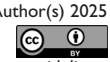
Book Review

EJWS

Book Review: From the movement for liberation of abortion and birth control to abortion pills

European Journal of Women's Studies
1–6



DOI: 10.1177/13505068251317956
journals.sagepub.com/home/ejw


Lucile Ruault, *Le spéculum, la canule et le miroir: Avorter au MLAC, une histoire entre féminisme et médecine*, ENS Éditions: Lyon, 2023; 384 pp., ISBN: 979-10-362-0667-2.[1]
Sydney Calkin, *Abortion pills go global: Reproductive freedom across borders*, University of California Press: Oakland, CA, 2023; 278 pp., ISBN: 978-0-520-39199-4.

Reviewed by: Marlyse Debergh, *Swiss National Science Foundation, University of Fribourg, University of Bern, Switzerland. Associate researcher to the University of Amsterdam, The Netherlands and the University of Geneva, Switzerland*

This book review presents and discusses two fascinating books on abortion care and feminist activism published in 2023: sociologist Lucile Ruault' historical ethnography on the French 'Mouvement de libération de l'avortement et de la contraception' (MLAC) ['Movement for liberation of abortion and birth control'] and geographer Sydney Calkin's study on medical abortion and its global trajectory (from manufacture to transportation across borders). Both books shed light on current challenges for feminists in the struggle for abortion care, looking at different contexts and using different methodologies. I will start by presenting the key strengths of each book, and I will conclude with a discussion about possible future research.

The speculum, the cannula and the mirror by Ruault

At the beginning of her book, Ruault (2023: 17) asks, '[. . .] how, at a time in history when women's control of abortion is within reach, this possibility is so quickly reversed?'. To answer this question, she conducted fieldwork in different parts of France (Aix, Lille, Paris and Lyon) where MLAC activists provided abortions, some until 1984. In addition, Ruault also studied self-help groups in Grenoble, France, in Geneva, Switzerland, and Turin, Italy. Ruault collected data from archives and through 144 oral history interviews.

Her main argument is that the struggle for abortion led to a professional medical monopoly and a process of medicalisation defined as '[. . .] how medicine, as an instance of normalisation of conducts, places under its jurisdiction an increasing number of corporal states and of social issues' (Ruault, 2023:19)[2]. This represents a paradox, because, even if MLAC doctors were critical of medical authority, in the end, the medical profession was reinforced. Ruault's convincing demonstration indeed shows that this monopoly was notably obtained by taking abortion out of the domestic sphere, where it was traditionally practised, into hospital settings. Far from being a straightforward process,

this resulted from political struggles between medicine and feminism, as well as between 'expertise' and 'profane' knowledges and practices.

The book is divided into three parts, each representing a tool of the abortion technique used in MLAC groups. The first part – *Speculum* – looks at the context of the emergence of MLAC. In the 1970s, feminist and Marxist movements had a strong impact on leftist groups and this led to the creation of the 'Groupe information santé' (GIS) [Health Information Group] that linked medicine with working-class struggles. GIS specialised in abortion matters and brought a legitimacy to the so-called 'Karman Method'. American psychologist and clandestine abortion provider, Harvey Karman, argued in favour of the aspiration method that he viewed as painless, fast, cost-effective, and which could be easily learnt. However, Ruault (2023: 81) deconstructs the main narrative surrounding the 'Karman Method' '[which] makes [Karman] a hero in a story which in reality implicated more people in the development of a protocol of aspiration abortion (clandestine abortionists, birth control activists, gynaecologists and feminists since the second 19th century); and which overestimates the innovative character of this method, when French doctors took ownership of it in 1972'. Ruault claims that this method constituted, therefore, a political strategy that eventually led the GIS to create MLAC with members from the 'Mouvement français pour le planning familial' (MFPF) [French movement for family planning] and also with members from the 'Mouvement de libération des femmes' (MLF) [French women's lib] and other leftist groups. As a result, traditional methods of abortion that were used by women during the 19th and 20th centuries progressively lost acceptance in favour of this technique.

