights framework; and by documenting the public health impact of a harm reduction approach to the problem of unsafe abortion. Perhaps most importantly, they convey the urgent need for additional funding to ensure women’s continued access to life-saving services.

METHODS

Over the course of 13 months between 2010 and 2011, I conducted ethnographic research on Senegal’s PAC program. I used purposive and snowball sampling to recruit 89 participants with whom I conducted in-depth interviews. The sample included health workers, Ministry of Health (MOH) officials, personnel from national and international NGOs and donor agencies, members of medical and legal professional associations, law enforcement officials, parliamentarians, women’s rights activists, journalists, and scholars from l’Université Cheikh Anta Diop.

I conducted in-depth interviews with 36 health workers at eight government health facilities in three regions of the country. Interviews were in French and recorded manually or, if the participant consented, with a digital recorder. A research assistant transcribed the digitally recorded interviews in French, and I subsequently translated these into English. I observed and recorded extensive field notes on PAC services at three facilities: a tertiary regional hospital and two district hospitals. To avoid generating additional scrutiny of PAC patients suspected of procuring illegal abortion, I did not interview women patients at these facilities. As the study protocol approved by the Comité National d’Ethique pour la Recherche en Santé (CNRS) limited my research to hospitals, I did not meet with women patients outside the hospitals. Prior to observing PAC, a research assistant explained the study to women patients in Wolof. I received written consent to observe PAC from 53 patients.

At each hospital, I reviewed PAC registers from the gynecological ward and annual reports of obstetric care. I spent several weeks observing health workers, shadowing them in their daily activities and engaging them in informal conversation before requesting formal interviews. At two hospitals, a research assistant and I attended early morning staff meetings between the head gynecologist and incoming and outgoing shifts of midwives. At the first study hospital, I observed day and night shifts in the maternity ward. During my review of PAC records, I consulted frequently with health workers to explain medical terminology, to provide context for particular cases, and to detail discrepancies between what was articulated in formal interviews and informal conversations and what appeared in the PAC register. For example, I asked health workers to explain how women suspected of illegal abortion came to be classified as miscarriage. After manually recording material from PAC registers in a notebook, I transferred these data to an Excel file to generate descriptive statistics and compare them across facilities.

Additionally, I conducted an archival review of nearly 25 years of court records documenting the prosecution of illegal abortion in the region of Dakar. Throughout the fieldwork period, I reviewed accounts of illegal abortion reported by the national press. To situate the national program within a longer global history of reproductive health research and policymaking, I reviewed publications on abortion and PAC research conducted by Senegalese health professionals and health experts from international NGOs. To protect the confidentiality of research participants, I use pseudonyms in the following description of findings.

INDICATORS OF SENEGAL'S PAC "SUCCESS STORY"

The Senegalese penal code forbids induced abortion under any circumstance, including in cases of rape, incest, or when pregnancy threatens the woman's life (Suh 2014). Clandestine abortions, however, are not uncommon as an estimated 32 percent of women incarcerated in Senegalese prisons have been accused of abortion or infanticide (Iaccino 2014). My review of court records at the regional tribunal of Dakar found that 42 cases of illegal abortion had been prosecuted between 1987 and 2010, a number that likely represents a fraction of investigations of illegal abortion undertaken by the police during this time. For example, between September and October 2011, newspapers reported three cases of suspected illegal abortion referred to the police by medical professionals in Dakar (Suh 2014).

Conducted in 2013, the first national study of abortion incidence estimates a rate of 17 abortions per 1000 women. Most abortions (63 percent) are performed in unhygienic environments by untrained practitioners, or by women themselves. Although 37 percent of abortions are performed by trained medical workers (sometimes costing up to \$375, Turner, Senderowicz and Marlow 2016), the likelihood that some of these procedures are conducted under unsafe conditions is high due to Senegal's restrictive abortion law. While almost all low-income rural women (73 percent) experience complications, only 35 percent of non-poor urban residents do, and poor women in both urban and rural zones are less likely to receive care than wealthier women (Sedgh et al. 2015).

By the mid-1990s, the Senegalese MOH identified the need for PAC. After piloting PAC at several tertiary hospitals during the late 1990s, the MOH decentralized these services to district hospitals. The MOH has evaluated PAC using two related process indicators: the number of patients treated and the proportion treated with MVA technology. The number of women treated showed that women had access to care, and the proportion of patients treated with MVA conveyed the quality of care. In addition to being safer and less costly for women and hospitals than D&C, MVA carries fewer risks of infection and may be less painful than digital evacuation, a method that is not recognized by the WHO as a safe abortion care technique (Suh 2015).

Together, these indicators conveyed a public health success story of the introduction of a new set of life-saving obstetric services and technologies. Data from PAC studies signaled significant improvements in the organization and quality of care. By the end of the first research project in three large hospitals in Dakar between 1997 and 1998, investigators observed declines in the length of hospitalization and the cost of treatment (CEFOREP 1998). During the largest research project in five regions of the country between 2003 and 2005, the number of patients receiving PAC and the proportion treated with MVA in 23 district hospitals nearly doubled (Thiam, Suh and Moreira 2006). By decentralizing MVA to district hospitals, the MOH facilitated access to life-saving services among women in rural zones who would otherwise have to travel to tertiary hospitals in large cities.

Additionally, in a context with a highly restrictive abortion law, the global PAC model offered a new ethic of obstetric care, grounded in the principles of reproductive rights, in which the kind of abortion experienced by the patient no longer mattered to health workers. The ultimate obligation of the provider was to treat patients. Study participants explained that prior to the introduction of PAC, health workers actively sought out and at times discriminated against women suspected of induced abortion with threats and harassment. For example, Mr. Diallo, a demographer who worked with a national reproductive health NGO, described how health workers “positioned” themselves as “judges” or “inquisitors” when it came to managing suspected cases of illegal abortion. Such patients, he explained, “were very poorly received.”

Through a series of research projects conducted in collaboration with international NGOs, the MOH transformed the treatment of abortion complications into a medical matter to be managed by health workers rather than law enforcement officials. For health officials and politicians concerned about clinical and conceptual overlaps between treating complications of incomplete abortion and terminating pregnancy, these studies illustrated not only that PAC could be safely decentralized to lower levels of the health system without breaking the law (Suh 2017), but that it made good public health sense with respect to savings in time, money, and human resources. Put differently, the data demonstrated compliance with both the national abortion law and the ICPD’s rights-based mandate for an evidence-based harm reduction approach to unsafe abortion.

The gradual decentralization of PAC has been so successful that Senegal is considered a model for the West African region (Dieng et al. 2008). Since 2007, the MOH has collaborated with international NGOs to clinically test the effectiveness of Misoprostol in

treating abortion complications in government health facilities (Gaye et al. 2014), and in 2013 added Misoprostol to the national list of essential medications (LEM) (Reiss et al. 2017).

In contrast to the careful documentation of clinical research, the nuances of daily obstetric care disappear from the routine collection of service statistics. PAC registers in maternity wards require health workers to differentiate between induced and spontaneous abortions. When I asked Mr. Sall, a nurse at a primary healthcare clinic, to describe how PAC recordkeeping occurs, he explained that his facility did not specify abortion type: “We count the total number of abortions because really, it’s not our role here... We put everything in terms of abortions.” These practices reflect the MOH’s priorities for the routine surveillance of PAC. At the time of my fieldwork, the MOH required health facilities to report only the number of women treated, the proportion treated with MVA, and the proportion who received contraceptive services. Mme Camara, a district health official in the second study region, explained that given the legal status of abortion, it made little sense to collect information on abortion type. “We can’t really find out the number of induced abortions,” she said, “because people will always hide and say no, I didn’t have an induced abortion, it just happened like this.” In contrast, PAC process indicators allowed the MOH to measure public health impact in terms of the program’s increasing accessibility to rural communities and improvements in quality of care.

PAC metrics in Senegal perform the intervention’s effectiveness as a maternal mortality reduction intervention, even in the absence of statistically robust data. At the time of my fieldwork, one of several “retention des données” was in effect, in which health workers withheld service statistics from the MOH to improve working conditions (Tichenor 2016). Nevertheless, Dr. Keita, an official in the MOH’s Division of Reproductive Health, expressed confidence that with “a greater offering of services” generated by the decentralization of care, the MOH could expect improvements in PAC services, including the availability of MVA syringes and increased contraceptive uptake. Mme Mbow, a midwife who worked for an international NGO, expressed a similar interpretation of PAC data, in which good hospital indicators signaled that rights-based approaches to maternal mortality reduction were working, when she described the MOH’s PAC strategy as “favorable to the population” and “part of the larger strategy to reduce maternal mortality and morbidity by 2015, which is part of the MDGs.”

How else do PAC metrics enact reproductive governance? They may foreclose opportunities for interventions such as abortion law reform that are associated with reductions in maternal mortality. Stakeholders like Mr. Mbaye, a demographer at a national reproductive health NGO, have suggested that the decline in the maternal mortality ratio from 435 to 320 maternal deaths per 100,000 live births between 2005 and 2010 (ANSD 2012) indicates that PAC can reduce maternal mortality *without* reforming the abortion law. “You can have a good PAC program that has been implemented and accepted,” he said, “with quality services and with results on the impact on maternal mortality without a revision.” Similarly, in Burkina Faso, PAC, rather than legal abortion, is framed by MOH officials as a way to achieve the fifth MDG (Storeng and Ouattara 2014).