The second part – *Canule* – looks at how abortion practise between 1973 and 1975 put doctors and 'profane' abortion providers at odds with each other. Midwives, nurses and caregivers were situated between these two statuses. One of the most interesting aspects of this part is Ruault's analysis of the emotional gendered invisibilised labour, which was accomplished by women called 'intermediates'. Their role was to meet women a few days before the abortion, and to explain the procedure to them. During the abortion, 'intermediates' provided both technical and emotional support. In contrast, many male doctors had few care-giving skills and focused on the technical aspects on the procedure. This gendered division of labour is important for understanding how MLAC was created and how it perpetuated a hierarchy between 'experts' and 'profanes'. Furthermore, the creation of this 'professional expertise on abortion' (Ruault, 2023: 168) would later contribute to the expansion of gynaecology, especially its preventive contraceptive dimension.

The third part – *Mirror* – concentrates on what Ruault calls 'dissident MLAC' activists in Aix, Lille, Lyon and Paris, who continued to provide abortion services after the 1975 'Veil law', which made termination of pregnancy within 10 weeks of gestation legal under certain circumstances. *Mirror* is a very well-chosen notion because it is an activist tool that would be lost in the medicalisation process of abortion. For these dissident groups of women abortion providers who were not doctors, the 1975 law was considered a 'liberalisation' but not a 'liberation' (Ruault, 2023: 205). According to the law, women could only abort during the first 10 weeks of pregnancy, and they had to prove that they were in a 'situation of distress'. Under-age women required parental authorisation, and migrant women needed to prove that they had been living in France for at least 3 months prior to the abortion. At this time, some women also turned to

MLAC after facing some issues within hospital settings because it was cost-free and because they felt better supported.

In this section, Ruault also investigates the profile of these 'profane' abortion providers. Almost half of them shared similar experiences related to sexuality, maternity and non-consensual abortions, as well as facing gender-based discrimination. This created a political unity and sense of a common mission between them. These groups also blurred the lines between technical and care-giving abortion work by developing new techniques to manage pain, such as holding the hand of the woman undergoing the procedure or using humour. After the abortion, 'profanes' organised informal moments such as sharing a meal that would facilitate the transition to 'ordinary life' as one of Ruault's (2023: 273) interviewees explains. Furthermore, the meal also contributed to countering the stereotypical representation of abortion as a traumatising event. Many women also later shared their testimonies about the abortion procedure to other women who were seeking an abortion through the MLAC.

The book ends by arguing that dissident MLAC activists did not, however, completely challenge 'the dominant (biomedical) paradigm of taking charge of fertility' (Ruault, 2023: 314). This is notable, given the fact that they did not make use of the technique of early aspiration. Also called mini-aspiration, this technique '[. . .] consists of emptying the content of the uterus with a syringe connected to a cannula as soon as possible in the case of a period delay, in case of a suspicion of a pregnancy or if one was confirmed' (Ruault, 2023: 194). Moreover, the heteronormative and dominant penetrative sexuality norm (vaginal penetration with ejaculation) was not criticised. According to Ruault (2023: 295), this can be explained by 'a relative homogeneity in the sexual biographies' of MLAC abortion providers.

Abortion pills go global by Calkin

There are usually two pills used in medical abortions. This first pill – Mifespristone – blocks pregnancy hormones. The second one – Misoprostol – is taken 24 to 48 hours after Mifepristone and creates contractions that expel the pregnancy. Taking the combination of the two pills is the most effective procedure, but Misoprostol can also be taken alone. By following the transnational trajectory of these pills, Calkin (2023: 2) asks this very clear but complex question: 'What if abortion were as simple as ordering a small package of [those] pills online and taking them in your home?'. To answer this question, she conducted 80 interviews between 2017 and 2021 with 'activists, abortion providers, campaigners, lawyers, politicians, pill suppliers, and others in the medical abortion and abortion rights movements' (Calkin, 2023: 19) in Northern Ireland, the Republic of Ireland, Poland, India, the United States and at the transnational level.