PAC metrics provide evidence that something is being done about abortion mortality and morbidity in Senegal. Generated by routine health monitoring and through research projects conducted in collaboration with at least nine NGOs since the late 1990s, these metrics have enabled the MOH to comply with the ICPD's framework for rights-based maternal mortality reduction while adhering to the national abortion law. These metrics demonstrate the intervention's compliance with and eligibility for the anti-abortion funding of one of the government's primary reproductive health donors, the USAID. PAC is included in the USAID's population policy and reproductive health sector, which is the fourth largest sector of USAID funding, receiving 16 million in 2016 (USAID 2017).

ABORTION TYPE: THE PAC INDICATOR THAT DOESN'T COUNT

Despite the MOH's interest in process indicators of obstetric care, health workers were very concerned with compiling a different indicator of daily PAC provision: abortion type. My review of PAC registers at three hospitals over 24 months between 2009 and 2010 suggests that almost *all* patients were recorded as having spontaneous abortion. This belies the extent to which health workers actively *seek out* suspected cases of illegal abortion among their patients. In a context where law enforcement officials expect health workers to cooperate with investigations of illegal abortion inside and outside the hospital, they are often compelled to identify women who may have procured illegal abortions (Suh 2014). For example, Mme Ndir, a midwife at Hospital 1, described a case in which her colleagues had been "summoned" to the police station to discuss a patient who had received PAC at the facility and was later suspected of having procured an illegal abortion. Although the police eventually dropped the investigation, Mme Ndir emphasized the importance of determining what happened, through questioning and clinical exams, so that "you're covered" in case of police involvement, because the patient "does not always tell you what really happened." In a 2009 case prosecuted by the regional tribunal of Dakar, police officers arrived at a health center in a working-class neighborhood of Dakar within two hours of receiving an anonymous tip about a young woman receiving treatment for abortion complications. The police officers requisitioned a medical report from the attending physician, who confirmed an induced abortion had occurred. The patient received a six-month prison sentence.

In what follows, I describe the clinical and administrative processes through which health workers observe their patient's bodies and behavior for physiological and social markers of illegal abortion. Health workers exercise reproductive governance over their patients by evaluating their adherence to normative expectations of motherhood that bind women's sexuality and fertility to marriage. The subsequent masking of suspected induced abortions in PAC registers, however, suggests another form of reproductive governance is at work in which health workers *deliberately* create an account of PAC that shows that most patients have had spontaneous abortions. Health workers thereby assemble a particular reproductive "subject" (Morgan and Roberts 2012: 242-243): an expectant mother who has suffered a miscarriage. While such women are of little interest to the police, they represent the kinds of mothers in need of saving and thus entitled to the care provided by maternal health programs like PAC.

Bodily surveillance occurred through vaginal examinations and ultrasounds, which allowed providers to observe signs of illegal abortion such as a perforated uterus or objects inside the vagina. During a process that health workers described as *l'interrogation* (interrogation), they questioned patients not only about physiological symptoms such as bleeding or pain, but also their marital status and care-seeking itineraries. Without obvious signs of illegal abortion, medical providers relied on *l'interrogation* to assess the likelihood that a patient had attempted to terminate a pregnancy and, if possible, to obtain the identity of the *avorteur* (abortionist).

Health workers' calculations of abortion type drew on gendered and classed expectations of women's reproductive health care seeking practices. Although a 2005 reproductive health law entitles all citizens to quality reproductive health care regardless of age, gender, or marital status, many medical providers in this study believed that the typical PAC patient was a married woman who desired children but had experienced a miscarriage. They expected the woman's husband and other family members to invest in her reproductive outcomes by accompanying her to the hospital and paying for services, medication, and other resources not offered by the hospital, including food, bed linens, and sanitary napkins. Additionally, providers expected women to seek care for abortion complications in a timely manner. Although PAC services are available 24 hours a day, health workers believed that patients who arrived late at night were attempting to seek treatment at a time when they would be less likely to run into family members or neighbors.

Women suspected of illegal abortion were singled out for additional questioning. Mme Bâ, a midwife at Hospital 1, explained that "you have to push them to speak, to get certain information, otherwise they will not just admit it like that." Mme Thiam, another midwife at Hospital 1, told me that if a woman did not initially reveal what happened when she first arrived, they waited until the next day to "push the interrogation further." Mlle Diop at Hospital 3 evoked a form of surveillance when she described the need to carefully "watch" such patients because "sometimes they escape" before health workers are able to question them.

Medical workers believed that illegal abortion was more common among young, unmarried women engaged in inappropriate sexual relations that resulted in unwanted pregnancy. Consequently, Mlle Diop at Hospital 3 explained, they sought out single women for more "intense" forms of interrogation. Women with husbands who lived abroad also seemed likely candidates for seeking illegal abortion to conceal evidence of extramarital sexual relations that might result in divorce. In addition to inquiring after the patient's marital status, health workers demanded to know her husband's whereabouts.

Providers pushed the interrogation with women whose care-seeking narratives and behaviors did not adequately align with their expectations. At Hospital 1, during an early morning staff meeting, the head gynecologist, Dr. Diatta, instructed midwives to re-interrogate a patient in her early 30s who had arrived alone "in the middle of the night." She had self-identified as unmarried and reported having an 11-year-old child. According to Mme Bâ, the midwife responsible for the re-interrogation, "she had taken a *décoction* (infusion) to clean her stomach because she was feeling unwell." She also reported not knowing she was pregnant.

Later that morning, Mme Bâ conducted an ultrasound procedure that displayed an inanimate fetus with an estimated gestational age of 17 weeks, evidence she believed was highly suggestive of induced abortion. In such cases, Mme Bâ explained, it was important to “investigate” because patients “will never tell you what they did.”

One morning at Hospital 3, the midwives notified Dr. Faye, the head gynecologist, of a peculiar case. The patient lay weak and feverish on a plastic mattress in the maternity ward, surrounded by a cluster of doctors, midwives, nurses, and auxiliary staff. “*Soxna si* (Madame),” Dr. Faye asked the woman as he performed a vaginal exam, “how long have you been bleeding? What color was the blood? Where do you feel pain?” Two midwives chimed in with responses from their earlier questioning of the patient. She had arrived alone late into the night shift with severe bleeding and abdominal pain. She reported taking a decoction to “relieve a headache after a disagreement with her husband.” Soon after taking the medication, she began to bleed heavily after not menstruating in nearly two months. Three days later, she consulted a nurse at a community clinic in a nearby district, who immediately referred her to Hospital 1.

When Dr. Faye asked the patient to describe the decoction she had ingested, she said she did not know what was in it but had taken it on other occasions to relieve headaches. Why did she wait three days to seek medical care after she started bleeding? The woman replied that had she known she was pregnant, she would have sought care much sooner. Where was her husband? She said she had not seen him since their argument several days earlier.

Over the next two days, health workers continued to interrogate the woman during treatment and hospitalization. The arrival of her parents, who paid for food and medication, did not deter midwives from asking after the whereabouts of her husband, who never appeared at the hospital. When I asked Dr. Faye about the case, he shrugged his shoulders and explained that the woman had aroused a good deal of suspicion among the midwives. “Her story doesn’t add up, and up till now her husband has not come to the hospital.”

Despite the rigorous interrogation of patients in daily practice, health workers rarely recorded patients as cases of induced abortion. Such record keeping actively protected women from arrest in a context where police officers aggressively investigate illegal abortion. For example, the woman at Hospital 1 who ingested the decoction to “clean her stomach” appeared in the PAC register as a case of “late abortion.” The woman at Hospital 3 whose husband never appeared at the hospital was recorded as a case of “incomplete abortion.” Health workers removed traces of suspected induced abortion from the PAC register by using ambiguous language that did not specify abortion type. For example, the term “avortement,” which refers to induced *or* spontaneous abortion, appeared frequently in the column requiring providers to identify abortion type. In some cases, medical providers left this space in the register entirely blank.

Unless women admitted to having procured an abortion, health workers were reluctant to mark them in the record as such. At Hospital 3, Dr. Faye explained that even if they found “foreign objects in the vagina,” they preferred to obtain the woman’s verbal admission before classifying her as a case of induced abortion in the PAC register. Without the

woman's admission, Mme Sène, the head midwife at Hospital 3, explained that "we treat her like it's a case of spontaneous abortion." Most cases of suspected illegal abortion thus end up being recorded in the PAC register as miscarriage. Additionally, medical workers interpret cases that are not formally identified as induced abortions as spontaneous abortions (Suh 2014). For example, Mr. Sall, the head nurse at the primary health clinic who initially explained that he counted all PAC cases as "abortions" later revealed that he considered all of these "abortions" as "spontaneous."