One of Calkin's convincing key arguments is that medical abortion shifted the landscape of abortion, because it increased the safety of the procedure and its availability, especially for people living in countries with restrictive laws. As she (2023: 26, 34 and 35) explains, because abortion pills travel quite easily due to the speed, ease and anonymity of transnational commerce, they blur the lines between what is illegal and what is legal (determined by political and legal processes), as well as between what is illicit and what is licit (determined by social norms). Therefore, a country can make abortion

pills illegal and at the same time socially accept them. On the other hand, *stigmatisation* can make a legal product illicit even though it is legal.

The book develops four main sub-arguments: (1) feminist activists are pursuing a long-term political objective through medical abortion, which is in itself a short-term solution; (2) because of its fluidity, medical abortion redefines what abortion is and where it should take place; (3) as medical abortion travels alongside other globalised medication, it becomes hard for governments to stop it and (4) because of the last argument and due to the fact that criminalising individuals for obtaining medical abortion is rather unpopular, restriction of abortion is more difficult (Calkin, 2023: 3). The chapters of the book are devoted to specific national contexts.

The first chapter is about India. Most abortions seekers interviewed by Calkin obtained pills that were manufactured in India online at a lower price than pills bought in abortion clinics. One major feminist network, which provides abortion pills that were manufactured in India to people living in other countries, is the Dutch organisation Women on Web (WoW). This part of the book well illustrates the 'fuzziness' of what is considered legal in one country and illegal in another. Global trade is, indeed, characterised by this rule: it is possible to sell prescription-only drugs without a prescription if buyers and sellers are not in the same country.

The second and third chapters examine the context of the United States, arguing that the 2022 decision to overturn the 1973 constitutional right to abortion was part of a long-term attack on women's and gender minorities' reproductive rights. Before 2022, women already self-managed their abortions by using feminist clandestine networks and online pharmacies. Similar to women in France who turned to dissident MLAC to obtain abortions after 1975, seeking abortion pills online can be explained by cost-related reasons, among others, such as legal restriction, the need for discretion or the physical distance from clinics. As Calkin explains, medical abortion has transformed abortion travels because pills are difficult to restrict, contrary to surgical abortions. For instance, a person in Texas can travel to New Mexico, purchase pills at the border and have an online consultation rather than driving further away to a clinic.

The fourth and fifth chapters focus on Poland, where abortion is legal only in cases of rape or if the life of the person who is pregnant is in danger. This almost total ban on abortion has had a profoundly negative impact on access to the procedure, which has become mainly clandestine. As Calkin shows, the Polish State preferred to ignore the demand for abortion and, as a consequence, clandestine medical abortion is now the main option, because it is less expensive and less risky than other methods (such as clandestine surgical abortion at home). Moreover, according to the Polish law, it is not a crime to import abortion pills, but these pills cannot be sold within the national territory. Therefore, 'silence and stigma are key to keeping abortion "illegal but accessible"' (Calkin, 2023: 98).

Chapters 6 and 7 focus on the Republic of Ireland. Abortion was banned by the 8th Amendment that was added to the Irish Constitution in 1983. This resulted in some thousands of people taking 'the boat to England' since abortion was possible there following legalisation in 1967. In 2006, abortion pills were introduced in the Republic of Ireland via WoW and the number of women travelling abroad to clinics started to decline. Calkin also shows how activists developed strategies to make sure that pills arrived, such as

changing the packaging so that it did not look like medication. More broadly, medical abortion activists progressively brought about 'social decriminalisation' in the Republic of Ireland, a concept defined initially by Latin American feminists as '[a process of] changing the social status of abortion among the general public and persuading them that it is unacceptable to jail people for having abortions even while it remains criminalised by the state' (Calkin, 2023: 8). Moreover, social decriminalisation was coupled with another strategy by the feminist organisation WoW, which consisted of publishing in top rank medical journals in order to give legitimacy to their data. Then, after the repeal of the 8th Amendment in 2018, there were debates on the 'regulation, restriction, and medical supervision' (Calkin, 2023: 159) of medical abortion. Calkin (2023: 160) argues that 'the emergence of self-managed abortion with pills cast doubt on the idea that doctors could reliably continue to play that role [of gatekeeper]'. Interestingly, this echoes the debates on medicalisation and the monopoly on abortion that French doctors achieved, as we saw in Ruault's (2023) research.