Medical workers drew on discourses of professional ethics and autonomy to explain their record-keeping practices. In a context where abortion is completely criminalized, they carefully distinguished their professional clinical and record-keeping responsibilities from those of law enforcement officials. Mme Guèye, the head midwife at a district hospital in the third study region, explained: "We are not the police. We don't have the right to say that it's an induced abortion if the patient doesn't admit to it. If it's induced, it's not my problem. The obligation of a midwife is to care for the patient."

Mme Camara, a district health official and a midwife in the second study region, believed she had no obligation to report cases of suspected illegal abortion to the police. "It's not what we do," she said. "When there's a suspicion, we do what we can. I have nothing to say to the police, I don't ever do it." For these providers, recording suspected cases of induced abortion as miscarriage represented a strategic decision to maintain professional control over what happened in the maternity ward (Suh 2014).

Some health workers went a step further by suggesting that they deliberately disguised such cases as miscarriage to avoid police involvement at the hospital. "People don't want to point fingers, so they won't put it in the register," Mme Camara explained. "If it's in the register, people will look for it. If we don't ask, people won't look." Additionally, health workers disguised cases to avoid testifying in the prosecution of an illegal abortion. Mme Diouf, the head midwife at Hospital 2, was reluctantly serving as an expert witness at the time of my fieldwork at her facility. She complained that there was too much "back and forth" that "influenced her work." Additionally, she was not compensated for transportation between her home and the courthouse in the regional capital, located approximately 49 kilometers away. "It's so frustrating," Mme Camara explained, "that midwives prefer to do things so that you can't tell it's an induced abortion. We manage problems in the health facility without talking to law enforcement."

Knowledge of what would happen to women who were arrested and prosecuted often motivated health workers to disguise suspected cases of illegal abortion. "We know that these women, if they're denounced to the police, they'll be in prison for two years or more," said Mme Diouf at Hospital 2. "We try to manage the emergency and the rest is not our problem." Mme Sylla, a nurse at Hospital 2, aptly summarized health workers' record-keeping practices when she said: "We are accomplices because we pity these women."

One of the primary indicators of daily PAC, the type of abortion treated, elides critical dimensions of what it means to experience and provide these services. Health workers actively seek out and at times discriminate against women suspected of induced abortion in

Senegalese hospitals. At the same time, they systematically disguise such cases as miscarriage to protect themselves and their patients from the police. These contradictory practices illuminate the precariousness of providing PAC in a context where abortion is legally prohibited and national health authorities have not issued guidelines on managing possible or probable cases of induced abortion. Senegalese health workers conduct the interrogation to demonstrate, in the case of police involvement *during* or *after* treatment, that they attempted to determine abortion type (Suh 2014). Discriminatory practices are thus institutionalized into PAC as health workers must signal that they are competently practicing obstetric care.

Assembled across multiple levels of the health system, PAC statistics suggest not only that women are being treated, but that most have experienced miscarriage rather than induced abortion. They generate a metric portrayal of PAC patients as expectant mothers that differentiates them from women who seek to terminate pregnancy, thereby contributing to a vicious cycle of abortion stigma within and beyond the hospital (Suh 2017). This is how abortion stigma operates -- fueling a sense of difference between women who have abortions and those who have not (Kumar, Hessini, and Mitchell 2009). The desire to avoid discrimination at the hospital may account, at least in part, for why up to 42% of women with abortion complications do not receive medical attention (Sedgh et al. 2015).

CONCLUSION

PAC metrics in Senegal have conveyed pragmatic “truths” (Adams 2005) about the kinds of women treated in government hospitals and the extent to which the intervention cost effectively reduced maternal mortality. For MOH officials and NGO stakeholders, PAC statistics have demonstrated compliance with rights-based ICPD mandates on maternal mortality reduction without engaging in the politically fraught task of advocating abortion law reform (Suh 2017). A similar “ambiguous consensus” around PAC has been observed in Burkina Faso, where the ability to offer “life-saving care” in compliance with global accords on maternal mortality reduction conveniently “evades public debate on abortion” (Storeng and Ouattara 2014: 951-952).

By examining the daily context of care provision in which these indicators are assembled, however, another “world” (Merry 2016) comes into view in which hospitals are places of clinical, administrative, and legal precariousness for women seeking care and health workers who desire to maintain professional control over the maternity ward. PAC metrics obscure the physiological, social, and financial distress of patients who are suspected of illegal abortion. They also mask how health workers struggle to demonstrate due diligence in the provision of obstetric care while risking their professional reputations by disguising suspected cases of illegal abortion as miscarriage. The number of women receiving PAC therefore could represent the failure of the health system to provide information, contraception, and safe abortion care that would preclude the need for the extensive provision of emergency, curative services in the first place.