In the last chapter, Calkin focuses on Northern Ireland. Surprisingly, we learn that even though abortion pills could be mailed there directly to women's houses, contrary to what happened in the Republic of Ireland, there was not a less restrictive environment for self-managed abortion in Northern Ireland. For instance, there were indeed more police investigations against pill users and the people who helped them. Most of them were not activists but 'vulnerable abortion seekers' and the people who helped them, such as the mother of a woman in an abusive relationship who bought abortion pills for her daughter in 2013 (Calkin, 2023: 178–179). In 2019, abortion was decriminalised in Northern Ireland but only up to 12 weeks gestation, and this means that many women continue to travel to England.

Conclusion

Despite their different methodologies, temporal milestones and geographic contexts of data collection, these two inspiring books provide a relevant feminist dialogue. They both convincingly show that feminist struggles for abortion care in contexts where it is forbidden, restrictive or legally permissive but practically obstructed, can constitute a source of inspiration for future abortion politics. In particular, both books question the medical gatekeeping of abortion provision. As Calkin (2023: 198) explains, 'like earlier generations of activists in the reproductive self-help movement, advocates of self-managed abortion do not want to move abortion back into the medical setting where unequal power relations between doctors and patients are pervasive'. Therefore, *medicalisation* even with abortion pills is also a call for *demedicalisation*.

Furthermore, these two books powerfully question the normalisation of the locus of abortion care in hospital settings rather than in the domestic sphere. Ruault shows that dissident MLAC activists practised abortion at home; the same applies to people who self-managed their abortions at home with abortion pills, as we have seen in Calkin's research. Certainly, as Calkin argues, this has some limits as individuals still need medical care for certain situations, but – to a certain extent – the home setting could better normalise and destigmatise abortion.

These two books also open the way to future promising research. First, the links between anarchist movements and abortion practices, both from a historical and sociological perspective, should be explored. As Ruault explains, these links have been overlooked, despite the fact that some activists performed abortion in anarchist circles before becoming members of MLAC. Regarding Calkin's research, I wonder: are there possible links between anarchism and the abortion pill activists she interviewed? Currently, as I learnt at an anarchist gathering in the Netherlands in 2023, there are indeed some anarchist groups that self-manage the production of abortion pills and it would be relevant to conduct ethnographic research on their practices.

Another possibility for future research is to further investigate the 'menstrual extraction' technique that was used in France, as Ruault's book demonstrates, and was also used in the United States by groups such as the Jane Collective (1969–1973) (Calkin, 2023: 68). Has this technique completely disappeared, or is it still used – and how – in some parts of the world or in activist circles?

In a nutshell, these two inspiring books remind us that women and pregnant people will always find a way to get an abortion if they do not want to carry a pregnancy to term, no matter how restrictive their context is (notably by using pills nowadays). This proves that patriarchy will never completely dominate their bodies and that the feminist flame of resistance is still burning.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article: Swiss National Science Foundation (Grant number P5R5PS_225644), and the University of Fribourg, Switzerland.

ORCID iD

Marlyse Debergh https://orcid.org/0000-0003-1867-679X

Notes

1. All quotations from Lucile Ruault's book are translated from French to English by myself.
2. Ruault parafrases Zola (1972: 487-504)

Reference

Zola I (1972) Medicine as an institution of social control. *The Sociological Review* 20(4): 487–504.