That the availability of PAC, rather than safe abortion, has been established as a marker of rights-based reproductive governance in developing countries, where practically all (97%)

global unsafe abortion occurs (Ganatra et al. 2017), raises troubling questions as to who matters in national and global reproductive health policy making. Despite claims by MOH officials and NGO personnel that PAC has transformed the treatment of abortion complications into a strictly medical matter, PAC patients in Senegalese hospitals who are suspected of illegal abortion continue to experience stigmatizing treatment, and at times, criminalization. Discriminatory practices (including harassment, threats, and police notification) have been documented worldwide since the integration of the global PAC model into national reproductive health policies (d'Oliveira, Diniz, and Schraiber 2002, Ipas 2016), suggesting the persistent incommensurability between the ICPD's language of reproductive rights and the daily provision of PAC in countries with restrictive abortion laws.

The difficulties experienced by health workers in treating abortion complications further reveal the professional, technological, and clinical limitations of the global PAC model in countries with restrictive abortion laws. In Burkina Faso, health officials' concerns about Misoprostol "encouraging" illegal abortion temporarily blocked its registration as a PAC drug (Storeng and Ouattara 2014). In Senegal, similar anxieties about MVA's capacity to terminate pregnancy have isolated it from the national drug supply system, resulting in the overuse of MVA syringes and the persistence of uterine evacuation methods such as dilation and curettage (D&C) and digital evacuation in hospitals that pose a greater risk of infection and uterine perforation (Suh 2015).

PAC offers a narrow articulation of reproductive rights that hinges on women's survival, thereby foreclosing possibilities for developing interventions that simultaneously strengthen the quality of obstetric care and reduce abortion stigma for women and health providers. Countries like Ethiopia and Mozambique, where advocacy by health experts led to abortion law reform in 2005 and 2014 (respectively) (Durr 2015, Holcombe, Berhe and Cherie 2015), offer hope that public health metrics can be used to catalyze policy changes that cultivate reproductive justice for women and girls in developing countries.

ACKNOWLEDGMENTS

I am very grateful to Mounia El Kotni and Elyse Singer and to three anonymous reviewers for their generous feedback on this article. Research ethics approval for this project was provided by Columbia University's Institutional Review Board and the Comité National d'Ethique pour la Recherche en Santé of the Senegalese Ministry of Health.

FUNDING

This research was funded by the National Institutes of Child Health and Human Development, the Social Science Research Council, and the American Council of Learned Societies.

Author Bio:

Siri Suh is Assistant Professor in Sociology at Brandeis University. Her research bridges the fields of medical anthropology and sociology, population and development studies, and feminist and post-colonial studies of science and technology. She received her PhD in Sociomedical Sciences and MPH from Columbia University and her BA in Sociology from the University of California at Berkeley.

REFERENCES

- Adams V 2005 Saving Tibet? An inquiry into modernity, lies, truths and beliefs. *Medical Anthropology* 24 (1):71–110. [PubMed: 15823898]
- Adams V 2013 Evidence-based global public health: Subjects, profits, erasures In *When People Come First: Critical Studies in Global Health*. Biehl J and Petryna A. eds. Pp. 54–90. Princeton, NJ: Princeton University Press.
- Andaya E 2014 *Conceiving Cuba: Reproduction, Women, and the State in the Post-Soviet Era*. New Brunswick, NJ: Rutgers University Press.
- ANSD. 2012 Enquête Démographique de la Santé à Indicateurs Multiples au Sénégal (EDS-MICS) 2010–2011. Calverton, MD: Agence National de la Statistique et de la Démographie and ICF International.
- Barot S 2017 When anti-abortion ideology turns into foreign policy: How the Global Gag Rule erodes health, ethics and democracy. *Guttmacher Policy Review* 20:73–77.
- Biruk C 2018 *Cooking Data: Culture and Politics in an African Research World*. Durham, NC: Duke University Press.
- Bullough C, Meda N, Makowiecka K, Ronsmans C, Achadi EL, and Hussein J 2005 Current strategies for the reduction of maternal mortality. *BJOG: An International Journal of Obstetrics & Gynaecology* 112(9): 1180–1188. [PubMed: 16101594]
- CEFOREP 1998 *Introduction des Soins Obstetricaux d'Urgence et de la Planification Familiale pour les Patientes Présentant des Complications Liées à un Avortement Incomplet*. Dakar, Sénégal: Centre de Formation et de Recherche en Santé de la Reproduction.
- Connelly M 2008 *Fatal Misconception: The Struggle to Control World Population*. Cambridge, MA: Harvard University Press
- Corbett MR and Turner KL 2003 Essential elements of post-abortion care: Origins, evolution and future directions. *International Family Planning Perspectives* 29 (3):106–111. [PubMed: 14519586]
- Crane BB 1994 The transnational politics of abortion. *Population and Development Review* 20:241–262.
- CRR and UNFPA. 2013 *ICPD and Human Rights: 20 Years of Advancing Reproductive Rights Through UN Treaty Bodies and Legal Reform*. New York: Center for Reproductive Rights.
- Curtis C 2007 Meeting health care needs of women experiencing complications of miscarriage and unsafe abortion: USAID's post-abortion care program. *Journal of Midwifery & Women's Health* 52 (4):368–375.
- d'Oliveira AFPL, Diniz SG, and Schraiber LB 2002 Violence against women in health-care institutions: An emerging problem. *The Lancet* 359 (9318):1681–1685.
- Dieng T, Diadiou M, Diop N, and Faye Y 2008 *Evaluation des Progrès de l'Initiative Africaine Francophone Pour les Soins Après Avortement*. Dakar, Sénégal: CEFORP and FRONTIERS.
- Durr B 2015 Mozambique loosens anti-abortion laws. *Al Jazeera*, 1 26: <https://www.aljazeera.com/indepth/features/2015/01/mozambique-loosens-anti-abortion-laws-150120081246992.html>
- Erdman JN 2011 Access to information on safe abortion: A harm reduction and human rights approach. *Harvard Journal of Law & Gender* 34:413–462.
- Erikson SL 2012 Global health business: The production and performativity of statistics in Sierra Leone and Germany. *Medical Anthropology* 31 (4):367–384. [PubMed: 22746684]
- Ganatra B, Gerds C, Rossier C, Johnson BR, Jr, Tunçalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, and Bearak J 2017 Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet* 390 (10110):2372–2381.
- Gaye A, Diop A, Shoché T, and Winikoff B. 2014 Decentralizing post-abortion care in Senegal with misoprostol for incomplete abortion. *International Journal of Gynecology & Obstetrics* 126 (3): 223–226. [PubMed: 24893962]
- Gerds C, Vohra D, and Ahern J 2013 Measuring unsafe abortion-related mortality: A systematic review of the existing methods. *PLoS ONE* 8 (1): e53346. [PubMed: 23341939]

- Greenhalgh S 1996 The social construction of population science: An intellectual, institutional, and political history of twentieth-century demography. *Comparative Studies in Society and History* 38 (01):26–66.
- Greenslade FC, McKay H, Wolf M, and McLaurin K 1994 Post-abortion care: A women's health initiative to combat unsafe abortion. *Advances in Abortion Care* 4 (1):1–4.
- Huber D, Curtis C, Irani L, Pappa S, and Arrington L 2016 Post-abortion care: 20 years of strong evidence on emergency treatment, family planning, and other programming components. *Global Health: Science and Practice* 4 (3):481–494.
- Iaccino L 2014 Senegal: Women 'strangle or throw babies into septic tank' as abortion law too strict. *International Business Times*, 12 2, 2014.
- Ipas 2016 *Betraying Women, Provider Duty to Report: Legal and Human Rights Implications for Reproductive Health Care in Latin America*. Chapel Hill, NC: Ipas.
- Jaffré Y 2012 Toward an anthropology of public health priorities: Maternal mortality in four obstetric services in West Africa. *Social Anthropology/Anthropologie Sociale* 20 (1):3–18.
- Holcombe SJ, Berhe A, and Cherie A 2015 Personal beliefs and professional responsibilities: Ethiopian midwives' attitudes toward providing abortion services after legal reform. *Studies in Family Planning* 46(1): 73–95. [PubMed: 25753060]
- Kulczycki A 1999 *The Abortion Debate in the World Arena*. New York: Routledge.
- Kumar A, Hessini L, and Mitchell EMH 2009 Conceptualising abortion stigma. *Culture, Health & Sexuality* 11 (6): 625–639.
- L'Observateur. 2012 Avortement clandestin à Tambacounda: une élève de 1ère condamnée à 3 mois fermé. *L'Observateur* (2580).
- Lane SD 1994 From population control to reproductive health: an emerging policy agenda. *Social Science & Medicine* 39 (9):1303–1314. [PubMed: 7801167]
- McKay R 2018 *Medicine in the Meantime: The Work of Care in Mozambique*. Durham, NC: Duke University Press.
- Merry SE 2016 *The Seductions of Quantification: Measuring Human Rights, Gender Violence and Sex Trafficking*. Chicago, IL: University of Chicago Press.
- Morgan L and Roberts E. 2012 Reproductive Governance in Latin America. *Anthropology & Medicine* 19 (2):241–254. [PubMed: 22889430]
- Murphy M 2012 *Seizing the Means of Reproduction: Entanglements of Feminism, Health and Technoscience*. Durham, NC: Duke University Press.
- Oni-Orisan A 2016 The obligation to count: The politics of monitoring maternal mortality in Nigeria In *Metrics: What Counts in Global Health*. Adams V, ed. Pp. 82–104. Durham, NC: Duke University Press.
- PAC Consortium. 2012 Fact Sheet: Results from the 2012 PAC Consortium Mapping Exercise. http://www.pacconsortium.org/downloads/Mapping%20Exercise%20Factsheet_FINAL.pdf
- Packard RM 2016 *A History of Global Health: Interventions into the Lives of Other Peoples*. Baltimore, MD: Johns Hopkins University Press.
- Reiss K, Footman K, Burke E, Diop N, Ndao R, Mane B, Min M, and Ngo T 2017 Knowledge and provision of misoprostol among pharmacy workers in Senegal: A cross sectional study. *BMC Pregnancy and Childbirth* 17 (1):211. [PubMed: 28673342]
- Robinson RS 2015 Population policy in sub-Saharan Africa: A case of both normative and coercive ties to the world polity. *Population Research and Policy Review* 34 (2):201–221.
- Sedgh G, Singh S, Shah IH, Åhman E, Henshaw SK, and Bankole A 2012 Induced abortion: Incidence and trends worldwide from 1995 to 2008. *Obstetrical & Gynecological Survey* 67 (6):341–342.
- Sedgh G, Sylla AH, Philbin J, Keogh S, and Ndiaye S 2015 Estimates of the incidence of induced abortion and consequences of unsafe abortion in Senegal. *International Perspectives on Sexual and Reproductive Health* 41 (1):11–19. [PubMed: 25856233]
- Storeng KT and Béhague DP 2014 "Playing the numbers game": Evidence-based advocacy and the technocratic narrowing of the Safe Motherhood Initiative. *Medical Anthropology Quarterly* 28(2): 260–279. [PubMed: 24599672]

- Storeng KT and Béhague DP 2017 “Guilty until proven innocent”: The contested use of maternal mortality indicators in global health. *Critical Public Health* 27 (2):163–176. [PubMed: 28392630]
- Storeng KT and Ouattara F 2014 The politics of unsafe abortion in Burkina Faso: The interface of local norms and global public health practice. *Global Public Health* 9 (8):946–959. [PubMed: 25132157]
- Suh S 2014 Rewriting abortion: Deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal. *Social Science & Medicine* 108: 20–33. [PubMed: 24608117]
- Suh S 2015 “Right tool,” wrong “job”: Manual vacuum aspiration, PAC and transnational population politics in Senegal. *Social Science & Medicine* 135: 56–66. [PubMed: 25948127]
- Suh S 2017 Accounting for abortion: Accomplishing transnational reproductive governance through PAC in Senegal. *Global Public Health (Special Issue: re-situating abortion: biopolitics, global health and rights in neoliberal times)* 13(6): 662–79. [PubMed: 28287330]
- Sullivan N 2017 Multiple accountabilities: Development cooperation, transparency, and the politics of unknowing in Tanzania’s health sector. *Critical Public Health* 27 (2):193–204.
- Thiam F, Suh S and Moreira P 2006 Scaling up PAC services: Results from Senegal. *Management Sciences for Health Occasional Papers* 5:1–27.
- Tichenor M 2016 The power of data: Global malaria governance and the Senegalese data retention strike In *Metrics: What Counts in Global Health*. Adams V, ed. Pp. 105–124. Durham, NC: Duke University Press.
- Turner KL, Senderowicz L, and Marlow H 2016 Comprehensive Abortion Care Needs and Opportunities in Francophone West Africa: Situational Assessment Results. Chapel Hill, NC: Ipas.
- UNFPA. 1994; Programme of Action of the International Conference on Population and Development; Cairo, Egypt: ICPD.
- USAID 2017 US foreign aid by country, Senegal. The United States Agency for International Development (USAID). https://explorer.usaid.gov/cd/SEN?fiscal_year=2016&implementing_agency_id=1&measure=Disbursements.
- Wendland C 2016 Estimating death: A close reading of maternal mortality metrics in Malawi In *Metrics: What Counts in Global Health*. Adams V, ed. Pp. 57–81. Durham, NC: Duke University Press.
- WHO 2011 Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008. Geneva, Switzerland: World Health Organization.

Media teaser:

Despite offering life-saving obstetric treatment, post-abortion care extends medical and legal surveillance over women patients, and normalizes survival as a state of reproductive health.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript