Reproduction Policy in the Twenty-First Century

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A Comparative Analysis

Edited by

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Contents

Tables

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NOTE

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1. The case for comparative reproduction policy research

Hannah Zagel

INTRODUCTION

Reproduction policy is an insufficiently defined domain of state regulation. This is because comparative welfare state research has neglected the area of reproductive welfare (O'Connor, 1993; O'Connor et al., 1999), and reproduction research tends to focus on 'ideas' or normative motives in the political processes of policymaking, rather than on the institutional setup. Depictions of welfare state systems and their typical policy configurations, such as in the universal, liberal and conservative models, commonly disregard state intervention in reproduction, and so it is unclear how these regulations align with common typologies and the differential systemic logics which they convey. These are significant shortcomings given the high political topicality of reproduction issues such as abortion, medically assisted reproduction and sexuality education, and the major insights comparative scholarship can produce into institutional drivers and barriers for particular policy goals and instruments. This introduction seeks to advance the understanding of reproduction policy by discussing key conceptual and methodological issues that arise in this regulatory domain, and foreshadows how the contributions in this edited book advance the field.

Viewing welfare states from their functional side of developing policies as responses to social issues of the time (Kaufmann, 2013), the omission of policies regulating reproduction is particularly glaring in the current era. Reproduction, that is, the processes around avoiding, starting, carrying or ending pregnancy and procreation (Almeling, 2015; Ginsburg & Rapp, 1991), has resurfaced as a hotly debated topic in many countries in the 2000s. Visible liberalisation in some aspects of how reproduction is regulated, most notably the diffusion of abortion legalisation since the 1960s, met with the emergence of new social issues.

Sexualities, relationships and family constellations have diversified (Adler & Lenz, 2023; Smock & Schwartz, 2020; Sobotka & Berghammer, 2021), and

this has gone hand in hand with increased visibility of diverse reproductive life courses. Yet, living arrangements that fall outside of the heteronormative ideal still lack recognition. Individual attitudes are often still more accepting of conventional living arrangements (Cheng et al., 2023), and show prejudices against reproductive practices such as abortion (Adamczyk, 2022) and fertility treatment (Szalma & Djundeva, 2020).

In addition, public attention towards reproduction is driven by major technological advancements in reproductive medicine, which promise greater control for individuals over their reproductive life courses, such as with improved contraceptive methods and medically assisted reproduction (MAR). The latter technology, in particular, fuels hopes to overcome infertility (Franklin, 2022), both among individuals with a desire for children as well as among politicians in and outside of governments wishing to increase fertility rates. These new possibilities initiated calls on states to regulate MAR procedures from various stakeholders in different countries (Griessler et al., 2022).

Social movements and non-governmental organisations have also pushed reproduction onto political agendas (De Zordo et al., 2016). In the European context, groups working towards increasing gender equality, in particular, address reproduction. Although gender equality initiatives at the European level have mainly focused on the work–family intersection, commitment to 'sexual and reproductive health' (SRH) is part of the nomenclature used by the EU (European Parliament, 2021). International organisations such as the World Health Organization (WHO), the International Planned Parenthood Federation (IPPFN) and the United Nations Fund for Population Activities (UNFPA) are vocal advocates for improving SRH globally. Not least, in the United States, the issue of reproduction has been extremely re-politicised after the constitutional right to abortion was overturned in 2022, so that commentators believe it would take a central role in the 2024 presidential election. What have these trends meant for how reproduction is regulated?

Historically, states have heavily restricted reproduction, with some of the most widely referenced examples being authoritarian China's one-child policy (White, 2016), Romania's Ceausescu regime (Kligman, 1998) and Nazi Germany's eugenic sterilisation and forced abortion laws (Timm, 2016). In these cases, states used coercive or punitive measures that severely restricted people's possibilities to pursue the reproductive lives they wanted. These interventions primarily targeted and took control over the bodies of women and those able to procreate (Ginsburg & Rapp, 1991; Riley & Chatterjee, 2022).

More recent examples highlight that restrictive state interventions in reproduction are not a thing of the past. Prominent cases are abortion restrictions in Poland and many US states (De Zordo et al., 2016; Halfmann, 2011; Roberti & Wright, 2024), and some EU countries' reluctance to implement the EU Commission's 2015 decision to legalise non-prescription emergency contra-

ceptive pills (European Consortium for Emergency Contraception, 2024). To the contrary, advocacy research and activist groups warn against backtracking on reproductive freedom and justice. In many countries, right-wing populist movements and conservative parties are increasingly attacking hard-won achievements of liberalisation struggles (Cook et al., 2022; Inglot et al., 2022). But democratic governments too have subscribed to a pronatalist paradigm (Kim, 2019; Schultz, 2015). How can we make sense of these approaches?

Social science research discusses state involvement in reproduction from various angles, many of which highlight underlying ideologies. A common perspective is that states regulate reproduction in the course of wider efforts to control their populations, both in countries with authoritarian rule as well as in democracies (Dumbrava, 2017; Riley & Chatterjee, 2022; Schultz, 2015; Timm, 2016). Centring on individuals' experiences, reproduction scholarship hints 'bottom up' at the multiple ways in which the state interferes with reproductive lives (Roberts, 1997). That literature gestures at the significance of states, revealing the often problematic aspects of its involvement, and teaches about the rich and heterogeneous policy landscape but without a policy-lens or particular interest in the policy configurations.

Facilitated by demographic monitoring, and driven by fears of the respective population growing too fast or shrinking too much, governments across the world have sought to install policy measures to avert the realisation of their fears. Recurrently, population control narratives go along with economic objectives (Solinger & Nakachi, 2016), such as maintaining a sizable workforce for sustaining the social security systems or securing economic growth. Nationalism is invoked as a further ideological driver of regulating reproduction. By enabling reproduction for some groups in society while restricting it for others, states define whose procreation is valued and whose is not in order to mould the national citizenry (Heitlinger, 1991; Roseneil et al., 2017). These accounts reveal the ideological endeavours that underpin the regulation of reproduction.

The focus on the close links between ideas and the institutional setup of regulating reproduction is also reflected in the concepts that researchers use. One example is the framework of 'reproductive governance' (Mishtal, 2019; Morgan & Roberts, 2012), which understands governance in a broad (Foucauldian) sense to include state and non-state actors' actions, narratives and moralities. The framework considers how historical constellations of actors shape the dominant ideas underpinning laws and policies regulating reproduction. For example, Morgan and Roberts (2012) discuss how abortion restrictions and IVF-bans in several Latin American countries in the 1990s and 2000s cemented ideational shifts from 'universal human rights' towards the 'rights of the unborn child'. Overall, the literature on how reproduction is

regulated highlights the emergence of new ideas and the recurrence of others, such as pronatalism.

An implication of the strong focus on ideas such as pronatalist approaches or rights-based approaches in much of the previous literature is that, more than in research on most other regulatory domains of the welfare state, policies addressing reproduction tend to be analytically treated as a subcategory to such ideas. In this view, policies appear to primarily follow from higher-order goals, such as preserving a particular image of the nation or upholding moral order. Likely in part due to different research traditions, the focus on normative motives also differs from the way policies such as social policy, family policy and pension policy are conceptualised and analysed in the literature. In these domains, too, policies are assumed to build on underpinning ideas (Béland & Cox, 2013; Hall, 1993; Lewis, 1992; Orloff, 1996), but processes of how policies emerge, what are the policy goals and policy instruments, and how are all of these changing are much more central to the analysis. In the domain of reproduction, policies have rarely been considered as a dimension worthy of study in itself.

Policies and ideas are closely connected, but they may also diverge. Prevailing ideas are crucial for which problems are addressed, which policy goals are formulated and which instruments sought out (Hall, 1993; Pfau-Effinger, 2005; Rothstein & Steinmo, 2002). However, policies can endure and outlive the normative motivations that initiated them or they may be changed or abolished, for example because a competing idea is gaining traction (Princen & 't Hart, 2014). In fact, one reason for explicitly focusing on the policy level rather than primarily on the ideational level is to tell it apart from ideologically driven political narratives, to show where policies and ideas align and to uncover where they might diverge. This is conceptually especially important in the sphere of reproduction where morally loaded issues are omnipresent.

While reproduction policy is not the only institutional factor that shapes individuals' reproductive welfare (Riley & Chatterjee, 2022), it is an important component. Beyond the reproductive rights advocacy benchmarking of international organisations[1] (EPF, 2023; EPF & IPPF, 2021; Ketting & Ivanova, 2018), we still lack a systematic understanding of policy configurations in the regulatory domain of reproduction. Pursuing questions commonly addressed in other policy domains will allow a new understanding of the field: What are the different policy approaches taken to regulate reproduction in different countries and how does reproduction policy change over time? What is the design of different policy instruments and how do they sit beside each other? How do different types of policies regulating reproduction align with or contradict each other in their goals or in their instruments?

In the remainder of this introduction, I will discuss some conceptual considerations and outline a framework for studying reproduction policy as an institutional domain of welfare states. I will then make the case for a comparative approach. I suggest that this approach can make at least two contributions. First, it introduces new analytical tools to reproduction research that will facilitate the identification of recurring configurations, complementarities and contradictions in reproduction policies. Second, the perspective contributes to comparative policy research, which has tended to sideline the domain of reproduction, and allow for cross-domain comparisons and more comprehensive appraisal of welfare production. Third, going forward, this introduction sets the path for an interdisciplinary research agenda of comparative reproduction policy research.

INSTITUTIONAL LOGICS OF REPRODUCTION POLICY

For establishing reproduction policy as a component of the welfare state, this section proposes an analytical framework that applies a bottom-up consideration of state involvement in reproductive processes and builds on the perspective of policies as institutions. Reproduction policy can usefully be defined as the combined formalised statements of governments about what they intend to facilitate or obstruct with regards to reproduction across people's life courses. It is the regulatory domain in which the welfare state makes use of a range of techniques to achieve reproductive welfare. Here, policymakers formulate policy goals, develop policy instruments, and align their goals with underpinning ideas (Hall, 1993; Kaufmann, 2002; Saraceno, 2011). Following institutionalist traditions (Hall & Taylor, 1998; Palier, 2010), I assume that countries historically develop characteristic logics by which they strive to achieve welfare, and in this case: reproductive welfare.

Instruments

Since reproduction has so far largely gone unacknowledged in welfare state research, a bottom-up approach is instructive, which brings unattended policy areas into attention (Michener et al., 2022). Applied to reproductive welfare, the question "what programs a person might encounter in their daily lives while trying to meet basic needs, secure against risk, and improve their circumstances" (ibid., p. 159) returns a number of crucial policy instruments, that is, techniques to attain specific policy goals. Instruments span different fields of regulation, addressing reproduction at various points throughout people's life courses (Zagel, 2024).

Reproduction policy instruments comprise states' involvement in educating about reproduction and how (sex education), measures allowing the planning and control of fertility in the life course (contraception), provisions (if any) for pregnant people who want to end their pregnancy (abortion), and measures to support pregnancies and birth (pregnancy care). In addition, states may provide measures to address the issue of involuntary childlessness, or support other people with parenthood intentions such as same-sex couples (medically assisted reproduction). In each of these fields, states intend to enable or obstruct particular reproductive processes that are considered to be conducive to reproductive welfare, and instruments may be designed in different ways to achieve such goals.

Broadly aligning with institutionalist frameworks applied in comparative welfare state research (Palier, 2010), the institutional setup of reproductive welfare provision may be defined by: rules and criteria governing eligibility and entitlement (who is entitled to access, what are claimant groups?); the types of benefits and services (what is being delivered?); the financial mechanisms (who pays and how?); and the organisation and management of the policy (who decides and who manages?). In the domain of reproduction, this translates into the following:

a. As for eligibility and entitlement, reproduction policy is more permissive if more reproductive procedures and technologies are accessible, and it is more restrictive if these are criminalised or access is limited, for example by age thresholds, marital status or other social conditions.
b. Reproduction policy varies in terms of generosity in providing different reproductive procedures and services, such as comprehensive sex education, contraceptive methods, abortion facilities and information, MAR treatment methods and pregnancy care services.
c. In terms of financial mechanisms, reproduction policy varies in the degree to which reproductive procedures and services are covered by contributions-based or tax-based flat-rate health care systems or have to be paid out-of-pocket.
d. The organisation and management of reproduction policy varies by the level at which it is regulated, such as the national or regional levels, and by whether it is primarily governed by laws, by medical guidelines, and/or by the degree of court involvement.

Comparative research of these principles across countries can reveal countries' specific approaches to combine these principles, the institutional configurations. Future empirical research will show how coherent the institutional configurations of reproduction policy are across different branches of the system. For example, do systems with high permissiveness go together with generosity

in types of services and coverage of costs, while restrictive systems also have limited in-kind and in-cash generosity?

It should be noted that the institutional configurations of reproduction policy will relate to the structure and organisation of health care systems. This is important because health care systems diverge from other policy domains in the welfare state, mainly because of the exceptionally high support of health care in the population, the important role of professions, and because it is driven not only by demand (such as an ageing population) but also by supply (medical knowledge and technology) (Kennedy et al., 2015). Reproduction policy is a special domain in that, on the one hand, it comprises health issues that are comparatively uncontroversial, and on the other hand, it touches on moral issues that are extremely controversial. Reproduction policymakers navigate this uneven terrain with the domain's receptivity for ideological controversy.

Considering institutional configurations of reproduction policy also raises the question of potential complementarities between the different institutional components. Although these have, in the context of macroeconomics, labour market and social policy, primarily been considered in terms of economic objectives (Hall & Soskice, 2001), analogies can be drawn in the domain of reproduction. The question would be, given a particular goal (see next section and Table 1.1), are the institutional components somehow more successful together (Crouch, 2010)? Possible complementarities, for example to achieve the goal of reducing unwanted pregnancies, could be expected between maximising young people's knowledge about sexuality and reproduction through compulsory comprehensive sex education and providing permissive and accessible contraceptives. For the same goal, restrictive sex education may be complementary with comprehensive abortion information and services, and pregnancy care that centres on the pregnant person's welfare.

Ideas and Goals

Ideas and goals for achieving reproductive welfare can vary over time and place. Table 1.1 gives an overview of variations on the analytical dimensions of ideas and goals in the domain of reproduction policy, also considering the role of paradigms as dividing ideas and goals. Prevailing ideas influence the nature of problems that policymakers consider worthy of addressing and provide the motives for policies. Paradigms, as understood here, set the tone for how reproduction is regulated. Table 1.1 divides ideas and goals by two principal paradigms that have been prominent in the domain of reproduction policy, the population control paradigm and the rights-based paradigm. The 1994 International Conference on Population and Development in Cairo marked a watershed moment in paradigm shift towards a rights-based

Table 1.1 Analytical dimensions of reproduction policy and variants

Dimension	Ideas and Goals by Paradigm
Ideas *ideological, normative motives*	Population control: • Economic pronatalism • Nationalist pronatalism • Eugenic (racist) pronatalism • Antinatalism Rights-based: • Justice • Human rights • Gender equality • Choice • Protection of unborn life
Policy goals *orientations regarding policy outcomes*	Population control: • Fostering population health • Increasing pregnancies • Reducing pregnancies • Increasing deliveries/births Rights-based: • Supporting sexual development • Reducing unwanted pregnancies • Increasing reproductive autonomy • Improving (women's sexual and reproductive) health

Note: Lists examples of ideas and goals of reproduction policy by population control and rights-based paradigms and gives examples for policy instruments.

perspective (Shalev, 2000), which has since then influenced reproduction policymaking. While I assume strong links between paradigms, goals and instruments, paradigms are not deterministic. The loose coupling is illustrated by the stark differences between and even opposing character of some of the ideas and goals within the realm of each paradigm as suggested in Table 1.1.

It is well known from previous research that ideas around reproduction are commonly implicated with norms about gender relations, sexuality, bodily autonomy, and the beginning of life, but also with perceptions of the 'national body', the population (Marx Ferree, 2021; Roseneil et al., 2017; Solinger &

Table 1.2 Policy instruments dimension

Policy instruments *techniques to attain goals*
Examples for increasing the autonomy goal following the eligibility and entitlement principle: comprehensive sexuality education as compulsory school subject, provision of free contraceptives without prescription, abortion on request, medically assisted reproductive treatment to singles, regular routine examinations during pregnancy

Nakachi, 2016). These themes can be seen as cross-cutting to the analytical dimensions. In general, due to the morally charged nature of some of these issues, ideas are often presented in a fierce way in the political arena, especially for abortion and MAR (Engeli et al., 2013). Overall, the literature documents an ideational shift from 'population control' to more 'rights-based' since the 1994 Cairo International Conference on Population and Development, which structures the ideas and goals governments tend to pursue with reproduction policy.

Historical examples show a strong orientation towards pronatalist ideas of many countries in the first half of the twentieth century (Solinger & Nakachi, 2016; Timm, 2016). Pronatalism can conceptually be differentiated further by distinguishing more culturalist from more economic motives (see also Szalma & Sipos in this book). A competing idea is the human rights motive, which has, in extension of the reproductive rights idea and alongside the gender equality motive, underpinned sexual and reproductive health initiatives of international organisations since the 1994 Cairo conference (see Conlon in this book).

More recently, the justice motive has become more visible, although it still has a marginal role for policymakers internationally. It emerges from the reproductive justice movement, which criticises the individual autonomy-focused rhetoric and activism of the 'choice' framework and offers instead a more expansive notion of reproductive advocacy rooted in a human rights framework, encompassing not only the right to avoid having a child, but the right to have a child, and to parent one's children in safe communities (Ross, 2006). Originating in the US, the reproductive justice framework is increasingly used in the academic and legal spheres (Luna & Luker, 2013).

A normative idea diametrically opposed to reproductive justice is the 'protection of unborn life' motive, which is championed by so-called pro-life organisations. This motive is an illustrative case for looking at potential competition of ideas or at contradictions between them (see Kaminska in this book). It is at odds with the gender equality and the justice motives, but can be aligned with pronatalist motives. Although contradicting the intention of the original human rights logic, the protection-of-unborn-life motive has discursively been integrated with human rights narratives by 'pro-life' groups, with some impact on policy, for example in Latin America and in the United States (Morgan & Roberts, 2012; Penovic in this book).

Policy goals tend to be formulated and policy instruments to be designed in accordance with the dominant ideas. However, these links are not deterministic and policy change is possible even without a change in ideas (Hall, 1993). There may also be different competing ideas underpinning one policy domain in the same period (Princen & 't Hart, 2014). Likewise, and similar to other policy domains (Mätzke & Ostner, 2010; Palier, 2005), reproduction policy can comprise different policy goals, which are sometimes pursued at the same

time. This book aims to provide further insights into the links between ideas, goals and instruments in the domain of reproduction policy.

COMPARISON AS ADVANTAGE

In addition to the proposed framework for establishing reproduction policy as a domain of the welfare state worthy of study, this introduction promotes a comparative approach. Mapping the institutional configurations of reproduction policy and disentangling links between ideas, goals and instruments requires systematic analysis of a range of issues including the policy landscape, policy variations and innovations, policy trade-offs and interactions between policies, policy coherence, policy conflict and interdependencies, policy change, policy drivers, as well as policy effects. Although many of these issues are for future research to explore, several are addressed by chapters in this book.

Due to the breadth in disciplines, approaches and internationality of the contributions, the authors of this book's chapters did not follow one coherent conceptual framework. What unites the chapters is, in fact, the decidedly comparative endeavour and the focus on the policy level of how reproduction is regulated across many parts of the world today. Each chapter sets out a clear conceptualisation of what is the subject of comparison and a solid argument for case selection as required by a comparative approach. Finally, each chapter explicitly considers how the comparison advances our understanding of its particular area of reproduction policy.

So far, knowledge on state regulation of reproduction heavily relies on (historical) case study research. Comparative research can add to these rich accounts. Of the reproduction policy fields, abortion policy may be considered an exception in that there is a dynamic literature using multi-country cross-country comparisons (Fernández, 2021; Johnson et al., 2018; Sommer & Forman-Rabinovici, 2021). A growing number of available abortion policy datasets, such as the Global Abortion Policy Database (Johnson et al., 2017), makes quantitative multi-country studies possible. However, these accounts commonly consider abortion separately from other reproduction issues and rarely link it to broader questions of regulating reproduction (but see Vayo, 2022).

Comparative research is a multidisciplinary field, includes a variety of qualitative and quantitative methods, and relies on a diversity of data sources and materials (Della Porta & Keating, 2008; Peters & Fontaine, 2020). This book advocates a pluralist methodological view to comparative policy research generally and comparative reproduction policy research in particular. Rather than pushing for a specific methodological approach, the book suggests that

different types of comparison are useful for analysing the domain of reproduction policy.

Different types of comparison have features that are suitable for different kinds of research questions and analytical goals around the nature of reproduction policy as a policy domain. First, comparing the same policy across countries is particularly useful for identifying variations in ideas, goals and instruments, explaining policy change and evaluating policy effects. It is also a good descriptive exercise to learn from other contexts, especially in a field such as reproduction policy that is arguably understudied. Many chapters of this book are cross-country comparative, some comparing across several countries (Conlon, Gietel-Basten, Ivanova et al.), others comparing two countries (Mahmoud, Tamakoshi).

Comparing different policies within the same country can also be a favoured approach. It is particularly useful for understanding the broader policy landscape, identifying policy trade-offs and interactions, locating policy biases such as how some social groups are catered for and others are excluded, and analysing coherence or conflict in goals. It is also conducive to understanding policy interdependencies. Three chapters in this book compare policies within one country (Kaminska, Khan, Szalma & Sipos), while one chapter compares within country across federal states (Kluge) and one chapter compares cross-border politics in one policy field (Penovic).

CONTRIBUTIONS TO THIS BOOK

This book is structured into four parts framed by an introduction and a discussion chapter. Part I includes two chapters that each focus on one reproduction policy field and one country, but use comparison to unravel a particular aspect of the organisation and management of the respective reproduction policy field in focus. In Chapter 2, Tania Penovic traces the US anti-abortion movement's cross-border efforts to drive a backlash to abortion rights within the international regulatory framework, looking in particular at influences on Australian policymaking. The chapter illuminates how powerful political networks originating in the US context actively sought to determine abortion bans as policy instrument domestically and internationally by spreading the idea of the 'protection of unborn life' rooted in Catholic doctrine. In light of the above framework, this case also illustrates the glaring lack of a specific policy goal that goes beyond the normative motivation. In Chapter 3, Anna E. Kluge also considers the distribution of power between actors involved in reproduction policy by introducing the concept of knowledge responsibility in sexuality education. Applying it comparatively to Germany's federal states, she shows a high diffusion of responsibility and reveals the complex organisation and management structure in the field of sexuality education. In this environment,

the links between particular ideas, policy goals and the translation into instruments seem more processual than deterministic.

Part II comprises three chapters that compare single policy fields across multiple countries. In Chapter 4, Stuart Gietel-Basten compares five Asian countries' approaches to promoting ideal family sizes with information, education and communication programmes. The chapter discusses the possible link between such programmes' promotion of small families and current (low) fertility preferences, alerting us to the possibility that new goals and policy instruments may be working against the force of previous ones that are still unfolding in society. In Chapter 5, Olena Ivanova, Elizabeth Kemigisha, Mariana Cruz Murueta and Rayan Korri reveal challenges to implementing comprehensive sexuality education (CSE) in contexts normatively opposed to ideas underpinning CSE, comparing Lebanon, Mexico and Uganda. The chapter carves out particular policy instruments that could help to reduce conflict over ideas in sexuality policymaking. In Chapter 6, by comparing abortion policy in high-income countries against a WHO health care standard, Catherine Conlon shows the persistence in exceptionalism of this policy field in countries expected to adhere to human rights standards, as well as the different approaches to over-regulate abortion. As Ivanova et al. do for sexuality education, Conlon's chapter identifies gaps between internationally agreed ideas and countries' reproduction policy instruments.

Part III features three chapters that compare different types of reproduction policies within single countries. In Chapter 7, Rohan Khan introduces a research agenda to study the links between public attitudes and reproduction policy by drawing on insights from other domains of the welfare state. His chapter provides the conceptual toolkit to trace the effects of ideas on reproduction policy instruments and vice versa. In Chapter 8, Ivett Szalma and Alexandra Sipos look at the evolution of the idea of pronatalism in Hungary, and analyse how reproduction policy instruments reflect variants of this orientation. In Chapter 9, Monika Ewa Kaminska looks at changes in reproduction policy within the context of post-communist transition in Poland. She reveals contradictions both between different reproduction policies as well as between policies and the goals of pronatalism stated by the conservative political and religious actors.

Part IV comprises two chapters that each consider the interactions between policies in two countries. In Chapter 10, Mio Tamakoshi contrasts how Japan and Italy regulate multifetal pregnancy reduction (MFPR), a medical case in which abortion policy and MAR policy both apply. The chapter highlights how the evolution of reproduction policy instruments (MFPR) may depend on ideas inscribed in another instrument (abortion), such as about the status of the foetus vs. the pregnant person's autonomy. In Chapter 11, Zaina Mahmoud compares how, in California and the UK, surrogacy regulation interacts with

kinship law. She shows that the instruments in the two jurisdictions differ but that they uphold similar ideas about motherhood and family.

Finally, in the Discussion chapter, Hannah Zagel and Rene Almeling reflect on the contributions of this edited book to the study of reproduction scholarship broadly and to reproduction policy research in particular. They invite thinking about the implications of viewing reproduction policy as a cohesive policy field and embark on thought experiments regarding what reproduction policy might look like if it were to support reproductive autonomy, as well as how different welfare systems would likely implement this goal.

The chapters in this edited book offer diverse reflections of scholars from different disciplinary and geographic spheres on one of the most hotly debated issues of state regulation to date. Together, the chapters reflect an impressive range over the scholarly terrain of what I have here called comparative reproduction policy research. Each chapter presents an original analysis of a particular aspect of reproduction policy while developing new analytic tools for future research. I expect comparative reproduction policy research to become a growing field in the years to come, and hope this edited book will spark new questions and inspire empirical research among welfare state scholars and beyond. My hope is, too, that the book contributes to intellectual work that informs political thinking towards creating policy landscapes supportive of reproductive welfare for all.

NOTE

1. Advocacy research may be considered an exception, but the goal of that research is to reveal shortcomings in how countries currently deliver on what is often called "sexual and reproductive health and rights" (SRHR) (Starrs et al., 2018) – a concept that comprises both state regulation ('rights') and outcomes (health).

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PART I

Comparing within and across borders

2. Exporting the American playbook: the international reach of the US anti-abortion movement

Tania Penovic

INTRODUCTION

In the past three decades, the liberalisation of abortion laws in more than 50 countries has been driven by cross-national influences. These include advances in international political consensus on reproductive rights and the recognition by international bodies that access to safe and lawful abortion is a corollary of compliance with core human rights norms. But unlike other liberal democracies, the United States (US) has charted a trajectory of regression, with abortion bans now in place in large swathes of the nation.

This chapter seeks to explore the vulnerability of reproduction policy insofar as it concerns abortion to the national and cross-national influence of anti-abortion movements. It will do so by examining the reach of the US anti-abortion movement (hereafter: the US movement) which has positioned itself as a global leader in the backlash against liberalisation, looking at how it has worked domestically to reshape the US regulatory framework and expanded its aspirations to the international regulatory domain and domestic reproduction policy of other countries.

Identifying itself as a human rights movement (Williams, 2023), the US movement has promulgated an understanding of human rights grounded in natural law, opposing contraception and seeking to protect foetal life from the point of conception and the 'God-given natural family' comprising a heterosexual, married, nuclear unit (Buss & Herman, 2003, p. 8). The disjunction between this understanding of human rights and the work of international human rights bodies has galvanised the US movement's efforts to bring international law into line with its own understanding.

After locating abortion within the international regulatory framework, the chapter will outline the work of the US movement to undermine abortion access domestically and internationally. It will conclude with an examina-

tion of anti-abortion activity in Australia as a case study of the movement's cross-border influence.

ABORTION IN THE INTERNATIONAL REGULATORY DOMAIN

At the international level, reproductive rights were recognised within the broader rubric of human rights at a series of United Nations (UN) sponsored conferences in the 1990s. Landmark statements of political consensus emanating from the World Conference on Human Rights held in Vienna in 1993, the International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women in Beijing in 1995 recognised the right to reproductive healthcare as integral to the realisation of fundamental human rights.

In line with the advancement of international political consensus, access to comprehensive abortion services has been recognised by the World Health Organization (see, for example, World Health Organization, 2022) and UN human rights bodies as a corollary of compliance with international human rights norms. For example, the UN Working Group on Discrimination against Women and Girls described abortion restrictions as 'inherently discriminatory', 'a violation of human rights' and 'one of the most damaging ways of instrumentalizing and politicizing women's bodies and lives' (UN General Assembly. Working Group on Discrimination against Women in Law and in Practice & UN Human Rights Council Secretariat, 2016, para. 79). The UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) which supervises the implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has described 'violations of women's sexual and reproductive health and rights', including 'criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, [and] forced continuation of pregnancy' as 'forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment' (CEDAW Committee, 2017, para. 18). The work of UN human rights bodies has been echoed at the regional level (also see Chapter 6, by Conlon, in this book). For example, the Inter-American Court of Human Rights has found that laws banning abortion have facilitated structural discrimination and gender-based violence in breach of the American Convention on Human Rights (Inter-American Court of Human Rights, 2021).

The normative advancement of reproductive rights has influenced a liberalising trend in domestic regulatory frameworks of democracies worldwide. The US meanwhile has charted a trajectory of regression. Far-ranging restrictions, including total abortion bans, now operate in large swathes of the nation

since the US Supreme Court decision in *Dobbs v Jackson Women's Health Organization* (2022) which overturned *Roe v. Wade* (1973), the landmark authority that conferred federal constitutional protection on the right to obtain an abortion prior to the point of foetal viability.

UN human rights experts denounced the court's decision for showing complete disregard for human rights norms and 'strip[ping] women and girls … of legal protections necessary to ensure their ability to live with dignity' (UN Office of the High Commissioner for Human Rights, 2022a) while the then UN High Commissioner for Human Rights, Michelle Bachelet, described it as a 'huge blow to women's human rights and gender equality' (UN Office of the High Commissioner for Human Rights, 2022b).

The situation decried by human rights experts represents the realisation of a longstanding aspiration of the US movement; a movement that has not confined itself to the domestic sphere. Its broader agenda has encompassed the reshaping of international law and the exportation of money, strategies and discourses to other countries to facilitate abortion bans. After outlining its influence on the US regulatory framework, the following section will examine the movement's efforts to undermine abortion beyond the US.

THE US MOVEMENT

The US Movement in the Domestic Regulatory Arena

The US movement, which worked for decades to secure *Roe*'s fall, comprises myriad organisations, actors and networks within the religious right. Having emerged in the 1960s as a largely Roman Catholic movement, its membership diversified during the 1970s when political strategists recognised the potential for opposition to abortion to mobilise evangelical Protestants and 'enlist them in a conservative political coalition' aligned with the Republican Party (Williams, 2023, p. 249). The movement now comprises individuals from diverse backgrounds but retains a strong association with branches of Christianity that 'share a perspective on the sacredness of human life from the moment of conception to natural death that closely corresponds to the Catholic theological perspective' and accords with an understanding of human rights grounded in natural law (Williams, 2023, p. 243).

Some sectors of the movement have taken action to stop abortions by 'counselling' those contemplating abortion with a view to persuading them to continue their pregnancies. Anti-abortion crisis pregnancy centres have been established by the movement to provide this form of 'counselling' and now far outnumber abortion clinics in the US (Williams, 2023). Other sectors of the movement have focused their efforts on the space outside abortion clinics. For example, Brooklyn-founded Helpers of God's Precious Infants (hereafter:

HoGPI) and Texas-founded 40 Days for Life conduct prayer vigils and provide what they characterise as 'sidewalk counselling' outside clinics to stop abortions. Other groups engaged in anti-abortion conduct outside clinics include Operation Rescue, known for its illegal and confrontational clinic blockades. A small sector of the movement has utilised violence as a strategy for stopping abortions, such as clinic bombings and attacks on staff, including the murder of abortion providers (Williams, 2023; Ziegler, 2020).

Other sectors of the movement have focused on effecting legal change. After efforts to amend the Constitution's text failed in the early 1980s (Ziegler, 2020), the movement became increasingly enmeshed within the Republican Party, shaping its policy, strategy and priorities. These included the elevation of political candidates and judges willing to advance the anti-abortion agenda. The election of political candidates opposed to abortion facilitated the passage of hundreds of state laws, many based on model legislation provided by the US movement. These include onerous, costly and unnecessary requirements imposed on providers, mandatory conditions (such as waiting periods) which delay and undermine access to time-critical healthcare, the defunding of abortion providers and banning of abortion after a specified gestational period. Over the past two decades, efforts to ban late gestation abortion became a focus for galvanising support and redefining the legal parameters of abortion (Flowers, 2020). In the judicial context, the movement has had substantial influence in facilitating the appointment of judges willing to overturn *Roe* (Ziegler, 2020). The court's dismantlement of the constitutional framework established in *Roe* has facilitated the imposition of far-ranging restrictions, including abortion bans, in a number of US states.

While *Roe*'s reversal was a longstanding aspiration of the movement, its end goal has been the recognition of foetal personhood and conferral of fundamental human rights on the foetus from the point of conception (Ziegler, 2023). There is a clear disjunction between the advancement of reproductive rights in the international regulatory domain and the movement's understanding of human rights grounded in natural law. This has galvanised the movement's efforts to bring international law into line with its own understanding.

Exporting Influence: The US Movement in the International Arena

The US movement has pressed the US to remain a non-signatory to human rights treaties, portrayed the UN as a threat to US sovereignty and framed the pro-choice approach advanced by UN organs as a threat to the 'natural family' in 'pursuit of a godless world' (Buss & Herman, 2003, p. 38). But the opportunity to stall the normative advancement of reproductive rights saw anti-abortion groups become actively engaged in UN negotiations since the 1990s (Buss, 2004). US anti-abortion groups have formed alliances with the

Holy See and like-minded nations and positioned themselves as leaders in the global backlash to the 'international feminist agenda' (Buss & Herman, 2003, p. 8). Some anti-abortion groups, including the New York-based Centre for Family and Human Rights, or C-Fam, have obtained official accreditation as civil society organisations within UN structures. Formerly known as the Catholic Family and Human Rights Institute, C-Fam has engaged actively in UN social policy debate since its inception in 1997.

The politicisation of abortion and growing interdependence between the US movement and Republican Party have enabled anti-abortion groups to advance their international agenda. Ziegler has observed that former US President Donald Trump understood the movement's electoral power and was more willing to advance its aspirations than any previous Republican President (Ziegler, 2022). Mike Pompeo, Secretary of State in the Trump administration declared that 'like no other president in history, Trump has mounted an unprecedented defence of the unborn abroad' (US Department of State, 2020b). The administration's efforts to advance the movement's extraterritorial aspirations included the reinstatement and dramatic expansion of the Global Gag Rule (which barred aid funding to organisations providing abortions or abortion-related services), the withdrawal of funding to the Organization of American States over its abortion advocacy (Morgan, 2023), and the power it gave anti-abortion groups to direct its engagement in international political negotiations.

While representatives of the US movement accompanied Former President George W. Bush's administration to UN meetings (Buss & Herman, 2003), the involvement of anti-abortion groups in international negotiations reached a high point under Trump's presidency. C-Fam not only participated in official US delegations to international political negotiations (US Department of State, 2017), but is reported to have provided line-by-line instructions and overridden the authority of state department officials (Borger & Ford, 2019). Under C-Fam's direction, the US opposed the use of language which could facilitate abortion access from international consensus documents; this included references to 'reproductive and sexual health' in a consensus document at the UN Commission on Population and Development which previous US administrations had participated in drafting (Borger & Ford, 2019) and all references to reproductive health, including abortion, in the UN's humanitarian response plan to COVID-19 (Atwood, 2020). The threat of invoking the US veto power secured the deletion of 'sexual and reproductive health' and 'health services' from a Security Council resolution on sexual violence in conflict and post-conflict situations (Kosinksi & Watkins, 2019).

Coalition-building and Re-engineering Rights

Working with the US movement, Trump's administration sought to redefine international law. As its Secretary of State, Mike Pompeo established a Commission on Unalienable Rights to 'provide fresh thinking about human rights discourse where such discourse has departed from our nation's founding principles of natural law and natural rights' (US Department of State, 2019). The Commission's report privileged the rights to private property and religious liberty and dismissed sexual and reproductive rights as 'divisive social and political controversies' (US Department of State, 2020a).

The Trump administration's efforts to redefine international law extended to the international regulatory domain and included coalition-building with like-minded states operating under the mantle of the 'Group of Friends of the Family' to drive a new international anti-abortion consensus. Working with groups such as C-Fam and The Heritage Foundation, the administration co-sponsored and drove the drafting and adoption of the 'Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family' which

> [reaffirms] that there is no international right to abortion, nor any international obligation on the part of States to finance or facilitate abortion, consistent with the long-standing international consensus that each nation has the sovereign right to implement programs and activities consistent with their laws and policies. (Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, 2020)

Like Pompeo's Commission on Unalienable Rights, the Declaration denies an international right to abortion on the basis of its absence from the text of foundational instruments.

Adopting UN imagery and the structures and mechanisms of international law, the declaration was presented at its launch with the words 'Geneva Consensus Declaration 2020' encircled by olive branches, resembling the UN flag. A further UN association was evoked by the inclusion of Geneva, home to key UN bodies, in its title. The Declaration was not UN-sponsored and not adopted in Geneva, but at a ceremony in Washington and streamed online two weeks before the 2020 US election. Although it purports to represent international consensus, finding consensus proved a challenge. Alongside the US, its 31 original signatories (including Sudan, Belarus and Iraq) are not renowned for their commitment to its titular promise of promoting women's rights.

The Declaration has been promulgated in submissions to bodies such as the UN Human Rights Council (C-Fam, 2022) and 'side events' at fora such as the UN Commission on the Status of Women where it has been used to repudiate the work of human rights bodies and celebrate abortion bans as a manifestation of national sovereignty (UN Web TV, 2023). Although the Biden administra-

tion withdrew US support, this non-binding Declaration with few signatories continues to be utilised as if it were a binding instrument of international law, operating as what Furgalska and de Londras (2022, p. 301) describe as an attempt to create an instrument of 'international human rights counter-law' epitomising 'the kind of distorting lawfare' that seeks to generate an 'alternative touchstone in international human rights law to which anti-abortion advocates can continue to refer *as if it were authority*' (Furgalska and de Londras, 2022, p. 300, emphasis in original). Such references by anti-abortion advocates include *amicus curiae* submissions to the US Supreme Court in *Dobbs* which cite the Declaration as authority for the assertion that 'the consensus of human rights law and State practice confirms the absence of any global right to abortion, and the recognition that unborn children are rights-holders worthy of State protection' (US Supreme Court, 2021).

EXPORTING INFLUENCE

Beyond the US, the Geneva Consensus Declaration has been invoked as a statement of authority in other nations (see, for example, European Centre for Law and Justice, 2021) where US anti-abortion groups have devoted significant resources in exporting their strategies and agenda.

An investigation by openDemocracy reveals that US religious right groups, many linked to the Trump administration, provided at least $US280 million in funding anti-abortion and anti-LGBTIQ campaigns worldwide (Archer & Provost, 2020). These groups include the US-based Alliance Defending Freedom which has established a strong European presence over the past 15 years (Global Project Against Hate and Extremism, 2021; Provost et al., 2020). Its international arm, Alliance Defending Freedom International has offices in Geneva, Strasbourg, London and Brussels and works to influence key institutions, including UN organs, the European Parliament and Council of Europe (Global Project Against Hate and Extremism, 2021). Alliance Defending Freedom International has worked alongside other US-backed groups, including the European Centre on Law and Justice and far-right European groups, including Poland's Ordo Iuris (Martuscelli, 2022; Giuffrida & Garamvolgyi, 2022). It has intervened in proceedings in Poland's Constitutional Tribunal and the European Court of Human Rights and helped achieve Poland's near-total abortion ban (European Parliamentary Forum for Sexual and Reproductive Rights, 2021; Banerjee, 2021).

The US movement stands as a beacon of inspiration to anti-abortion actors. Its success in working over decades to restrict abortion and secure the fall of *Roe* has emboldened ani-abortion actors worldwide. The following portion of this chapter considers anti-abortionism in Australia as a case study of the movement's cross-border influence.

Australia's Regulatory Landscape

Australia would appear an unlikely site for the importation of US anti-abortion strategy. Australia's states and territories, which regulate abortion, have charted a trajectory of decriminalisation over the past two decades, dispensing with laws built on the template of the United Kingdom's *Offences Against the Person Act 1861*. In the past decade, all states and territories have enacted safe access zone legislation to facilitate safe and unencumbered access to abortion by prohibiting behaviour such as harassment, intimidation and access obstruction within a specified radius around clinics.

Australia's federal government regulates pharmaceuticals, provides healthcare funding and is responsible for foreign aid and engagement with international bodies with respect to its performance of treaty obligations. It has committed to advancing universal access to reproductive healthcare and, in reporting to the CEDAW Committee on its implementation of CEDAW, advised that 'Australia actively champions and maintains a long-standing commitment to the promotion and protection of sexual and reproductive health and rights as a global and domestic health priority, and as essential to the achievement of universal health coverage' (CEDAW Committee, 2021, para. 25). Moreover, in its foreign aid program, Australia explicitly seeks to strengthen access to sexual and reproductive health and rights (Department of Foreign Affairs and Trade, 2016).

While Australia's regulatory framework appears far removed from the US legislative and policy environment, efforts to erode reforms and undermine access have been made over the past five decades by a local anti-abortion movement which has sought guidance and inspiration from its US counterpart.

Anti-abortionism in Australia

Australia's anti-abortion movement, which is far smaller and less entrenched in the body politic than its US counterpart, emerged in the late 1960s contemporaneously with – and in opposition to – the movement to liberalise abortion. The nascent anti-abortion movement was largely comprised of observant Catholics, although some of its adherents eschewed displays of religious affiliation and framed their opposition to abortion on human rights grounds (Hedley, 2017). State-based 'Right to Life' organisations were formed in the early 1970s and campaigned together against proposed law reforms guided by the example of the US National Right to Life Committee (Hedley, 2017, p. 90). The coalition of state groups collapsed in 1979 due to animosity flowing from differences of approach, with some preferring tactics such as political lobbying while others opted for a more confrontational approach, including obstruction of access to clinics (Coleman, 1988).

Notwithstanding differences in approach, members of Australia's anti-abortion movement have looked to the larger and more established US movement for strategic guidance and inspiration since the 1970s (Wyatt & Hughes, 2009). Right to Life Australia was established in 1979 on advice from a visiting US anti-abortionist (Hedley, 2017). By the late 1980s, Australia's anti-abortion movement was observed to have borrowed 'rhetorically, strategically and, to an extent tactically' from the US movement (Coleman, 1988, p. 89) and had sponsored speaking tours to Australia by prominent US figures, including Henry Hyde (sponsor of the Hyde Amendment, barring US federal funding for abortion), televangelist Jerry Falwell and conservative activists Phyllis Schlafly and Paul Weyrich (Coleman, 1988, p. 89). An Australian branch of US anti-abortion behemoth Human Life International was established after a visit from its founder, Father Paul Marx in 1992 (Hedley, 2017).

Even some of the US movement's more extreme elements have afforded inspiration to Australian anti-abortionists. Operation Rescue became the catalyst for clinic 'rescues' conducted by Right to Life Australia during the 1980s (Hedley, 2017, pp. 123–129). When nine anti-abortionists were charged with offences associated with a clinic blockade in 1990, an 'Operation Rescue Appeal' was launched to fund their legal costs (Hedley, 2017, p. 127). In 2015, a national speaking tour for Operation Rescue President Troy Newman (sponsored by Right to Life Australia and Operation Rescue) was cancelled after Newman's visa was revoked on public safety grounds due to his writings which questioned why abortion providers are not executed (Glenday, 2015).

The spectre of legal costs brought an end to clinic rescues (Hedley, 2017), but Australian anti-abortionists found inspiration in other elements of US anti-abortionism. The Australian branch of Human Life International (now known as Family Life International) helped establish local chapters of HoGPI and 40 Days for Life and their followers became a regular presence outside Australian clinics, engaging in conduct such as entrance obstruction, distribution of medical misinformation, photography and targeted harassment of patients and staff (Sifris et al., 2020). After a man who had previously stood outside with HoGPI entered Melbourne's Fertility Control Clinic on 16 July 2001 planning a massacre, and murdered its security guard, HoGPI representatives echoed discourses utilised by the US movement, observing that 'violence begets violence. It's hardly surprising that abortion leads to acts of violence' (Allanson, 2021, p. 39). The murder, and unabated picketing that continued in its aftermath galvanised support for safe access zone legislation which now operates nationwide to distance anti-abortionists from clinics.

Although safe access zones have stopped the targeted harassment of patients and staff outside clinics, other elements of US anti-abortionism are now entrenched in Australia. The March for Life, which originated in Washington, DC in the wake of the *Roe* decision has become an annual event in Australian

capital cities. Narratives utilised by the US movement have been replicated by Australian anti-abortionists inspired by its example. For example, the Australian Christian Lobby, established in 1995 to influence Australia's political landscape by advancing a 'Christian perspective on social and political issues' echoed the triumphal pronouncements of the US movement following *Roe*'s reversal (see, for example, Grondelski, 2022), declaring 'This is just the beginning. Now is the time to join the pro-life movement and get active' with a 'new, young and pro-life generation… rising up!' (Australian Christian Lobby, 2022). The impact of US anti-abortion activity on Australian law and policy is considered below.

US Influence on Australian Law and Policy

The hyper-partisanship surrounding abortion in the US has not been replicated in Australia (Pringle, 2012) and members of both major political parties have remained free to vote on abortion laws in accordance with their conscience. But as a global hegemon which shares its language and some common historical and legal traditions with Australia, the US is a ready source of influence. During the socially conservative Coalition government led by John Howard from 1996 to 2007, US-style anti-abortion rhetoric emerged in Australian politics (Baird, 2013) and foreign policy guidelines modelled on the Global Gag Rule were introduced to bar Australian aid spending on activities involving abortion training, services and counselling. Successful calls to abandon these foreign aid restrictions were galvanised by the Obama administration's lifting of the Global Gag Rule (Grattan, 2009) and the Trump administration's reinstatement and expansion of the policy served as a catalyst for campaigning for a Trump-style global gag in Australia (Mantesso, 2017).

In recent years, the US movement has exerted an influence on Australian parliamentary debates. US activists from 40 Days for Life visited South Australia's parliament to share strategies for undermining draft legislation to decriminalise abortion (Brinkworth, 2019). Australian state parliamentary debates around decriminalisation have replicated US discourses, including narratives of escalating rates of late gestation abortions which are not supported by evidence (Keogh et al., 2021) and the conflation of liberalisation with 'abortion up to birth'. An election pledge by the Australian Labor Party to fund abortions in public hospitals saw candidates targeted by anti-abortion groups for their 'extreme late-term abortion agenda' (Butler, 2022).

The religious right gained influence under the government led by former Prime Minister Scott Morrison, from 2018 to 2022 and anti-choice parliamentarians became more vocal and visible. At the behest of religious right groups including the Australian Christian Lobby, Morrison promised and sought unsuccessfully to enact religious freedoms legislation which would have

eroded abortion access. Like Morrison's religious freedoms laws, attempts to restrict abortion have been largely unsuccessful during the past two decades and liberalisation enjoys widespread public support (O'Rourke, 2022).

Having failed to stem the tide of liberalisation, anti-abortion politicians have looked to the US movement, seeking to import narratives and tactics that have been successful in eroding abortion rights in the US. Its substantial playbook of initiatives, including its compendium of model legislation, has proffered a rich source of guidance and inspiration for Australian politicians who wish to stigmatise and restrict abortion.

Importing US Model Legislation

In the early 2000s, draft legislation based on the false narrative that viable foetuses are often born alive after abortion and killed or left to die, emerged as 'the promising start of a strategy' for stigmatising late gestation abortion in line with natural law arguments favoured by the US movement (Ziegler, 2020, p. 171). There have been repeated attempts to enact federal legislation to impose criminal penalties on US healthcare providers who fail to provide the same level of healthcare to a child born alive after abortion as any other child born at the same gestational age (Ziegler, 2020). A bill to the same effect, titled the Human Rights (Children Born Alive Protection) Bill 2022, was introduced into Australia's Senate in November 2022.

The born alive narrative has been a powerful vehicle for fomenting outrage, stigmatising those who seek and provide abortion and providing the context for former US president Trump's repeated assertions about his political opponents' tolerance for 'executing babies after birth' (Robertson, 2019). Its Australian iteration provided a rationale to focus attention on late gestation abortion, while denying an intent to regulate abortion. By invoking the federal government's constitutional power to implement Australia's international human rights treaty obligations, the Bill sought to legislate in an area of state legislative power and, to the extent of any inconsistency, override state law.

A Senate Inquiry into the Bill heard evidence from health professionals about the dangers of interfering with patient-centred care and medical decision-making in a highly regulated profession. Live births after termination were reported to be extremely rare, occurring for example when a pregnant person opts for a live birth to engage in rituals of bereavement in cases of fatal foetal anomaly. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists warned the bill would 'reintroduce the spectre of potential criminal liability to decisions around the management of abortion in Australia just as almost every state and territory has gone through the process of explicitly decriminalising abortion' (Senate Hansard, 2023, p. 46).

The author appeared before the Inquiry on behalf of a national human rights organisation and warned that the Bill would breach the international standards it purports to implement. Noting its striking resemblance to US initiatives, she stressed the need to safeguard against the discourses of an emboldened US movement taking root in Australia. But the importation of discourses extended beyond the Bill itself to the conduct of the inquiry. Rather than questioning the author on the substance of the bill, one of its sponsoring senators questioned her use of language and posted an edited video of the exchange on multiple social media platforms to ridicule her gender-inclusive response. The senator's interrogation bore a striking similarity to the questioning of Berkeley Professor Khiara M. Bridges by US anti-abortion senator Josh Hawley at a Senate Judiciary Committee hearing into the impact of *Roe*'s reversal (Zhou, 2022). Like the Bill itself, its co-sponsor's questioning replicated discourses which have been effective in spreading misinformation and polarising public opinion without engaging with the harm they cause to others, including those who seek and provide abortions.

Despite having little political support, the Bill was the subject of coordinated campaigning which elicited submissions, letters (Senate Community Affairs Legislation Committee, 2023) and demands for action on 'one of the greatest human rights abuses of our time' (Senate Hansard, 2023, p. 3). The Inquiry report expresses concerns about the bill's constitutional validity, compatibility with human rights and implications for patient-centred healthcare (Senate Community Affairs Legislation Committee, 2023). The Bill's sponsors have nevertheless utilised the report as a platform for seeking a national review of late gestation abortion procedures (Senate Community Affairs Legislation Committee, 2023), a call which will be amplified by the movement which coalesced around the bill.

CONCLUSION

Reproduction policy is a contested domain. The importation of US narratives into the Australian parliamentary process to build anti-abortion sentiment demonstrates the susceptibility of domestic reproduction regimes to cross-national influences. While Australia has charted a trajectory of liberalisation which enjoys widespread public support, the US movement's efforts to undermine abortion access domestically and beyond have stood as a beacon of inspiration for those who wish to challenge liberalisation. Australia's anti-abortion movement has looked for more than five decades to its US counterparts for strategic guidance and inspiration. The US movement has demonstrated that coalition-building, polarisation and tenacity can reshape reproduction policy. In Australia and elsewhere, local anti-abortion movements will continue to study the rich American playbook of anti-abortion

initiatives and replicate those initiatives that have been effective in undermining access and stigmatising those who seek and provide abortion.

By sketching the US movement's activities and global reach, this chapter illuminates the vulnerability of reproductive rights. It furthermore outlines what is required to protect reproductive rights from further encroachment; namely an understanding of anti-abortion strategies as well as the means by which abortion rights may be advanced, including the work of international bodies which anti-abortionists have sought to supplant. International bodies, such as the World Health Organization, human rights treaty bodies and specialist mandates have recognised abortion as a corollary of international human rights. Framed by human rights norms and an understanding of the lived experience of those who are denied healthcare access, their work has had a significant cross-national influence on the advancement of reproductive rights. The US movement's efforts to undermine this influence have included its championing of the Geneva Consensus Declaration; an ambitious but unsuccessful attempt to forge a new international consensus to legitimise the curtailment of abortion rights. Statements to the effect that it represents international law must be repudiated.

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3. The diffusion of knowledge responsibility: polity insights into the regulation of sexuality education across the German states

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INTRODUCTION

Educating young people about sexuality has always been a contested topic, particularly since its integration into public school education (Zimmerman, 2016). The controversy stems not least from its close ties to conceptions of sexuality and family (Sauerteig & Davidson, 2012), rendering it a socially and politically "touchy subject" (Bialystok & Andersen, 2022). Moreover, unlike other school subjects, sexuality education stands out as one of the most politically contested areas of education. This is manifest, for instance, in large protests and policy-pushbacks in numerous countries such as Hungary, Poland, and Belgium (BNN Correspondents, 2023; Korolczuk, 2020; Rankin, 2021). By touching on issues of social norms, sexuality education is frequently regarded as a matter of "morality" (Engeli et al., 2012), rather than economic interests or political technicality.

Considering the controversy around sexuality education, it comes as no surprise that the responsibility for providing knowledge about reproduction, encompassing both procreative and non-procreative aspects of sexuality, remains the subject of intense debate today. Since who is made responsible for sexuality education has rarely been considered systematically, this chapter explores the question: how can differences in who is (made) responsible for deciding on sexuality education policy be conceptualised? I argue that it is important to unravel the configurations of the political responsibility for sexuality education to identify the relevant actors and institutions at different stages of the policymaking process. This, in turn, helps to understand how different policies come into place or not, and which actors and institutional structures are (made) responsible for it. The political responsibility for sexuality education is rarely straightforward. Unlike other education policies, sexuality education

often involves a multitude of stakeholders that have a say in the arrangements of the school subject (Ketting & Ivanova, 2018). This chapter addresses the intricate regulatory landscape of sexuality education by introducing a new analytical framework with a specific focus on the polity level.

Most previous research on sexuality education focuses on the analysis of policies but does not consider the polity context. For example, a large body of research examines curricula and the type of content provided in schools (e.g., Cassar, 2022; Ezer et al., 2019). The focus is often on "comprehensiveness" of curricula, that is, whether a broad range of information on sexuality and reproduction tailored to students' lived experiences is provided, and on the context of delivery (Ketting et al., 2020). Others examine mandatory sexuality education, and at which ages it is taught, if at all (Parker et al., 2009). The politics of sexuality education form another strand of research, which is driven by the political controversy surrounding the topic. Here, political preferences for comprehensive sexuality education, especially in contrast to abstinence-based approaches are investigated (Arsneault, 2001), as well as political debates about whether sexuality education should be taught at all, and whose perspectives should be reflected in curricula (Svendsen, 2017; Taragin-Zeller & Kasstan, 2021). A systematic analysis of sexuality education from a polity perspective is lacking.

In this chapter, I address this gap by analysing who is (made) responsible for providing sexuality education in schools. I propose the concept of *knowledge responsibility*, adapted from Taragin-Zeller and Kasstan's (2021) work on the state–religion relationship regarding sexuality education in Israel and England. The concept is made applicable for comparison across different political contexts. Knowledge responsibility provides a useful analytical framework to explore variations in the regulation of sexuality education. As defined in this chapter, it illustrates the distribution of authority over sexuality education and shows whose perspectives are considered relevant to be included. I suggest that four regulatory dimensions define the configuration of knowledge responsibility in sexuality education: state control over education policy, curriculum development processes, the inclusion of external professionals in providing sexuality education, and the influence of court decisions. I will show that knowledge responsibility can be more or less *diffused*, depending on the dispersion of responsibility among different actors on the four regulatory dimensions.

Knowledge responsibility as a concept allows to critically assess who is responsible in the policymaking processes of sexuality education. As such, it is intricately linked to *educational sovereignty*, that is, the authority over education policy (cf. Moll, 2002) and thereby relates to general education policy frameworks. Nonetheless, there are specifics to sexuality education that leave general education policy theorising insufficient, which are outlined throughout

this chapter. Empirically, the chapter provides an illustration of knowledge responsibility by comparing the regulatory landscape of sexuality education across federal states in Germany. I combine previous literature with original data collection, and offer new empirical insights into variations of knowledge responsibility within one country but also between distinctly regulated federal states. With this, the chapter introduces a novel comparative perspective on the regulation of the contested school subject, and provides the first polity analysis of sexuality education.

KNOWLEDGE RESPONSIBILITY

The concept of knowledge responsibility is an analytical tool to comparatively assess regulations of sexuality education across diverse contexts. I build on the work of Taragin-Zeller and Kasstan (2021), who use knowledge responsibility for analysing sexuality education for Haredi Jews in Israel and the UK. They show how distinct state–minority relationships shape responsibilities in providing sexuality education knowledge in these contexts. For the purposes of this chapter, I define knowledge responsibility as a *formal designation of decision-making power over form and content of knowledge provision in schools*, and apply the concept to the case of school-based sexuality education. Knowledge responsibility is different from regulation of the knowledge itself, such as curriculum content or teacher training. Instead, analysing knowledge responsibility shows who is responsible for deciding on form and content of sexuality education in schools, helping to understand how and by whose involvement different sexuality education policies (e.g., curriculum content, or mandatory sexuality education in schools) come into place. What is more, knowledge responsibility can serve as an indication of whether sexuality education is treated as a public or rather a private (individual) matter, by incorporating more or fewer (public) actors in the policymaking process (cf. "moral responsibility" in Boryczka, 2009).

Four regulatory dimensions define knowledge responsibility for school-based sexuality education. The first dimension is the level of (de-)centralisation of education policy in general, such as whether the educational authority is located at the national level or in subnational units such as provinces or federal states. The second dimension is the process of curriculum development and the extent to which this is a "participatory" process. The third dimension is the degree to which external professionals are involved in the provision of knowledge in sexuality education classes (rather than the respective subject teachers). The fourth dimension is the extent of involvement in, and the significance of, court decisions for the policy landscape of sexuality education.

Each of the four dimensions has a specific relevance for sexuality education. First, the level of state control over education policy varies depending on

the institutional structures that are in place, such as federalism or decentralism. These are historically rooted and relatively stable over time (Arnold & Stadelmann-Steffen, 2017). Central governments, subnational states, or even individual schools may have (some degree) of knowledge responsibility. Typically, central and regional governments have power over different aspects of the education system. For example, central governments tend to be responsible for large-scale regulatory aspects such as whether schooling is mandatory, or overarching curriculum guidelines, whereas districts and schools may have authority over the more fine-grained processes of delivery (Ball, 2012). There are notable differences in the level on which decisions on sexuality education are made across countries. Data from the International Reproduction Policy Database[1] (1980–2020), show that, in Bulgaria, Latvia, Romania, Slovakia, Slovenia, and the UK, it was primarily up to individual schools to regulate sexuality education in schools. What is more, in a large number of countries, such as in Belgium, Estonia, the Netherlands, Germany, or the US, sexuality education is primarily regulated sub-nationally, such as the Cantons in Switzerland or federal states in the US.

The (de-)centralisation of education policies serves as a baseline dimension for the three other regulatory dimensions. That means for example that, in countries with decentralised political systems (such as in Germany, Canada, Italy, etc.), there are differences between subnational states, leading to variation in sexuality education policy within a country. Consequently, there may also be more variation in curriculum development, involvement of external actors and court ruling impact. This connection underscores that the four regulatory dimensions are intricately interrelated.

Second, the degree to which curriculum development is a participatory process that includes public stakeholders beyond pedagogical staff is a further dimension. It indicates whether curricula are seen as a public matter or as a purely administrative task (compare Vollstädt, 2003). Curriculum development is one of the central regulatory tools in education policy with school curricula being reflections of dominant political interests (Vollstädt, 2003). Research highlights that curriculum development can include a spectrum of "participatory" practices (Standley et al., 2024). This refers to the extent to which the curriculum development procedure for a specific school subject engages the targeted audiences and stakeholders (Standley et al., 2024). Curriculum development methods vary significantly across and within countries (Priestley et al., 2021). The variation revolves around who is involved in the development process of curricula (e.g., teachers, researchers, students) and the extent of public discussion at different stages of the curriculum development process (public development of curricula drafts vs. the possibility of statements) (Standley et al., 2024).

Third, the extent of external professionals' involvement in sexuality education delivery is another dimension of knowledge responsibility. It indicates whether sexuality education is primarily organised as a technical, pedagogical task or also as a matter of broader public concern. In many countries, sexuality education lessons are partially carried out by external professionals rather than by teachers (Parker et al., 2009). The range and extent of professionals engaged can vary significantly (ibid.). The responsibility for actually delivering the content of sexuality education can be seen to sit with different kinds of so-called "street-level bureaucrats" (Lipsky, 2010). This concept highlights that governmental resources, while decided in policy frameworks, are commonly shaped and implemented by small-scale bureaucracies and individual bureaucrats (ibid.). Teachers are often considered street-level bureaucrats due to their considerable discretion in the teaching process (Taylor, 2007). Consequently, the inclusion of external professionals indicates the degree to which teaching responsibility is transferred to others rather than school teachers.

How external involvement of professionals in sexuality education teaching is regulated varies. In some contexts, professionals are granted discretion in shaping instructional content, while in others, different types of professionals are involved with limited autonomy. Moreover, depending on the type of professionals involved, the knowledge that is taught can vary. For instance, while health professionals emphasise aspects related to health, violence prevention professionals focus more on aspects related to their goals (Douglas et al., 2001; Ketting & Ivanova, 2018).

Fourth, the courts' relevance for sexuality education policy can differ substantively in that they may act as veto players in the policymaking processes. Court involvement is not regulated a priori but rather contingent upon the "constitutional context" (Patton, 2007), which renders court involvement more or less likely. Political systems with stronger courts that are more politicised often show what is called "judicial activism" (Lindquist & Cross, 2009). Here, court decisions effectively denote policy content. Conversely, courts employing "judicial constraint" (Langer & Brace, 2005) are less policy-focused. Here, major political decisions tend to be made in the legislative.

Court involvement depends not only on the constitutional context but also on the political environment of the policies in question. Insights from research on so-called "morality policies" (Knill, 2013), which are as equally controversial as sexuality education (e.g., abortion or medically assisted reproduction policy), reveal systematic cross-country differences in the extent to which courts or parliaments decide over policies (Studlar et al., 2013). This research shows that morally charged policies are often decided via court decisions, even in countries with overall low court involvement in policymaking (ibid.). Irrespective of whether sexuality education policy can be categorised as

Table 3.1 Regulatory dimensions of knowledge responsibility of sexuality education

Regulatory dimension	*Conceptual range*
Level of State Control	Nation state Federal states Communities Schools
Curriculum Development	Closed, administrative-style curriculum development *to* Participatory curriculum development, inclusion of civil society at various states
Involvement of External Professionals	No involvement of external experts, relying on teachers *to* Regular and strong reliance on external experts
Court Involvement	No court decisions (have) influence(d) sexuality education, policy based on parliamentary decisions *to* Court decisions form main basis for sexuality education policy

Note: Shows exemplary cases and ideal types of knowledge responsibility of sex education by Level of State Control, Curriculum Development, Involvement of External Professionals, and Court Involvement.

morality policy, courts shape the policy landscape of sexuality education to varying extents in different political contexts.

Table 3.1 gives an overview of the range of how knowledge responsibility can be configured within and across countries on the four dimensions. For the dimension "level of state control", the table gives an exhaustive overview based on examples in research; although there may be more possibilities in some states which have not been considered in the literature so far. For the other dimensions, the table indicates the range by giving ideal types marking the poles of a continuum, for example between completely closed curriculum development at the one end to participatory curriculum development at the other end.

Overall, knowledge responsibility can be more or less *diffused* within each of the regulatory dimensions, that is, the power can be more or less concentrated on one or on several actors respectively. Specifically, a more decentralised system, a more participatory process, the inclusion of external professionals, and a stronger court involvement indicate a higher diffusion of responsibility. Depending on the configuration of regulation across the dimensions, overall knowledge responsibility can also be more or less diffused.

Configurations of knowledge responsibility do not have a direct impact on sexuality education policy, but the level of diffusion of knowledge responsibility *structures* the political conflicts that result in specific policy outputs. The key determinants of policy outcomes are (the congruence of) public opinion, economic conditions and social structures (Brooks & Manza, 2008; Budde & Heichel, 2015; Ezrow et al., 2020). For sexuality education specifically, it has been shown that political parties and the church–state relationship appear to influence the type of sexuality education policy in a country (Bialystok et al., 2020; Lewis & Knijn, 2002).

The following examples illustrate how knowledge responsibility structures politics, rather than determining policy output: In decentralised political systems, the positions of political parties at subnational level tend to be contingent on national actors' positions (Katz & Crotty, 2006). For example, under a right-wing central government that is in favour of conservative sexuality education policy, subnational actors may introduce comprehensive sexuality education policies to position themselves against national policies. Likewise, allowing participation of different actors in curriculum development can affect politics in this context: liberal actors are better able to formulate curricula in line with their preferences despite the conservative national government. By contrast, liberal political actors advocating for comprehensive sexuality education may also encounter opposition from conservative actors such as a conservative constitutional court. In summary, considering the different dimensions of knowledge responsibility does not foremost serve to make predictions about the nature of policy outputs. Rather, the framework helps to understand which actors and institutions are (made) responsible for specific aspects of policy-making and how this may lead to interest collision.

Finally, a scenario not explicitly covered in the framework of knowledge responsibility should be noted: the absence of regulations. One interpretation is that it is a deliberate choice by the state to refrain from regulation (cf. Engeli, 2009), thus allowing for a greater degree of variability in sexuality education policy. However, it may also be the result of a lack of political agreement over responsibility structures. As can be seen in the empirical example below, non-regulation regarding the involvement of external professionals results in greater responsibility of individual teachers to decide on whether (and which) external professionals should be involved in sexuality education classes.

ANALYTICAL APPROACH

For empirical illustration, the concept of knowledge responsibility is applied to the German federal states. Germany is an ideal case to comparatively examine knowledge responsibility in sexuality education, because of its federal structure. It hosts considerable variation in the approach to sexuality education

among the different federal states while still featuring a common national framework of shared social, economic, cultural and institutional characteristics (Grotz & Schroeder, 2021). The autonomy of each federal state to shape its own education policies creates a diverse landscape, showcasing variations of knowledge responsibility across the country.

For describing knowledge responsibility in the German states across the four regulatory dimensions, different sources of data were used. The first source is previous literature. However, for two of the four dimensions – curriculum development and involvement of external professionals – little to no empirical description exists for Germany. To address this gap, the second step included original data collection. First, for information on curriculum development, I contacted all education ministries responsible for sexuality education in the German federal states. Interviews were held between April and June 2023. The final sample includes seven states[2] for which I was able to gather detailed information regarding the curriculum development process. The other states could not be considered because ministries never responded to emails (despite follow-ups to initial non-responses) or were not able to provide sufficient information. The sample covers different geographical regions across Germany, in both western and eastern states, thus accounting for historical and contemporary differences in education systems and outcomes between the regions (Blossfeld et al., 2015). The information given by the ministries was recorded during the interviews with handwritten notes, which were completed from memory directly after to comprehensively reflect the information given by the administrators. Second, for information on the involvement of external professionals, I consulted the curriculum guidelines of the federal states. Due to the public accessibility of the guidelines, I was able to gather information on all federal states for this dimension. The obtained data were then analysed in two steps. In the first step, I evaluated similarities and differences between the cases on the four dimensions. Second, I categorised the data for each federal state according to the ideal types of regulatory dimensions outlined in Table 3.1.

THE REGULATORY LANDSCAPE OF SEXUALITY EDUCATION ACROSS THE GERMAN STATES

Level of (De-)Centralisation of Education Policymaking

Germany is a federalist country with a national central government and 16 federal states, in which the federal states have political autonomy over some policy fields and not over others. Areas such as fiscal or foreign policy are decided on the national level, whereas others, such as agricultural and also

education policy, remain (largely) in the hands of the federal states (Schmidt, 2021).

Education policy, including sexuality education in schools, is primarily governed within the federal states, while the national government provides, for example, state-wide curriculum guidelines that have to be adapted by the individual states (Schmidt, 2019). However, the federal states have the main education policymaking authority, for instance, over curricula and compulsory schooling (Helbig & Nikolai, 2015). Therefore, the educational outputs can be seen to reflect political preferences on the state level, rather than those of the national government.

Curriculum-making

Curricula may denote different aspects of the provision of knowledge (Vollstädt, 2003), ranging from describing overarching goals of schooling to specific classroom timetables. Here, I focus on the creation of specific *syllabi* that describe substantive topics and competences that should be taught in school. In Germany, sexuality education is taught as part of different subjects, including biology, ethics, and sometimes broader social sciences classes (Scharmanski et al., 2021).

The procedure of developing school curricula is often described as a practice that has undergone only few changes in Germany in the past decades (Vollstädt, 2003). In principle, the education ministries of the federal states delegate the curriculum development processes for a specific subject to one of their agencies, which then develops the curriculum and passes it back to the ministry, who accepts it with no or minor revisions. However, beyond this procedural description, we have little insight into the processes within the ministry or its agencies regarding the development of curricula.

According to the data material gathered from the ministries, the process of creating the curriculum generally follows a similar pattern between the different states. All of the ministries described that, whenever the need arises for the development of a new curriculum or the revision of an existing one, the education ministries delegate this task to the respective sub-agency responsible for curricula and teacher training. This agency convenes a curriculum commission, entrusted with the task of formulating the curriculum. Subsequently, the proposed curriculum is submitted to the education ministry for approval. The initiative for the creation or revision of curricula formally comes from the ministry; however, diverse stakeholders have the possibility to submit requests for such modifications through curriculum and teacher-training agencies, predominantly teachers and teacher associations.

There are two noteworthy differences in curriculum-making processes across the states. First, the composition of the curriculum commission

installed by the sub-agencies varies. In some states (Baden-Wurttemberg, Rhineland-Palatinate, Saxony, Schleswig-Holstein), the commission comprises exclusively or primarily teachers, occasionally in conjunction with education researchers from universities. In other states, there is a somewhat higher degree of public involvement in the commissions. For example, in Lower Saxony, the association of local schools has the possibility to have one of its representatives join a commission. Similarly, in Saxony-Anhalt, the law specifies the possibility of involving consultants but does not detail which consultants may be included and when. Similar regulations apply to Bavaria.

Second, the level of public deliberation on proposed curricula varies among states. Some states, such as Rhineland-Palatinate, Bavaria, Schleswig-Holstein, and Baden-Wurttemberg, partially publish curricula and engage a wide range of stakeholders. For example, in Schleswig-Holstein, mandated stakeholders include teachers, student associations and representatives from the political sphere. Comparable regulations exist in Saxony-Anhalt. In contrast, Rhineland-Palatinate and Lower Saxony do not specify who can provide curriculum feedback, granting more discretion to the ministry. Baden-Wurttemberg has a standing advisory board that involves representatives from universities, churches, teacher associations, employer and employee associations, and political parties. The advisory board has significant influence. Conversely, Saxony does not have explicit regulations but the ministry mentions occasional contact with select public stakeholders for input.

In summary, states adopt two contrasting strategies for stakeholder engagement. Some German states do not regulate public input in the curriculum development process. Conversely, others actively involve a broad range of civil society stakeholders, including actors in the field of education (teacher and student associations) or political actors. This variation highlights the different degrees to which curricula are made a public – and political – matter.

Involvement of External Professionals

The regulation of external professionals' involvement in German sexuality education classes is still largely a black-box with little systematic empirical insights so far. The following overview is the first of its kind and draws on original data collection as described above. The findings reveal three categories of regulations.

First, some states make no explicit reference to the involvement of external professionals in sexuality education classes (e.g., Baden-Wurttemberg,[3] Hamburg,[4] Bremen,[5] Saxony-Anhalt,[6] Schleswig-Holstein,[7] Thuringia[8]). This may imply that teachers autonomously determine whether to collaborate with external professionals, or that school-specific regulations address the involvement of external professionals.

Second, in some states, regulations mention the general possibility of collaborating with organisations that promote sexuality education and sexual wellbeing or run counselling facilities (in Berlin/Brandenburg,[9] Rhineland-Palatinate,[10] Saarland,[11] Hesse[12]). In these contexts, external professionals may be involved in sexuality education sessions in classroom settings or as facilitators of information sessions outside the school setting.

Third, in some states, regulations refer to specific institutions which teachers could work with for sexuality education, such as the Federal Center for Health Education (Berlin, Hesse, Mecklenburg-West Pomerania,[13] Lower Saxony,[14] Saarland), health departments (North Rhine-Westphalia,[15] Saarland, Saxony[16]), AIDS counselling organisations (Saarland), or organisations providing counselling for issues related to (sexualised) violence (Saarland). In Bavaria,[17] the curriculum guidelines call for an annual "Day for Life" (*Tag für das Leben*) in which the state appeals to schools to acknowledge "the unborn life". This regulation entails a recommendation for collaboration with external agencies. Among the states in my sample, this is the sole instance of a content-specific collaboration mandate or potentiality.

In summary, states differ in acknowledging external professionals' involvement in sexuality education. Some have detailed regulations, while others omit the issue. Notably, none of the examined curricula contain explicit guidance on integrating external professionals regarding duration or specific content. School-specific laws might offer more details, but analysing such regulations exceeds this chapter's scope. In any case, the absence of regulations raises questions about responsibility, in that schools or instructors are granted independence in shaping sexuality education.

Court Involvement

The trajectory of sexuality education in Germany has been significantly shaped by court ruling, and only to a lesser extent by (national) parliamentary decisions. Four key rulings continue to exert a profound impact on sexuality education policies (Hilgers, 2004). First, in 1977, the Federal Constitutional Court confirmed the legality of sexuality education in schools, following an appeal by parents who advocated for a ban. The court also affirmed that sexuality education content is permitted to diverge from parents' individual preferences on the subject (Hilgers, 2004).

Second, in 1979, the Federal Administrative Court clarified the 1977 position. It emphasised the importance of sexuality education classes having to be considerate of various religious and ethical perspectives (Hilgers, 2004). These pivotal court rulings continue to be invoked in current legal deliberations when actors contest pupils' participation in sexuality education within school contexts (Bundesverfassungsgericht, 2009). Furthermore, these two rulings

secured the autonomy of states in the realm of education vis-à-vis parental preferences (Müller, 2017).

Third, in 1993, the Federal Constitutional Court asserted – in a ruling originally pertaining to abortion policy – that sexuality education ought to extend beyond the teaching of factual knowledge, encompassing emotional engagement as well. In response to this decree, nearly all federal states were asked and consequently did revise their sexuality education curricula to include facets beyond mere biological processes, often integrating topics related to contraception. In this instance, the court assumed an active role as a policy influencer by delineating a concrete policy agenda across all federal states.

The fourth influential ruling was in 2006 when the Federal Constitutional Court specified the so-called "indoctrination prohibition". The court ruled that it is prohibited for educators to steer students towards specific political or ideological orientations, or openly identify with a particular ideology or religion. While the state may adopt a specific ideological stance in education, it must remain receptive to alternative values and content (Widmaier & Zorn, 2016), meaning that also sexuality education must maintain an openness in its content.

Nonetheless, the legal realm is not only shaped by court decisions, but also by national legislative law. A notable law is the Pregnancy and Family Assistance Act of 1992 which established the provision of reproduction knowledge and counselling as a collective concern across all federal states. This statute has, in part, superseded the exclusive jurisdiction of individual federal states. According to this law, federal states' sexuality education curricula and guidelines should be "comprehensive in order to appeal to a wide range of age and target groups" by providing a wide range of factually correct information (Hilgers, 2004). The law was reinforced by the above-mentioned 1993 ruling. It is hence evident that court rulings, rather than legislative choices, play a significant role in shaping overall policy directions for sexuality education. This indicates that, in Germany, courts harmonise policies across the otherwise independent federal states, particularly in terms of broad guidelines.

Taken together, knowledge responsibility for sexuality education in Germany is highly diffused due to its decentralised political structure on three of the four dimensions, with a strongly harmonising influence of national courts. There is significant variation among states in curriculum development, ranging from administrative processes to involving diverse stakeholders. The involvement of external professionals also varies strongly, and many states do not have any explicit regulations. Notably, judicial activism has significantly shaped policies through court decisions across all federal states.

CONCLUSION

This chapter introduced the concept of knowledge responsibility as a tool for comparative analysis of sexuality education to gain insights into the distribution of power over reproduction knowledge across various polity dimensions. The framework includes the analysis of responsibilities for education policy, curricula, implementation in schools, and overarching jurisdiction in sexuality education. Comparative analysis of knowledge responsibility facilitates understanding regulatory structures in sexuality education across countries by identifying different actors and institutions across the policymaking process.

The chapter uses the concept of knowledge responsibility to empirically compare sexuality education policy across the German federal states. The exploratory analysis yields novel empirical insights based on original data collection. I demonstrate that Germany has a high level of diffusion of knowledge responsibility across three of the four analytical dimensions, delegating responsibility to numerous actors. First, education policymaking is decentralised, with substantial autonomy granted to individual states in shaping their educational systems. Second, the process of curriculum-making in Germany shows some similarities across the federal states, with notable differences relating to the composition of commissions that are responsible for curriculum development and the level of public deliberation that is possible over curricula. Third, the involvement of external professionals varies significantly between states. While some states explicitly mention collaboration possibilities, others do not regulate the involvement of external professionals, leaving it to teachers or school-specific regulations. Fourth, court rulings significantly shape sexuality education policies in Germany, with pivotal decisions influencing and partially harmonising curriculum content across the federal states. The diffusion of responsibilities across a diverse set of actors and different levels of the policymaking process highlights the complexity of the sexuality education landscape. Decisions on different policy aspects, including the engagement of experts or the requirement of mandatory sexuality education, are made at different political levels. Disentangling these aspects of knowledge responsibility for sexuality education helps to gain a more comprehensive understanding of policy-processes in this field, and provides a roadmap for political actors aiming to influence these processes.

Sexuality education holds a distinct role compared with other school subjects because it provides reproduction knowledge, which has been shown to impact reproductive experiences and outcomes (Guzzo et al., 2018). Hence, understanding who has the responsibility to decide over sexuality education also reveals who is involved in shaping reproductive experiences. The concept of knowledge responsibility adds a critical perspective in sexuality education

and broader education research, allowing insights into the societal role of reproduction and the extent to which it is regarded as a public concern, if at all.

NOTES

1. See Zagel et al. (forthcoming).
2. Baden-Wurttemberg, Bavaria, Lower Saxony, Rhineland-Palatinate, Saxony, Saxony-Anhalt, Schleswig-Holstein.
3. Guidelines for sexuality education in Baden-Wurttemberg: https://www.landesrecht-bw.de/jportal/?quelle=jlink&query=VVBW-2206-KM-20010512-SF&psml=bsbawueprod.psml&max=true
4. School curricula for Hamburg: https://www.hamburg.de/bildungsplaene/
5. Guidelines for sexuality education in Bremen: https://www.transparenz.bremen.de/metainformationen/verfuegung-nr-59-2013-schulische-sexualerziehung-98788?asl=bremen02.c.732.de
6. Guidelines for sexuality education in Saxony-Anhalt: https://mb.sachsen-anhalt.de/fileadmin/Bibliothek/Landesjournal/Bildung_und_Wissenschaft/Erlasse/Sexualerziehung.pdf
7. School curricula for Schleswig-Holstein: https://lisa.sachsen-anhalt.de/unterricht/lehrplaenerahmenrichtlinien
8. Curriculum guidelines for Thuringia: https://bildung.thueringen.de/bildung/bildungsplan
9. Sexuality education curriculum guidelines for Berlin/Brandenburg: https://lisum.berlin-brandenburg.de/einzelansicht-tt-news-fuer-solr?tx_news_pi1%5Baction%5D=detail&tx_news_pi1%5Bcontroller%5D=News&tx_news_pi1%5Bnews%5D=5632&cHash=2fb31793a97294c773c373082b1e82a0
10. Sexuality education guidelines for Rhineland-Palatinate: https://gesundheitsfoerderung.bildung-rp.de/sexualerziehung/richtlinien-zur-sexualerziehung.html
11. Sexuality education guidelines for Saarland: https://www.saarland.de/SharedDocs/Downloads/DE/mbk/00_Portalstart/publikationen/RichtlinienSexualerziehung2013.pdf?__blob=publicationFile&v=2
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14. School curricula for Lower Saxony: https://www.mk.niedersachsen.de/startseite/service/rechts_und_verwaltungsvorschriften/lehrplane/
15. Sexuality education guidelines for Nordrhein-Westphalen: https://www.schulministerium.nrw/Schulsystem/RuL/Richtlinien-fuer-die-Sexualerziehung-in-NRW.pdf
16. Sexuality education guidelines for Saxony: https://www.schule.sachsen.de/download/OR_FSE_Endfassung_August_2016.pdf

17. Sexuality education guidelines for Bavaria: https://www.gesetze-bayern.de/Content/Document/BayVV_2230_1_1_1_1_3_K_964

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PART II

Cross-country comparison

4. Asian family planning programmes and the construction of fertility preferences

Stuart Gietel-Basten

INTRODUCTION

It will not have escaped the reader that there is a panic in many parts of the world regarding low birth rates. Many governments around the world (and their client media) continue to espouse targets for fertility rates (either to go up or to go down) as a means to a macroeconomic (or ethno-nationalist) end.

As it happens, relatively few pronatalist[1] policies have had a lasting influence on increasing cohort rates of fertility. Instead there is, it has been argued, a role for policies that slow the pace of population ageing (through fertility changes) by supporting families to meet their reproductive intentions (Gietel-Basten et al. 2022). The same, of course, has been said of family planning policies which slow rapid population growth (which brings its own set of issues and challenges) through reproductive empowerment. These policies, however, rely on understanding people's fertility preferences, which rarely match up to the actual fertility rate. Indeed, in higher fertility settings, fertility preferences are usually somewhat lower than outcomes.

In lower fertility countries, however, fertility preferences generally tend to be *higher* than outcomes. In short, where replacement fertility levels are the aim, the policy game is to identify a gap between reproductive aspirations, look for the reasons behind the gap, and then implement policies to close the gap. This is usually reflected in the empirical literature. For example, Sobotka and Beaujouan (2014, 319) observe that "a two-child ideal has become nearly universal among women in all parts of Europe", with similar evidence of a two-plus child norm being found in North America, Australasia, and across the OECD.

Recently, the idea of a two (plus)-child norm in 'low' fertility countries has been challenged by evidence from China. For decades, fertility preferences have been lower than two children (Basten and Jiang 2015; Zhenzhen et al.

2009), although this was often ascribed to the birth control context and surveys not being able to report 'true' preferences. However, in the context of changing fertility regulations in recent years, it has been shown that such sub-replacement fertility preferences in China are more 'genuine' than was previously thought (Chen and Gietel-Basten 2023). This does not reject the importance of birth control policies in shaping fertility preferences. Indeed, it may well be the case that such policies (and the associated messaging) entrench these preferences, and may contribute to a mindset around the ideation of very small families which may be difficult to shift in the contemporary pronatalist paradigm. The following comparative discussion of the extent to which certain family types – especially surrounding numbers of children – were presented as part of family planning programmes across low-fertility countries in large parts of Asia can shed new light on the link between policies and fertility preferences.

FERTILITY ASPIRATIONS AND REALITIES IN ASIA

East and South-East Asia is currently a global locus of very low fertility rates. China, Hong Kong SAR, South Korea, Singapore, Japan all account for some of the lowest fertility rates in the world and have done for some time. More countries have joined this low fertility club in recent years, such as Thailand and Viet Nam. At the sub-regional level, we also see very low fertility rates in South Asia, for instance in India and Nepal (Gietel-Basten and Scherbov 2019). In many – if not most – of these settings governments have expressed concern about their low fertility rates, and have set out policies to try to encourage childbearing and often used actualising fertility preferences as a justification.

This, however, begs the questions of where these fertility preferences 'come from' and 'what do they mean'. While these questions have been explored in depth elsewhere, the potential role of family planning programmes has been largely overlooked. Asian settings were characterised by comprehensive anti-natalist programmes over recent decades. As well as providing access to contraception and other reproductive health services, these programmes were and sometimes still are also generally characterised by large-scale 'Information, Education and Communication' (IEC) activities. In addition, some of the policies in the late 1970s "contained a certain degree of coercion, particularly in terms of incentives and disincentives, and this has become a source of controversy in the region" (Miro and Potter 1980, 63). In short, coercive practices were not limited to China.

In this chapter, therefore, I set out to explore the potential role of such IEC programmes (and any coercive elements) and their messages in shaping norms regarding preferences and childbearing in a set of Asian territories where there is some anxiety about low fertility rates. Indeed, it is curious that various theoretical frameworks of reproductive decision-making generally ignore the

family planning messages of IEC programmes as a means by which fertility preferences might be shaped, as mediated through social and cultural norms. Rather than focusing on China, which has the most contested view of the role of family planning policies in shaping fertility preferences (Zheng et al. 2018), I focus on other parts of Asia. I will, however, return to what we can learn from the discussion of China later in the chapter.

ANTI-NATALIST POLICIES REVISITED

While the Chinese family planning restrictions are undoubtedly the most famous of these programmes regarding the scope of activities and the IEC campaigns, other territories invested equally heavily in their own family planning systems. It is often remarked that it is unusual that, given the clear low fertility in China and potential challenges from an 'ageing and declining population', the country still has a framework of anti-natalist policies in place (albeit at a current limit of three children per couple). Yet, it is essential to emphasise that anti-natalist policies in other low fertility settings of Pacific Asia do not belong to a bygone era. In many countries of the region, there were significant delays between replacement fertility rates being reached and anti-natalist policies being reversed. Jones et al. (2009) observe three reasons for this delay: demographic momentum continuing to push the population up, even with below replacement fertility rates; "inertia and the entrenched bureaucratic interests and mindsets of agencies entrusted with anti-natalist policies"; and "a deficiency in the theory of demographic transition" (p. 6). Indeed, Jones et al. explicitly note that the UN assumptions of a rebound to replacement levels "added official weight to the idea that there was no need for a policy response to very low fertility" (p.7). It is safe to say that anti-natalist IEC schemes were still in place when fertility rates were below replacement rates and can be in evidence within the past generation. While it is not possible to outline the IEC components of the family planning programmes of each of these territories, I will briefly outline the parts of the IEC schemes that explicitly dealt with what was considered to be an 'ideal' or 'optimum' family size. Given that this is the first such investigation, I will rely on disparate sources, including the media, mottos, images, and official communications. By doing so, I will be able to explore the extent to which this messaging may be one component in shaping social and cultural norms toward family sizes.

In this chapter, I focus on six territories in Asia which have both a strong recent history of promoting small family sizes through their family planning systems, and denote a contemporary anxiety regarding low fertility: South Korea, Taiwan, Singapore, Hong Kong, Thailand and Viet Nam. As Table 4.1 shows, each of these territories continued to implement anti-natalist policies after their fertility rates fell below the replacement rate (of around total

Table 4.1 Delays in reversing anti-natalist policies, selected Pacific Asia countries

Country	Year in which replacement fertility was reached	Year in which anti-natalist policy was reversed/ ceased	TFR when anti-natalist policy reversed/ ceased	Number of years elapsed	% below replacement rate when reversed
Singapore	1975	1987	1.62	12	20.98
South Korea	1984	1996	1.59	12	22.44
–	–	2004	1.14	20	44.39
Taiwan	1984	1992	1.73	8	15.61
–	–	2006	1.12	2	45.37
Hong Kong SAR	1980	2003	0.93	23	54.63
Thailand	1991	2002	1.59	11	22.44
Viet Nam	1999	2015?	1.77	16?	13.66

Note: Across six Asian countries provides year replacement fertility was reached, year anti-natalist policy was reversed, no. of years elapsed since policy change, and at policy reversal: % below replacement rate and Total Fertility Rate.
Source: Adapted and extended from Table 1.2 in World Bank, "World Development Indicators" (New York, NY, 2014), http://data.worldbank.org/data-catalog/world-development-indicators?cid=GPD_WDI; National Development Council (ROC), "Population Projections for R.O.C. (Taiwan): 2012~2060".

fertility rate (TFR) 2.1). Each of them also had extensive IEC programmes as part of their family planning systems (hence the exclusion of, for example, Japan). A final specification is that birth restrictions in each of these settings were effectively non-mandatory (while, of course, the degree of coercion and 'strength' of policies differed significantly). For this reason, analysis of Mainland China is omitted.

ASIAN FAMILY PLANNING PROGRAMMES AND THE CONSTRUCTION OF FERTILITY IDEALS

South Korea

In 1962, South Korea inaugurated its family planning programme based on providing basic maternal and child health services, providing family planning supplies and services, and a significant IEC campaign to reduce unwanted

births (Haub 2010). This was to be delivered by the 'Planned Parenthood Federation of Korea' (PPFK). Regarding ideal family sizes, the initial slogan of the PPFK was "have an optimal number of children and raise them well" (Yang 1977, 68). Three years later, this was changed to '3335,' or 'have three or fewer children with three years spacing before mother's age of 35'. Other IEC programmes included 'Seoul is full', a serial publication in many newspapers that evoked the demographic pressure on the city (DiMoia 2009, 367). During this time, the fledgling family planning programme had great success, with DiMoia (2009, 367) observing that "contrary to expectations, the embrace of new birth control technologies … would turn out to be most enthusiastic among rural women, those seeking to gain a measure of control over their lives". In 1970, meanwhile, in an attempt to tackle the son preference issue, which led to highly skewed sex ratios (Hesketh et al. 2011), it was changed again to "Daughter or son, stop at two, and raise well" (Yang 1977, 68). At this time, eligible mothers were enlisted into Two Children Clubs and Mothers Clubs and travelled the country encouraging participation in family planning programmes. During the late 1970s, the family planning budget for South Korea accounted for almost half of the entire health budget (Miro and Potter 1980, 62).

The 1980s saw both continuity and change in IEC campaigns. Posters that exhorted parents to view sons and daughters equally abounded, often linking them to broader concerns about (over)population (Koreabridge 2011). However, during this period, there was also a significant shift in what DiMoia (2009, 376) calls the "state's … recommendation for the desired number of children" to one (see, also Kim and Ross 2007; Nikolaevich 2007). As Heon and Suh (2005) observe, the slogan of the 1980s was "Two children are also too many, let's get just one child and raise it well." It should be noted that this notion of an 'official' exhortation to one child is contested, with Clark (2000, 157) stating that family planning officials during the 1980s were trained to "insist that two children was the ideal number and that the gender of the children didn't matter." Finally, as is well known, there has been a push since the 1990s to increase fertility, with posters encouraging two and even three children.

Numerous scholars have identified the double-edged sword of these family planning activities and messages in South Korea (DiMoia 2009; Bae 2003). While it is often argued that access to family planning allowed women to maintain a life outside of the household, women were also, in effect, subjects and agents of the state in transforming beliefs relating to family sizes, not least through Two Children Clubs.

Taiwan

Taiwan's family planning system is widely considered one of the most comprehensive and successful in terms of shaping population growth (Freedman et al. 1974). Again, fertility decline began well before the family planning programme developed in earnest in the mid-1960s and "would have continued even in the absence of the initiative" (McGuire 2010, 190). However, as Freedman et al. (1994, 317) state, "contraceptive services supplied by the program were the major proximate cause of Taiwan's fertility decline". For the late 1970s, Miro and Potter (1980, 63) included Taiwan in the group of territories imposing disincentives for higher-order births. In terms of IEC motivation regarding ideal family sizes, Sun (2001) notes the existence of a multiple stage process. In 1967, the so-called 'five 3' motto was adopted, namely "to have the first child three years after marriage, have a baby every three years, and stop before age 33" (p. 69). In 1969, the more general motto of "Fewer children bring more happiness" was adopted. In the 1970s, an explicit two-child ideal was introduced using the slogan "Two children is just right" (Peng 2003). However, in the 1980s, the slogan was changed again to "One is not too few, two are just right" (Peng 2003). An anecdote of the actualisation of this slogan is recalled by Marc L. Moskowitz (2001, 17) in his book on sexuality in Taiwan: in cinemas in the mid-1990s, the sound of children singing the national anthem in the preview before the film was accompanied by "scenes of a young daughter and the happiness she brought to her parents and grandfather." Moskowitz interprets this as meaning that "having one child, and significantly one daughter was now presented not only as the foundation for familial harmony and happiness, but as the basis of national strength" (p. 17). In the 1990s, however, the Ministry of the Interior changed the slogan again to "Two is just right, three is not too many" as part of a general drive toward encouraging childbearing (Peng 2003). The new slogan is "Two children are very happy, three children and more are lively" (Ministry of Education [Taiwan] 2015).

Singapore

In Singapore, family planning also played an important role in shaping fertility decline. In 1965, a five-year Mass Family Planning Program was outlined, with the Family Planning and Population Board (FPPB) founded in January 1966. For the period of the late 1970s, Miro and Potter (1980, 63) observed that "Singapore's family planning program is by far the most aggressive" compared with other countries in the region. The FPPB set out an explicitly anti-natalist agenda until 1986–87. Over the period 1970 to 1986, "Stop at two" was the official slogan (National Archives of Singapore 2015) with

a 'two-child norm' adopted officially in 1972 (Teng 2007, 205). Variants of this include "Girl or boy, two is enough"; "One, two…and that's ideal"; "Plan a two-child family" (see National Archives of Singapore 2015). More often than not, where a two-child family was presented, two girls were shown (National Archives of Singapore 2015).

As with South Korea, the family planning system in Singapore has been critically appraised by various scholars, not least from a feminist perspective (Sun 2012; Song et al. 2013). A particular criticism is aimed at the eugenic and coercive overtones of the policies. It has been suggested, for example, that the 'two is enough' campaign was implicitly aimed at poorer couples (Remember Singapore 2013), not least through a series of penalties and disincentives which would disproportionately affect the poor. These included penalising larger families in housing assignments, and higher-order births in terms of access to the best schools and higher incremental fees in hospitals for treating them when sick. The coercive elements of Singaporean family planning policies were noted as far back as 1980 (Miro and Potter 1980). In the mid-1980s, there was a shift from 'universally applicable' policies toward "a differential class-specific pronatalism" (Wee 1995, 201). This involved the introduction of the *Graduate Mother Priority Scheme* which "sought increased fertility for university-educated women and provided major subsidies for the voluntary sterilization of poor and uneducated parents" (Palen 1986, 3). While this scheme was soon abandoned, a new IEC scheme was introduced in 1987: "Have three, or more if you can afford it." This meant that "emphasis was now placed on the adequacy of economic resources rather than parents' educational qualifications" (Sun 2012, 30). Drakakis-Smith and Graham (1996, 69) conclude that, for this period around the turn of the 1990s, "the control that the government wishes to exert over [fertility] as part of its nation-building project has largely been effected through class interests [measured as monthly household income]." (For an extensive review of recent pronatalist reforms in Singapore see Jones 2012; Sun 2012; Song et al. 2013.)

Hong Kong

Hong Kong's family planning programme is institutionally slightly different from its counterparts elsewhere in Pacific Asia. Rather than being formed as a government agency as such, the Family Planning Association was formed in 1950 out of the territory's Eugenics League which was, in turn, founded in 1936. The Family Planning Association grew significantly in the 1960s and developed an IEC campaign based around the slogan "Two is enough" during the 1970s (for a concise history of Hong Kong's family planning programme, see Fan 2007). Looking at IEC posters, in the 1950s and 1960, these tend to promote a more general message of 'less is better.' Moving into the 1970s,

however, there is a clear shift toward a message of a two-child norm, with posters stating: "Two babies is the best". In 1982, a poster was produced stating "Baby is not the more the better; at most two." Despite this *implicit* acceptance, unlike other places in Pacific Asia, there does not appear to have been an explicit push toward accepting one-child families in Hong Kong.

Thailand

Thailand's family planning programmes were initiated later than elsewhere (Knodel et al. 1987; Rosenfield and Min 2007). During the period 1968–1970, the so-called *Family Health Project* was set up as something of a precursor to the *National Family Planning Program* (NFPP) which was in force from 1970–1980. During this early period of the *Family Health Project*, IEC activities were prohibited. During the 1980s, the NFPP was "extraordinarily successful in providing services to Thai women" (Rosenfield and Min 2007, 229), with the number of new family planning clients increasing from 225,000 in 1972 to 1.12 million in 1980. However, this success came *despite* the absence of government support or widespread social and economic development. Instead, as various scholars have argued, aspects of Thai culture particularly lent themselves to the widespread adoption of family planning techniques – such as the higher status of women, the liberalism of Thai Buddhist culture and its sense of individual autonomy and privacy, the lack of major influence from extended families or the broader community over individual behaviour, and a sense of pragmatism in Buddhism (Knodel and Debavalya 1978).

In terms of explicit IEC activities, Knodel et al. (1987, 187) note that "the [NFPP] attempted to legitimate a preference for fewer children". These policies were generally met with approval from respondents (Knodel et al. 1987). However, "given the general lack of normative resistance to smaller families among Buddhists, even on the part of the older generation […], the legitimation provided by the program's activities may not have been crucial" (p. 187). Therefore, we might conclude that the IEC activities may have only played a marginal role in shaping Thailand's relatively low fertility preferences. Rather, it may be that the cultural modes that allowed the family planning programme to flourish and be so successful is, in turn, central to understanding these preferences.

Viet Nam

Viet Nam is notable for having what could, indeed, be called a 'two-child policy' or a 'one-to-two-child policy'. This has been explored in depth in a very stimulating article by Daniel Goodkind (1995) as well as a conference paper by Pham et al. (2012), as such, only a cursory review is required here.

The first Viet Namese population policies were introduced in the early 1960s, establishing the first Population and Birth Control Unit within the Ministry of Health in 1961. In 1964, a two-to-three child policy was promoted through an intensive IEC campaign in the northern region of Viet Nam (Vu 1994). This policy *promoted* limiting family size to three children (supplemented by some basic family planning services), but did not enforce it. As Goodkind (1995) observes, "this Northern region had been plagued for centuries by flooding, bursting dikes, and Malthusian misery, and in the late 1950s experienced sharp population growth approaching 4 percent per annum" (p. 87). In this sense, therefore, the policy implemented by the socialist authorities in the Northern Region were, to a degree, forerunners of the 'later-longer-fewer' campaign in China in the mid-1970s.

The protracted era of conflict between 1965 and 1975 meant that little effort was put into family planning programmes; at the end of this period, the fertility rate in Viet Nam was 6.0. Six years after the 1979 census showed signs of rapid population growth, the *National Council of Population and Family Planning* was founded in 1984. While a one-or-two-child ideal was promoted in some areas throughout the 1980s, it was unveiled as a national programme in 1988 with an aim to reduce the country's fertility rate which, in the mid-1980s, was around 4.2. Couples were encouraged to limit family size to two children through late marriage, delaying childbearing until after the age of 22, and ensuring a spacing of three to five years between the first and the second birth. While Goodkind outlines the programme in depth (Goodkind 1995, 90–91), we can say here that it combined a variety of incentives, disincentives, and methods of 'soft persuasion' to ensure implementation. Some of the disincentives alleged to have been employed on those who had three children included automatic expulsion from the Communist Party (which would affect officials, teachers, and other employees in state enterprises), parents being asked to pay for the health and education costs of children at parity three or above as well as the state denying them birth certificates, and the confiscation of land and heavy fines in some cases (Bennett-Jones 2000; Wilson 2011). As in China, IEC campaigns were perhaps the "most publicly visible Viet Namese strategies for encouraging small-family norms," with "posters and billboards advocating the one-or-two-child policy [being] ubiquitous in most of Viet Nam" in the mid-1990s (Goodkind 1995, 90).

In the early 2000s, the government officially recognised reproductive rights for the first time, noting that "couples have a right to decide number of children, birth timing and spacing" (Pham et al. 2012, 8). However, throughout the 2000s contradictory messages were also given about the need to maintain population control – even after the country reached a replacement-level fertility rate of 2.1. Indeed, in 2009, the government appeared to backtrack with the following remarkable interpretation of what reproductive 'rights' are: "Each

couple and individual has the right and responsibility to participate in the campaigns on population and family planning: (i) decide time and birth spacing; [and] (ii) have one or two children, exceptional cases to be determined by the Government" (Pham et al. 2012, 9). Only in 2015 was there serious discussion about completely lifting what is now increasingly referred to as the 'two-child policy' (Thanh Nien Daily 2015).

COMPARATIVE CONCLUSIONS: HOW FAMILY PLANNING SYSTEMS MAY SHAPE PREFERENCES IN ASIA

In this chapter, I have discussed the extent to which certain family types were presented as part of family planning programmes across Asian countries. In short, I argue that the very point of IEC campaigns within family planning programmes is to affect and alter fertility preferences. One example is the most extreme case China, where fertility decline would likely have occurred without the strict governmental regulations, but it is reasonable to assume that decades of relentless messaging regarding the benefits of one-child families coupled with a vast array of incentives and disincentives also had an impact upon popular attitudes toward ideal family sizes. In turn, the programmes have likely played a role in shaping the reported fertility preferences in the country. Similar mechanisms can be assumed for Viet Nam, which was also characterised by a coercive family planning system that sought to limit childbearing to two children. In 2002 in Viet Nam, 70.5 per cent of respondents expressed an ideal family size of two children. Consider, too, that 91 per cent of women at parity two in Viet Nam stated an intention to cease childbearing, even though having a third child was technically permissible. Again, these effects emerge alongside other economic and social factors in shaping these preferences.

I therefore suggest that the impact of IEC campaigns during periods of below replacement fertility might be felt much later in terms of fertility preferences. IEC campaigns may be a factor in the potential 'exceptionalism' of Asia in terms of an acceptance of having one child and a view of a ceiling of two children.

The mechanisms by which this might occur are certainly unclear. Apart from in China, IEC campaigns regarding 'stopping at two' were almost universal. As well as legitimising small family sizes, this may have delegitimised larger families (i.e. more than three). Indeed, the one country which has the highest preference for three or more children in the region, namely Japan, is the only country which has not undergone such a 'two-child norm' messaging paradigm over the last generation or two. With regard to one-child families, the narratives of the IECs which referred to the benefit of one-child families (e.g. Taiwan, South Korea, Viet Nam, and, of course China) not only served to

legitimise this 'new' family form, but used IECs to present an alternative view of the one-child family systematically. The one-child family was presented as a potential way to achieve a happy family and a prosperous nation.

Besides this 'enabling' feature of the IEC campaigns of challenging a stereotype, the political systems in which these campaigns operated should not be ignored. It is easy to conclude that China's regime type played an important role in driving home its family planning campaigns. Correspondingly, the comparison with other countries over the past 60 years (Taiwan, Singapore, South Korea and Viet Nam) shows that some of the most significant pushes in the family planning effort were made under historical conditions of strong, top-down modes of governance. For the case of South Korea, for example, family planning "was mobilized specifically in terms of the emerging 'modern' South Korean story and the state's relationship to the welfare of the individual family unit" (DiMoia 2009, 361). This 'modernisation' of society was to be driven both through the limiting of raw numbers of people, but also in ways that could be characterised as eugenic. Indeed, the IEC campaigns tackling son preference can be interpreted as challenging the idea of large families accruing from continuing to try for a boy, rather than devaluing discrimination against girls itself. Even in settings such as South Korea, Taiwan, and Singapore where efforts to bring about 'optimal family sizes' were not (by and large) coercive, the governments performing the campaigns generally *were*. As such, the messaging should not be seen as a casual piece of advice from a caring state; rather as more of an 'instruction' in all but words.

Family planning programmes have played an instrumental role in improving women's lives through an increased range of choices regarding childbearing, acting in tandem with other social and economic changes. But fertility reduction and family planning were (and are) also part of the nation-building project across Asia, and women's bodies were the crucible of this intervention. Through various means, some coercive others not, governments sought to affect both the physical and psychological views of women (and men) toward what an 'ideal' family might look like – an 'ideal' both for the individual and the (developmental) state. If this has permeated the consciousness and affected norms, perhaps this consistent messaging, possibly having been transmitted from generation to generation, could further shape the future impact of policies designed to reshape the family.

While this chapter was not able to prove the hypothesis that IEC campaigns have shaped contemporary fertility preferences in Asia, I propose that the cross-country comparison reveals a possible influence and an example of correlation. Further research should explore whether there is, indeed, an 'Asian exceptionalism' in fertility preferences, and the formative role of various different factors, including the history of family planning programmes. After all, the policy interventions mentioned at the start of the chapter, which have

largely been regarded as having limited impact on raising overall levels of fertility, might still supplement and accelerate already existing fertility declines and other widespread social and economic changes. These changes, such as urbanisation, female emancipation, education, and economic development, were each naturally inclined toward *decreasing* fertility.

In this sense, the family planning programmes played a *complementary* role. Today, however, in settings characterised by low fertility, there is, in fact, very little in these contemporary societies that would encourage a return to larger families, earlier/more marriage and so on. Against this, therefore, the more or less pronatalist policies of various governments across the region – even the very generous ones that we see in Singapore and the comprehensive ones we see in South Korea, for example – are going against the grain of not only decades of consistent anti-natalist messaging but general social and economic conditions. This can perhaps explain their relative lack of traction; the continuation of anti-natalist policies under conditions of lower fertility (largely due to bureaucratic inertia) adds to the situation. More generally, however, could it be that the successes of the family planning programmes in shaping fertility preferences gave a false sense of optimism about the role the state could play in determining family formation?

NOTE

1. Here, pronatalist policies are those which not only support childbearing and families, but do so explicitly within a framework of attempting to increase the total fertility rate.

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5. Sexuality education from an international perspective

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ACCESS TO SEXUALITY EDUCATION AS A RIGHT AND INTERNATIONAL POLICY LANDSCAPE

Sexuality education (SE) is a significant subfield of reproduction policy in that it addresses crucial aspects of people's sexual and reproductive health (SRH) and decision-making around it. The aims of SE vary across countries and over time and sometimes go beyond the key focus of reproduction policy to enable or obstruct processes related to pregnancy and procreation. For example, comprehensive SE (CSE) aims to prevent poor SRH outcomes and ensure the well-being of young people. The quality of SE is widely dependent on the provision of knowledge beyond basic biological information about procreation. Quality SE encompasses a broader understanding of sexual health, contraception, sexually transmitted infections (STIs), puberty, consent, gender norms, gender identity, sexual orientation, and pleasure. It should be age-appropriate, based on human rights and gender equality approaches, and should be scientifically accurate as well as culturally relevant (UN Women & UNICEF, 2018). CSE is considered an approach to SE that caters to these aims. It provides young people with the knowledge and skills needed to make informed, thought-out, and free decisions about their SRH and family planning, and gives support from an early stage in their life journey.

From a rights perspective, access to SE for children and youth is embedded in the fundamental right to health and education. For example, the UN Convention on the Rights of the Child 1989 states: "Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society" (UN General Assembly, 1989). There are many other international commitments to SE at the UN level, including the Sustainable Development Goals (SDGs), specifically Goal 4 on achieving quality education for all with an optional thematic indicator specifically focusing on SE (UN, 2015, pp. 1–13). In many regions, countries

also developed regional agreements to SE, such as the Eastern and Southern Africa (ESA) Commitment (2013) – a ministerial commitment to CSE and SRH services for young people (UNICEF, 2021) or the Ministerial Declaration "Educating to Prevent" in Latin America and the Caribbean (LAC) region (Declaration, M., 2008). These commitments and policy frameworks are well summarized in a number of recent reports and reviews (Michielsen & Ivanova, 2022; UNESCO, 2021).

Despite these international frameworks and pledges, SE, and access to knowledge on SRH more specifically, are regulated differently across countries. One reason is that they are often perceived as very sensitive subjects, SRH of young people and SE are contentious and polarizing issues. In the last decades, many countries have made significant progress in introducing SE policies, such as educational curricula. Creating a favourable policy and legal environment for SE is a very important step towards ensuring access to SRH information and knowledge for young people. According to the UNESCO 2021 report, most countries (85 per cent of countries included in available datasets), indicated the presence of policies (or, in certain instances, laws or frameworks) related to SE (UNESCO, 2021). The shape and extent to which SE is reflected in these policies differ – it might be simply mentioned within a national reproductive health strategy, or its provision can be mandated by law. However, these policies are rarely binding, and implementation of SE varies significantly.

Implementation depends on myriad factors, among which are governmental priorities, allocation of resources and responsibilities, public support, and opposition, and is often decentralized, that is, regulated by regional or local authorities or schools (UNESCO, 2021; Chapter 3, by Kluge, in this book). Further, in many contexts, the ability of adolescents to access SRH services and information is impeded by the perspectives of adults on adolescence and prevailing social norms. This may be due to cultural, religious, and legal debates against child sexuality or intimacy and prevailing gender and social norms on sexuality (Chandra-Mouli et al., 2019; Starrs et al., 2018). Research demonstrates that cultural environments, such as taboos surrounding sexuality and moral beliefs, create complexities in discussing this subject everywhere (Gillespie et al., 2022). These factors result in a fractured landscape of SE policies. Some countries implement a comprehensive approach to SE and discuss evidence-based information on reproductive health, contraception, STIs, gender identity, and sexual orientation. Conversely, other countries adopt a more restrictive approach, providing primarily abstinence-only education. The latter approach promotes sexual abstinence among young people as the most effective way to avoid STIs or pregnancy, while omitting certain topics due to cultural sensitivities or political shifts. In this case, the responsibility

for SE falls on parents and caregivers, who may decide whether or not to offer SRH information at home.

In this chapter, we illustrate the international range of SE policies and programmes using the cases of Uganda, Lebanon, and Mexico located in three different world regions. The countries can be considered "most-different systems" (Anckar, 2020), compared in terms of their regulative structures and socio-cultural settings. In particular, our comparative approach sheds light on the close links between cultural norms and SE policies in all of these different settings. However, we reject the idea that culture determines SE. Instead, we suggest four approaches to tackle opposition to CSE, and support a culturally sensitive perspective.

COMPARING MOST-DIFFERENT CASES: UGANDA, LEBANON, AND MEXICO

To contextualize the following analysis of SE policy, we give a short comparative overview of the country-specific settings in our three study cases. Table 5.1 shows various country-level indicators: political, economic, and social conditions, as well as demographic indicators, including sexual and reproductive behaviours and health outcomes.

Lebanon, Uganda, and Mexico are countries with diverse cultural and religious backgrounds, whose paths have been shaped by distinct historical events and global influences. In terms of demography, the figures show comparatively high shares of young people in the three countries, especially for Uganda, which is among the top ten countries with the highest numbers of adolescents worldwide (UNFPA, 2023). The state of SRH among young people varies between the three countries, with Uganda leading in the number of teenage pregnancies, followed by Mexico. All countries face challenges presenting statistics of the prevalence of STIs, and hence we cannot report on this indicator, but usage of modern contraceptives remains low, although comparatively higher in Mexico.

School-based Sexuality Education in Uganda

Sexuality education development and regulative structures

In Uganda, SE was a primary responsibility of parents and relatives following the cultural values of the community until the 1970s, when this was supplemented by school-based SE. Formal school-based SE can be traced to the beginning of the HIV/AIDS epidemic in the country. From the 1980s to the early 2000s, SE was delivered through school health programmes. In response to the HIV/AIDS epidemic, a specific SE programme was designed. In 2003, President Museveni introduced the Presidential Initiative on AIDS Strategy for

Table 5.1 Country characteristics and SRH indicators in Uganda, Lebanon, and Mexico

Indicator/characteristic	Uganda	Lebanon	Mexico
Country population (million)[1]	48.6	5.4	128.5
Population percentage of young people, 10–24 (%)[2]	35	27	25
Population percentage of adolescents, 10–19 (%)[3]	25	19	17
School enrolment in secondary education (% gross)[4]	24	NA	98
Global Gender Gap Index[5]	0.706	0.628	0.765
Adolescent birth rate among girls aged 15 to 19 per 1000[6]	128	12	71
Prevalence of modern contraceptive usage 15–49 (%)[7]	43.9	46.3	70.3
Age of sexual debut[8]	17.1	15.6	15
Percentage of child marriage by age 18[9]	34	6	21
GDP (USD) [10]	45.6 billion	23.1 billion	1.4 trillion
World Bank classification by income level[11]	Low	Lower Middle	Upper Middle

Indicator/characteristic	Uganda	Lebanon	Mexico
Constitutional form	Republic	Republic	Republic
Religious and cultural aspects	A country with robustly established cultural and religious institutions. Most of the population belongs to a religious sect. Christianity is the predominant religion (Roman Catholics and Protestants)	A country with 18 different officially recognized religious sects; power-sharing between the sects on the level of the parliamentary seats in addition to first and second grade. Islam is the predominant religion (Sunnis and Shias)	A multicultural country and secular state, with 62 indigenous peoples' groups distributed across its different parts. Christianity is the predominant religion (Roman Catholics)

Notes: Shows indicators of sexual and reproductive health, social, political and economic factors across Uganda, Lebanon, and Mexico.
Sources: [1–3] UNFPA (2023); [4] UNESCO, Institute for Statistics (2023); [5] World Economic Forum (2023); [6] UNICEF (2023); [7] UN, Department of Economic and Social Affairs, Population Division (2022); [8] Hallit et al. (2021); UBOS & ICF (2017); Barragán et al. (2019); [9] Girls Not Brides (2023); [10] World Bank (2021/2022); [11] World Bank (2022/2023).

Communication to Youth (PIASCY) programme to combat HIV among young people by sensitizing them about HIV prevention in primary schools. Despite the programme's successes, the PIASCY had limitations in its coverage of sexuality topics, with an emphasis on HIV prevention (Ministry of Education and Sports, 2018).

Various policy frameworks guide the implementation of SE in Uganda. These include the 2004 Uganda National Adolescent Health Policy (Ministry of Health, 2004), the 2012 Uganda National Adolescent Policy and Service Standards (Ministry of Health, 2012), the National School Health Policy and the 2018 National Sexuality Education Framework (NSEF) (Ministry of Education and Sports, 2018). All these regulations promote intersectoral partnerships between governmental and non-governmental organizations (NGOs) to strengthen the health of young people in Uganda. The Ministry of Education and Sports (MoES) oversees the implementation of SE in schools. In addition, the Ministry of Health (MoH) oversees the implementation of health education and services in schools and communities under the school health policy, which partially covers SE topics.

The MoES's NSEF uses mainly an abstinence-based approach for the delivery of SE to different age groups between 13 and 18 years under four main themes: human development, relationships, sexual behaviour, and sexual health, with life skills and values as a cross-cutting theme. That means, the focus is put on teaching young people not to have sex. Currently, SE in Ugandan schools is integrated into the primary and secondary school curricula. How SE is taught is inconsistent across schools, and it is mostly delivered in two different ways: (1) curriculum-based learning within different subjects; and (2) SE incorporated in extracurricular activities such as school assembly, drama, school clubs, and teacher-led mentorship sessions with pupils. Occasionally, it is taught as a standalone subject as part of the PIASCY programme, but it is also frequently integrated into the ordinary school curriculum.

Cultural, social, and political factors

The advancement of programmes addressing adolescent sexuality encounters significant hurdles within the Ugandan socio-cultural context, which hosts multiple different cultures. The common cultural and gender norms across most communities include bride price, early marriage, polygamy, and even wife inheritance in some cultures, all of which put women and girls in a compromised position to negotiate positive sexuality practices through subordination and control (Nyanzi et al., 2001).

Specific challenges to SRH of young people arise from these cultural practices. The practices mostly undermine young girls' sexual agency by promoting submissiveness to men's authority and sexual purity, and building boys' superiority, which creates an environment conducive to sexual abuse (Nyanzi

et al., 2001). The teachings and beliefs of the main religious denominations in the country are rather conservative and emphasize abstinence until marriage for young people. If anything, sexual experience at a young age is viewed as prestigious for boys, but is stigmatizing for girls, who are expected to remain virgins until marriage (Bell & Aggleton, 2013). In the non-permissive context of sexual relationships at a young age, secretive unprotected sexual relations become more likely. It may also hinder young people's ability to seek SRH support or advice (Ninsiima et al., 2018).

This interplay of socio-cultural and religious factors influences political action shaping the NSEF and how it is implemented. Extensive debate remains around the appropriateness of SE content, the range of topics, and the mode of delivery to suit the different stakeholder interests. In fact, SE has been portrayed as conflicting with the country's cultural and religious beliefs and values, impeding the implementation of comprehensive programmes (De Haas & Hutter, 2019). In August 2016, following a disagreement over the appropriateness of the SE content delivered by NGOs in schools, the government put a political ban on SE into effect. Although the MoES developed the NSEF in 2018, it has received opposition from religious and cultural leaders, who in turn are patrons of several educational institutions, further limiting the implementation of the programme (Segawa, 2020).

School-based Sexuality Education in Lebanon

Sexuality education development and regulative structures

The Lebanese national policy approach to SRH primarily focuses on reproductive rights and services for married individuals. The approach neglects details on the international framework of human rights per which it should act, as well as on the accessibility to knowledge and information (Arab Institute for Human Rights et al., 2020). Further, the policy approach omits sexual health services and consideration of different age groups and of marginalized social groups. This limitation is evident in several initiatives by Lebanese ministries, which prioritize religious, societal, and moral factors over scientific and international human rights principles (Arab Institute for Human Rights et al., 2020). One example is the inability of the Ministry of Education and Higher Education (MEHE) to integrate SE in school programmes due to historically pronounced political resistance, primarily from influential political and religious actors.

In 1995, a package of formal SE was developed as part of the work done by different UN bodies and the Lebanese Center for Educational Research and Development (CERD), to assist in the reconstruction and development of the country after the civil war (1975–1990) (Baydoun, 2016). The package included culturally and locally contextualized information on the following topics: puberty, reproductive organs, menstrual cycle, STIs, and birth control

(UNFPA, Arab States Regional Office, 2020). However, due to opposition from religious actors, SE was only partially incorporated into the biology classes of secondary schools (Baydoun, 2016; UNFPA, Arab States Regional Office, 2020).

In 2004, the Population Education Project on Reproductive Health and Gender in Schools was launched as a collaboration between United Nations Population Fund (UNFPA) and the Government of Lebanon. In line with this project, a school-based curriculum on life skills and reproductive health education from a gender perspective was generated in 2009 (UNFPA, 2004). The curriculum, which again adopted a culturally sensitive approach, was limited in focusing mainly on aspects of reproduction, rather than on sexuality more broadly. However, it was still considered a promising instrument for students to acquire knowledge on reproductive health and establish healthy perspectives and competencies on sexuality (UNFPA, 2004; The A Project et al., 2015; DeJong & Bashour, 2016). The curriculum was approved in 2010 by the MEHE and Ministry of Public Health (MoPH), but implementation remained partial due to other political priorities and the lack of full acknowledgement of the curriculum by the different Lebanese societal and religious actors (UNFPA, Arab States Regional Office, 2020; Mouhanna et al., 2017).

Since 2010, students also have been taught reproductive health topics with non-compulsory materials, used at the discretion of school administrations and teaching staff (DeJong & Bashour, 2016; Mouhanna et al., 2017). Throughout the country, some local initiatives and NGOs fill the knowledge gap by providing open and safe spaces for learning and discussion. As instruments, they use information sessions, open meetings, and workshops on youth SRH in schools, scouting organizations for kids, and universities (UNFPA, Arab States Regional Office, 2020; LAU News, 2017).

Cultural, social, and political factors

Lebanon is one of the most liberal and diverse countries in the Middle East and North Africa (MENA) region and hosts several marked trends of social change witnessed also in other parts of the world, such as penetration of youth culture by digital media (Mouhanna et al., 2017; Barbour & Salameh, 2009; Mady & El-Khoury, 2022). At the same time, Lebanon is considered a proxy battleground of major political powers in the region and has a contemporary history with several violent events and continuous foreign interference with its internal affairs (Traboulsi, 2015; Abouzeid et al., 2021).

Sectarian laws limit national progress on sensitive and critical subjects, such as SRH, in a scientific, systematic, and uniform way across the country (Arab Institute for Human Rights et al., 2020). The Lebanese civil war generated a political system that is based on democratic sectarian governance and includes the religious leaders and associations of 18 sects as active actors

in issues related to the state and the public. To the present, religious leaders acknowledge the government formation, manage the religious personal status courts, and influence the political decision-making processes on different issues such as censorship and education (Jadaliyya, 2012; Henley, 2016).

Not least, Lebanon has been experiencing multi-layered and complex crises for the last few years, especially since 2019: a large refugee influx mainly from Syria, a severe economic crisis, the COVID-19 pandemic, and the 2020 explosion at the Port of Beirut (World Bank, 2021; UNHCR, 2023). In these circumstances, topics such as SRH and SE are not prioritized on the agenda of governments, despite the worsening of health indicators, including the rise in maternal mortality due to non-communicable diseases (WHO, 2022).

In sum, political, religious, and societal factors obstruct the comprehensive implementation of an already approved and contextualized SE curriculum on a national level. Although experts in the fields of SRH and health education in Lebanon continue to advocate for SE by stressing its necessity and importance, and the positive effects on SRH, the politics of SE remain a problematic issue. Scholars have presented various recommendations for efficient and sustainable SE programmes in Lebanese schools (Bouclaous et al., 2021; Mouhanna et al., 2017; UNFPA, Arab States Regional Office, 2020). Integrating young people and their parents in the development of programmes and activities as well as in the process of implementation are some of these recommendations (Bouclaous et al., 2021). Yet, because of the highly sectarian and confessional system, the effectiveness of such recommendations will be limited if politicians, religious leaders, and representatives are not engaged.

School-based Sexuality Education in Mexico

Sexuality education development and regulative structures

The roots of the institutionalization of SE across educational and political systems in the ethnically and culturally diverse country of Mexico can arguably be traced to ideas about racial improvement among the ideological and religious elites (González, 2021). Going back to the 1920s–1930s, the eugenic movement and its biological approach were instrumental in shaping health and education research and policies pertaining to the Mexican population (Heredia & Rodríguez, 2021). Indigenous peoples were severely marginalized since they were viewed as a hinderance to Mexico's progress and economic development. Also in the 1930s, Mexico followed the recommendations emitted at the Pan-American Congress of the Child in Peru to implement SE programmes in schools. SE was incorporated in a higher secondary school programme, whose content was linked to adolescents' and youth hygiene, prevention of alcoholism and drug addiction, and maternal childcare. Shortly after, under

the leadership of the Public Education Secretary, Narciso Bassols, SE was introduced in primary schools (del Castillo Troncoso, 2000).

The following three decades (1940s to 1960s) were marked by an educational model focused on hygiene and the prevention of risks associated with sexual practices. Rather than guaranteeing SE in schools, the Mexican government focused on adults through the promotion of laws that regulated SRH in marriage, the use of a medical prenuptial certificate, and the establishment of centres for prenuptial hygiene (Heredia & Rodríguez, 2021, p. 49). By the end of the 1960s, the Ministry of Health (MoH) had initiated a policy shift towards a family planning approach, aiming to provide equitable access to reproductive services. Along with a constitutional reform to guarantee individuals' rights to decide the number and spacing of their children, the National Population Council was established. In line with population policy approaches of the period, the Council led several media campaigns to educate parents with slogans such as "Let's Become Fewer" and "The Smaller Family Lives Better" (Huska, 2016).

In the 1970s, the government introduced SE in primary education classes (natural sciences), and across the three years of basic secondary education (biology classes). In the same period, SE was introduced in teacher training. The content of SE in this period was based on a biological approach and promoted values adhering to a heterosexual couple norm with traditional gender roles that diminish women's participation in society (Chandra-Mouli et al., 2018).

More recently, developments paved the way to a more holistic approach to sexuality in school-based SE in Mexico. In 1993, the government installed a human rights SE approach by amending the General Law of Education (GLoE) to guarantee the delivery of SE in schools. In practice, although articles 7 and 8 referred to SE, they were linked to family planning rather than implementing a broader curriculum on sexuality. In 2019, a new GLoE was published, which established that the MoH can intervene and make suggestions about the contents of SE that is being taught at schools (article 26), and that comprehensive SE covers responsible sexual practices, family planning, prevention of adolescent pregnancies and STIs (article 30) (Cámara de Diputados del H. Congreso de la Unión, Ley General de Educación, 2019); and finally, in July 2023, the Mexican government integrated CSE in the new educational paradigm, and incorporated it in the free textbooks 2023–2024.

Cultural, social, and political factors

In Mexico as in other countries, access to SRH information including SE for adolescents and young people is influenced by cultural, social, and political factors. Notably, despite Mexico's constitutional principle to guarantee

a secular education, SE content in the curriculum has been influenced by religious and ideological groups (Díaz Camarena, 2020). In a context of continuous opposition to SE, civil society organizations have played a fundamental role in advocating for the right to SE and SRH services. The first advancements took place in the 1970s when social and political movements mobilized to prevent HIV transmission and early unintended pregnancy, as well as to promote LGBTIQ+ rights (Chandra-Mouli et al., 2018). Since the 2000s, Mexico's civil society and government have promoted a holistic approach to sexuality in the official textbooks. The inherent secular educational principle was criticized by conservative groups, which insisted that SE would have a negative impact on Mexican society (Bernal & Sandoval, 2019).

Despite the progress towards acknowledging SE and SRH information as a right in Mexico, there is still a long way to go. Mexico's cultural traditions are rooted in conservative and religious values across urban, rural, and indigenous communities. Traditional gender roles continue to be perpetuated within families and communities (Hietanen & Pick, 2015). Further, Mexico's multicultural diversity and systemic problems such as extreme poverty, inequality and violence have shifted the political focus to other priorities – despite the potential of SE to contribute to young people's awareness and prevention of violence and inequity.

FINAL REFLECTIONS AND RECOMMENDATIONS

The description of our country cases has highlighted the role of the state and its affiliated institutions in regulating access to SE. The comparison demonstrates several similarities and differences in terms of the structural and cultural conditions for accessing SRH information by young people in the three countries. In putting a spotlight on countries in three different world regions, we provide a broad perspective on state regulation of reproduction in different settings. In particular, our comparative approach highlights the close links between cultural norms and SE policies while rejecting cultural determinism. Rather, the chapter makes the case for culturally sensitive approaches that respect local beliefs and traditions.

One takeaway is that religious actors often successfully interfere in SE policy despite institutional prerequisites that should restrict them. Notably, each of our study countries had at least one ministry responsible for the development and implementation of the national SE curriculum and related laws. And yet, religious and ideological groups that oppose school-based SE have interfered and continue to do so. In the case of Mexico, such interference did not have a substantial impact, because of the continuous and growing encouragement of government members, civil society actors, and parents in favour of national SE in schools (Pick et al., 2000). By contrast, in Uganda and Lebanon, religious

leaders successfully framed SE as a threat to morality and values on a national level (Moore et al., 2022; Baydoun, 2016). Summing up our comparative conclusions, the following paragraphs outline four approaches for overcoming political challenges and opposition to access SRH information and SE.

Integrating Religion and Social Values in Sexuality Education

Sexuality and religion are commonly seen to clash within individuals' experiences and beliefs (Henry & Heyes, 2022). To overcome this conflict, experts propose a pedagogical approach to SE that encourages students to be involved in inclusive and extensive conversations on the religious, cultural, and societal scopes of gender and sexuality (Henry & Heyes, 2022; Sanjakdar, 2016). If SE is understood not only to foster information on protective and responsible sexual behaviour, but also to present means for individuals to recognize their sexual life options, needs, virtues, and quality, religion can be an entry subject for students to question their decision-making processes on sexuality issues (Sanjakdar, 2016; UNESCO, 2009). Following this approach, SE was to acknowledge students' opinions on religions, whether supporting or opposing, apart from concentrating on secular principles (Sanjakdar, 2016). Accordingly, the curriculum would incorporate accurate and scientific information in addition to societal and individual ideologies, values, and preferences. This integration can help to achieve the international standards for an effective, inclusive, and equitable SE (UNESCO, 2009). Moreover, raising awareness and engaging religious leaders, faith-based organizations, and communities in SE programmes is an important factor for success in many settings (Chitando & Moyo-Bango, 2016; Le Mat et al., 2023).

Incremental Approach to Sexuality Education Implementation

The potential benefits of SE have been severed by widespread resistance to the comprehensive approach to SE; where "comprehensive" refers to the breadth, depth, and consistency of topics (UNESCO, Health and Education Resource Centre, 2021). In many countries across the world, SE topics such as gender diversity or sexual orientation are regarded as so-called "western culture" and thus viewed as foreign (Vanwesenbeeck et al., 2018). This calls for a rethinking of what are the critical instruments for reducing SRH risks and achieving sexual well-being among young people. In socio-culturally restrictive contexts, implementation of an adapted "less comprehensive" SE programme that is culturally responsive may have some benefits (Kemigisha et al., 2019). Refining the content to be culturally acceptable would pave the way for an incremental approach to building comprehensive SE programs in different countries (Mukoro, 2017).

Strengthening Civil Society and Holding Governments Accountable

The past two decades of SE activism have witnessed vocal civil society organizations (CSOs) linked to different movements, including HIV prevention, early unintended pregnancy prevention, and LGBTQI+ rights promotion (Chandra-Mouli et al., 2018). In our three study countries, CSOs are typically locally led, follow human rights and gender equality-based approaches, and are known for holding organizations and governments accountable for their SRH actions and decisions. In Lebanon, despite the lack of support from governmental institutions and the shortcomings in the state's compliance with the international framework of human rights, CSOs have advocated to protect and guarantee SRH rights (Turkmani et al., 2020). In Mexico, CSOs have guaranteed continuity, exchange, and innovation, and their role has been fundamental in advancing SE (Corona, 2023). In Uganda, CSOs have been working to enhance advocacy for SRH and rights, promote a research agenda on SE, and guarantee the rights of underrepresented and marginalized people in a complex and changing context (Uganda Launches Sexual and Reproductive Health Rights League – Reproductive Health Uganda, 2021). CSOs are essential for ensuring comprehensive sexuality education, as they maintain a unified voice against misinformation, opposition, and restrictions, challenging SRH norms through evidence-based advocacy and holding states accountable.

Social Media as a Tool to Access SRH Information and to Overcome Restrictions

Due to the existing barriers and restricted delivery of SE in many countries, as well as widespread digitalization and internet penetration, some adolescents are turning to social media to become better informed about SE topics (Döring, 2021). Young people can find useful information on SE topics on social media, including topics that are less discussed in school-based SE, such as gender and sexual diversity. Social media can be used as a channel to implement wide-scale and cost-effective SE delivered by professionals and complement school-based SE (UNESCO, 2020). Moreover, the digital space and social media can be used to stimulate discussion, foster positive narratives, organize supporters of SE, and initiate advocacy campaigns. All the while, social media can also be a source of misinformation that should not be neglected and be tackled hand in hand with the provision of quality digital SE.

To conclude, the chapter shows a positive development of sexuality education in three countries over time despite changing and often challenging socio-cultural and political circumstances. The worldwide pushback against CSE calls for continuous advocacy, the collection of evidence on its effectiveness and quality, and implementation of culturally sensitive approaches.

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6. Variants of abortion exceptionalism: mapping adherence to healthcare standards in high-income countries

Catherine Conlon

INTRODUCTION

Recent empirical evidence highlights the cross-national differences of abortion regulation and the political factors driving them (Fernández, 2021; Forman-Rabinovici & Sommer, 2018). This chapter asks how the over-regulation of abortion as a healthcare service (abortion exceptionalism) varies across high-income countries. Regulation of abortion in any given state comprises some combination of laws, regulations and policies specifying conditions that govern access to abortion care. Abortion exceptionalism refers to how abortion is subject to unique, burdensome and more stringent regulation than other medical procedures of comparable complexity and safety related to the politics of abortion rather than its medical characteristics and giving effect to additional challenges for providers and stigma-in-action for service users (Borgmann, 2014; Joffe & Schroeder, 2021; Millar, 2023). Drawing on the Global Abortion Policies Database, this chapter gives a comparative overview of how abortion is regulated in high-income countries considered to be economically developed, politically stable and culturally liberal. Mapping the regulatory landscape in such settings that are expected to have well-developed healthcare standards and frameworks respecting international human rights obligations demonstrates the extent to which abortion exceptionalism persists.

Abortion regulation may occur in the penal code as well as legal texts beyond it, including reproductive health acts, general health acts, and medical ethics codes (Lavelanet et al., 2018). Additional instruments include ministerial decrees, abortion-specific acts, and court cases. Alongside the national regulations, global and regional policy frameworks and instruments have designated access to safe abortion as a human right. At the global level, the 1994 International Conference on Population and Development was an important milestone, when 179 governments signed a Programme of Action including

a commitment to prevent unsafe abortion (UNPF, 1995). Shalev (2000) characterises this as a new paradigm addressing reproduction wherein human rights featured as a primary principle. Reproductive rights were defined as embracing certain human rights, encompassing autonomy and gender equality already recognised in international human rights documents. Various international human rights treaties and conventions formed the basis for the Programme of Action (Shalev, 2000). In the intervening period, global abortion norms have shifted from preventing unsafe abortion to establishing access to safe abortion (WHO, 2022a). While abortion has been recognised as a human rights imperative by monitoring bodies of numerous UN treaties, at regional level, the European Court of Human Rights, the Inter-American Court of Human Rights and the African Commission on Human and Peoples' Rights have now all also deemed access to safe abortion a human right (Shalev, 2000; Fine et al., 2017).

The World Health Organization recognised unsafe abortion as a public health issue in 1967 and in 2003 developed technical and policy guidelines including a recommendation that states' laws regulating abortion should be consistent with protecting women's health (WHO, 2003). These guidelines were most recently updated in 2022, directed at removing regulatory, policy and programmatic barriers hindering access to and timely provision of safe abortion (WHO, 2022a). The WHO 2022 guidelines designate abortion as an essential health service and relates strengthening access to comprehensive abortion care as fundamental to meeting Sustainable Development Goals (SDGs) relating to good health and well-being (SDG3) and gender equality (SDG5) (WHO, 2022a, p. 1). The 2022 guidelines emphasise creating an *enabling environment* as the foundation of quality comprehensive abortion care. Three cornerstones of an enabling environment for abortion are specified as: respect for human rights including a supportive framework of law and policy; availability and accessibility of information; and a supportive, universally accessible, affordable and well-functioning health system (WHO, 2022a). This chapter uses the guidelines as a framework to assess the extent to which high-income countries' abortion policies comply with current international health standards, or how they implement unique regulations marking exceptionalist treatment of abortion. The analysis identifies persisting signs of exceptionalism, and demonstrates varying degrees and patterns of divergence from rights-based standards in high-income country abortion provision.

REGULATING ABORTION AND ABORTION EXCEPTIONALISM

Laws and policies governing abortion vary widely across countries. In most countries, "abortion law" comprises a range of laws, regulations and policies

and can fall within the ambit of criminal law, medical law, health law, administrative law, pharmaceutical regulation, procurement law, professional regulation of health workers, employment law and contract law (WHO, 2022a).

Abortion is currently lawful in many countries, at least under certain conditions, as numerous countries took some steps to liberalise their abortion laws following the ICPD Programme of Action in 1994. According to the WHO, unsafe abortion by now is increasingly concentrated in "low-income countries" (97 per cent of unsafe abortions) and among vulnerable and marginalised groups in both low- and high-income settings (WHO, 2022a). This has meant that commentary on abortion regulation usually centres on low-income countries. However, analysing how states who provide legal abortion adhere to frameworks for optimum regulation and provision supporting abortion access (Oja, 2017) can shed light on how this area of healthcare complies with rights-based standards.

A key feature of abortion provision is how it is regulated differently to other forms of healthcare. This has been termed "abortion exceptionalism" (Borgmann, 2014) referring to a tendency by legislatures and courts to subject abortion to unique and uniquely burdensome rules (p. 1047). Joffe and Schroeder (2021) defined abortion exceptionalism as "the idea that abortion is regulated both differently and more stringently than other medical procedures that are comparable to abortion in complexity and safety" (p. 5). They further explain the effect of abortion exceptionalism whereby abortion providers encounter "additional, unique challenges that can only be attributed to the *politics of abortion* and not to any credible medical issues" (p. 11, emphasis added). Millar (2023) posits abortion exceptionalism as a mode of stigma-in-action, a feature that signals the various discourses and practices that differentiate abortion from routine medical care, usually in the form of over-regulation. As examples of over-regulation, Millar (2023) cites regulating abortion in standalone Acts, allowing for conscientious objection, or preventing nurse and midwife provision. Another dimension of abortion exceptionalism is that, unlike other health services, abortion is commonly regulated through the penal code with criminal sanctions attaching to one or more among the person accessing abortion, individuals and networks assisting them or medical professional(s) providing abortion. Abortion exceptionalism is a feature of medication abortion where states designate special drug status to abortion medication (Millar, 2023).

Synthesising how abortion exceptionalism has been theorised to date then, it refers to how abortion as an area of healthcare is subjected to different, unique, more stringent and burdensome rules than other comparable medical procedures, constitutive of over-regulation arising from the politics of abortion rather than any medical issues entailed in the procedure. This chapter applies the concept of abortion exceptionalism as a framework to analyse national- and

sub-national-level abortion regulation comparatively for the first time. While any over-regulation of abortion can be defined as an indication for exceptionalism (Millar, 2023), comparing abortion policies across countries can reveal their degrees of adherence to an exceptionalist approach. This perspective allows us to identify countries – and sub-national regions where applicable – where abortion is more integrated in routine healthcare (no or lower exceptionalism), and reveals different variants of abortion exceptionalism showing divergence from rights-oriented reproductive healthcare to moderate or higher degrees.

ANALYTICAL PERSPECTIVE

To assess abortion exceptionalism, the laws, regulations and policies specific to abortion of countries and, where applicable, their sub-national regions will be compared against a state-of-the-art standard of abortion as healthcare. The chapter compares countries with relatively similar systemic characteristics such as welfare and fundamental rights (Hoffmeister, 2020), that is, high-income countries, in order to be able to focus on abortion exceptionalism as a digression from rights-based standards in abortion care. The chapter adopts the UN Secretariat Department of Economic and Social Affairs' 2022 definition of "developed economies" as a proxy for high-income countries. Developed economies are empirically well aligned with high-income countries that display characteristics of economic and political stability, are culturally relatively liberal in the global context and are expected to have well-developed frameworks respecting international human rights obligations.

For the comparative analysis of abortion policy as exceptionalism, the chapter assesses exceptionalism indicated by "different, unique, more stringent and burdensome rules" against criteria from a systematic, state of the art framework of abortion care. The framework builds on the new guidelines for abortion care issued by the World Health Organisation (WHO) in 2022 based on a comprehensive synthesis of evidence (WHO, 2022a, 2022b). The guidelines incorporate recommendations for law and policy towards creating an enabling environment for quality abortion access. In the guidelines, the WHO identifies seven specific, interdependent and interrelated instruments of abortion law and policy globally, comprising: criminalisation, grounds-based approaches, gestational age, mandatory waiting periods, third-party authorisation, provider restrictions and conscientious objection. These regulatory instruments provide a rigorous framework to comparatively assess the degree to which countries' abortion regulations divert from international public health standards, and hence display exceptionalism.

As the principal source of empirical data on laws and policies relating to abortion in specific countries, this chapter draws on the Global Abortion

Policies Database (GAPD) (Johnson et al., 2018). GAPD was launched in 2017 and is updated regularly, presenting current information on abortion laws and policies for all WHO member states. The database contains indicators for abortion laws, policies, standards and guidelines for United Nations (UN) and World Health Organization (WHO) member states. Data collection for GAPD is organised through a data extraction questionnaire; and includes an extensive search for source documents, data extraction, internal cross-checks, as well as reviews by country experts (Johnson et al., 2018). GAPD data goes beyond categories of lawful abortion to include information on additional legal requirements, such as mandatory waiting periods, clinical and service-delivery aspects of abortion care, conscientious objection, and penalties.

The database provides sufficient information to report on six of the seven instruments of abortion law and policy of the WHO guidelines (criminalisation, grounds-based approaches, gestational age, mandatory waiting periods, third-party authorisation and conscientious objection), and hence these will be discussed in the analysis. Provider restrictions were not covered in GAPD, and are not discussed in the chapter. At the time of writing, GAPD's latest update had been in August 2022 and so the chapter principally reflects regulation at this time, except for high-level legal changes between then and November 2023, which were added by the author. During the compilation of data for the chapter, some issues with completeness and accuracy of content of the GAPD were noted. Where necessary, GAPD data were cross-checked and supplemented with information from online governmental sources.

The analysis covers abortion policies from 37 national contexts of which three have combined 23 sub-national regions with devolved powers to regulate abortion, making for a total of 57 jurisdictions considered. The basis for selection of countries are those categorised as developed economies by the UN DESA (UN 2022) as well as South Korea, which also fits this profile. In Australia, the United Kingdom and Canada, regulations on abortion apply in their sub-national jurisdictions. In these cases, the analysis considers each instrument of abortion law and policy at the sub-national regulatory contexts. The United States is omitted from the analysis, as the regulation of abortion varies strongly across the 50 states (and Washington, DC), and is in an ongoing state of flux following the *Dobbs v. Jackson Women's Health Organization* judgment in 2022. Among the 57 jurisdictions in the final sample, only in the small municipality state of Malta is abortion prohibited in all circumstances. Thus, in effect, abortion is lawful to some degree in near to all high-income countries.

The analysis proceeds in three steps. First, different degrees of exceptionalism (no, low, moderate, high) are defined for each of the six instruments of the abortion law and policy framework, and countries are categorised in line with their policies. Table 6.1 shows the conceptual grid of levels of exceptionalism

Table 6.1 Levels of exceptionalism by abortion policy dimensions

Dimension	No exceptionalism	Low exceptionalism	Moderate exceptionalism	High exceptionalism
Criminalisation	No criminal sanctions	N/A	Criminalisation of provider or person assisting only	Criminalisation of person seeking care, provider and person assisting
Gestational age limits for on request abortion	On request, no gestational limit	On request, limit over 16 weeks	On request, limit 16 weeks or less	Not available on request at any stage
Grounds-based approaches	No application of grounds to access care	N/A	Moderate compliance with human rights laws e.g. including social as well as physical and mental dimensions when assessing risk to health	Low compliance with human rights laws e.g. excluding mental health in risk to health; foetal assessment as a standalone ground
Waiting periods	No waiting period	N/A	N/A	Waiting period of any duration
Third-party authorisation	None required	N/A	N/A	Requirement for parental/ judicial consent or attendance at counselling/for information
Conscientious objection	Not specifically provided for OR is specified as not permitted	Provided for but facilities may prohibit their staff from objecting to participating in abortions	Provided for specifically but with requirement to refer to provider	Provided for specifically but with requirement to assist in emergency

Note: Shows four levels of exceptionalism (no to high) in abortion policy by dimensions of criminalisation, gestational age limits for on-request abortions, requirement of grounds, waiting periods, necessity of third-party authorisation, provisions for conscientious objections.

by abortion policy instrument against which the combined 57 jurisdictions of the 37 countries are evaluated. For countries with sub-national regions, the UK (4), Australia (8) and Canada (11), the unit of assessment for exceptionalism of each instrument is the sub-national jurisdiction. For example, the UK may be counted four times in each category, while countries with no sub-national jurisdictions can be counted only once within any dimension assessed. Second, a synthesis of the variations of exceptionalism is presented in Figure 6.1 showing the distribution of countries by regulatory dimension for different levels of exceptionalism. Third, two select countries, Italy and Canada, are discussed as contrasting examples for high and low abortion exceptionalism, respectively.

FINDINGS: VARIANTS OF EXCEPTIONALISM IN ABORTION POLICY ACROSS HIGH-INCOME COUNTRIES

Criminalisation

General criminal offences apply to healthcare where it is administered without consent or negligently, while healthcare is also governed by professional regulation. Specific criminalisation of abortion is a common, longstanding feature of abortion regulation, making it exceptional as an area of healthcare. The WHO 2022 guidelines recommend full decriminalisation of abortion based on international, regional and national human rights bodies and courts (WHO, 2022a, p. 24) so that specific criminalisation of abortion in the legal code of any country indicates exceptionalism.

Abortion can appear in the legal code to designate grounds when abortion is legal or outside of which abortion is a criminal offence. Criminalisation relating to abortion can be directed at the person terminating their pregnancy, another person assisting them and/or a health professional providing abortion. Applying criminal sanctions to both the person seeking abortion and abortion provider is designated high exceptionalism, applying criminal sanctions to the person providing abortion and not to the person seeking abortion or person assisting is classified as moderate exceptionalism, while, it is argued, no designation of low exceptionalism applies in relation to criminalisation. Rather, no criminalisation constitutes no exceptionalism.

The policy data show that all countries except Canada, Australia, New Zealand, South Korea and Northern Ireland (no exceptionalism) have criminal sanctions specifically relating to abortion codified in law, with all but Canada moving to this position within the last ten years. All criminalise a health professional providing abortion outside proscribed grounds (moderate exceptionalism), all but eight criminalise a person other than a health professional

who assists with abortion and over half criminalise a person who terminates a pregnancy outside proscribed grounds for legal abortion.

Gestational Age Limits and Grounds-based Approaches to Regulating Abortion

Regulation of abortion may allow for provision at a woman or pregnant person's request at some gestational stages only and/or on specified grounds at some or all gestational stages. The 2022 WHO guidelines recommend against laws and other regulations that restrict abortion by grounds, indicating no exceptionalism pertains where abortion is available on request without gestational limit.

In practice, many countries specify a grounds-based approach to abortion provision. Gestational limits are often applied where abortion is provided without grounds, or else abortion without grounds is not permitted at all. Where grounds apply only after 16 weeks gestation, this is designated low exceptionalism. Moderate exceptionalism pertains where abortion is provided without grounds up to 16 weeks or lower gestational limit. The greatest tendency is for grounds to apply after 12 weeks gestation. High exceptionalism pertains in this category where abortion is only provided based on grounds at all gestational stages.

Of the 37 countries comprising 57 jurisdictions analysed, abortion is available at a woman or pregnant person's request with no limit specified in just three countries, South Korea, eight of Canada's 11 sub-national regions and one of Australia's eight sub-national regions. This constitutes full decriminalisation of abortion making it a matter solely of healthcare, displaying no exceptionalism. Grounds apply to access abortion at *all* gestational stages in eight countries (high exceptionalism), while in 26 countries and some regions of Canada and Australia grounds apply after specified gestational limits (moderate–low exceptionalism). The tendency has been to limit abortion on request to a specified gestation, most usually 12 weeks (moderate exceptionalism) and less frequently up to a limit of 16 weeks (low exceptionalism).

Specified grounds permitting abortion

Acknowledging that grounds-based approaches apply in many cases, the WHO 2022 guidelines recommend that, until these are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. Grounds relate either to the situation of the woman or pregnant person (or a co-parent) or regarding the foetus. The WHO guidelines avoid this separation by not focusing on the nature of the condition relating to the foetus but rather on the impact of any foetal anomaly on the person carrying the pregnancy.

Grounds relating to social and economic risks set comparatively low barriers. For example, Japan includes risk of damage due to economic reasons as a ground, and both Denmark and Finland refer to the responsibilities of caring for children of the family and the family's housing, financial and health conditions as grounds permitting abortion. Such social grounds more closely align with a human rights-based framework having regard to the reference to "social" in the definition of health employed: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2022a, p. xiv).

The barrier is higher where risk to life of the woman or pregnant person is a specified ground. Gestational limits do usually not apply in this case, but this can be contested around the issue of the viability of the foetus. The risk to health ground is characterised variously as "serious", "unavoidable risk", "danger of harm", "serious and permanent harm or injury" to the physical or mental health of the woman or pregnant person. In most countries, the risk specified is a clinical risk posed to physical or mental health, but this is not always the case and social risks can also feature.

Age features in some contexts as a ground, permitting abortion where the woman or pregnant person had not yet reached a certain age, specified as 16 years in Cyprus and 14 years in Austria or as a "young age not able to care for child in a responsible manner" in Denmark. In two countries both a younger age and an older age are specified grounds permitting abortion (Finland: under 17 years and over 40 years; Lithuania: under 13 and over 49). Finally, pregnancy resulting from rape or non-consensual sex is a specified ground under some countries' regulations (Japan, Cyprus, Czech Republic, Bulgaria, Croatia, Greece, Germany and Denmark).

Specified grounds relating to the foetus

The WHO guidelines avoid separating woman or pregnant-person-related grounds and foetal-related grounds by recommending that abortion be available when carrying a pregnancy to term would cause the woman or pregnant person substantial pain or suffering, including situations where the pregnancy is not viable. This moves the focus away from the nature of the foetal anomaly and onto the impact of the diagnosis on the person carrying the pregnancy. However, existing laws of countries analysed here treat risk to life of the foetus or a foetal anomaly as qualifying grounds on their own terms separate to concerns for the woman or pregnant person. Grounds vary, with some countries allowing abortion in the context of risk to life only (e.g. Ireland), whereas significantly diminished quality of life due to a foetal anomaly is a qualifying ground in more cases. Germany alone applies foetal anomaly as a ground for abortion, related to the impact of the diagnosis of foetal anomaly on the woman or pregnant person rather than to the foetal condition in itself.

Categorising exceptionalism for grounds-based approaches

Categorising exceptionalism in relation to grounds-based approaches then, no application of grounds to access care is deemed no exceptionalism. High compliance with human rights law by including social, physical and mental dimensions when assessing risk to health constitutes low exceptionalism (e.g. Finland). Low compliance with human rights laws, for example treating foetal assessment as a standalone ground instead of assessing the impact of foetal assessment on the pregnant person (e.g. Ireland), is designated high exceptionalism.

The instrument of grounds-based abortion access has several axes and so is too complex to designate a country to one global category. Rather, a country should be analysed for how each ground it specifies is applied. For example, in the Irish case, grounds apply after 12 weeks gestation, prior to which abortion is provided on request (no exceptionalism up to 12 weeks), physical and mental health dimensions are considered but not social (moderate exceptionalism) while foetal assessment is considered as a standalone ground, without regard to impact on the woman or pregnant person (high exceptionalism). It is argued that the country would then be categorised according to the highest variant of exceptionalism displayed – in Ireland's case as high exceptionalism in relation to grounds.

Waiting Periods

Waiting periods require a person seeking abortion to wait a specified period between first consulting with a health professional and completing the care. The WHO 2022 guidelines recommend against any waiting periods on the basis of evidence that shows they inhibit access, increase costs and resources involved for the person seeking care and may result in forced disclosure against the interests of privacy without any evidence of the benefits of wait periods (WHO, 2022a, pp. 40–41). Given this evidence, mandatory waiting periods of any duration constitute high exceptionalism.

Of the 37 countries comprising 57 jurisdictions studied, 12 countries and one sub-national region invoke waiting periods. The shortest period is 48 hours after seeing a doctor in Slovakia. Three days is the most common waiting period, enforced in Ireland, Poland, Portugal and Spain after seeing a doctor, and in Germany, Hungary and Latvia after attending abortion counselling. Belgium imposes a six-day waiting period while Italy and Jersey in the UK impose a seven-day wait. Despite evidence of the negative effects of waiting periods on abortion seekers, they feature even in very recently implemented regulations such as in Ireland.

Non-medical Third-party Authorisation

Authorisation of third parties for abortion access is commonly invoked for minors or those without capacity to consent. Alongside giving one's own consent, parental consent for minors is required in almost half (16) of the 37 countries comprising 57 jurisdictions analysed. The age of the pregnant minor at which parental consent is required for abortion varies; specified as 16 years in the majority of countries, while Italy, Denmark and Cyprus specify 18 years and Austria and Australia's Northern Territory and New South Wales specify 14 years. Some countries or regions specify alternative arrangements, where parental consent is not obtained such as judicial involvement in Poland and Québec, Canada, or a doctor's determination of free, informed consent in the Netherlands. Where parental consent is sought for abortion based on age, this constitutes high exceptionalism.

Besides parental consent, other conditions for abortion provision that limit the pregnant person's autonomy may also be invoked and indicate high exceptionalism. Counselling is mandatory to access abortion in some countries, most commonly in central and southern Europe, including Belgium, Germany, the Netherlands and Spain. Because this is at odds with WHO's 2022 Care Guidelines that state counselling should be made available but should always be voluntary, it constitutes high exceptionalism.

Conscientious Objection

While provision for doctors and allied health professionals to refuse to participate in medical care on grounds of conscience is provided for in a general way within professional regulation of health professions, abortion law has tended to provide specifically for conscientious objection as well. Chavkin et al. (2013) argues this locates the issue at the individual practitioner level rather than considering the obligations of the professional and health system levels. The WHO 2022 guidelines recommend that access to abortion care be protected against barriers created by conscientious objection.

Most of the 37 countries, including all 23 sub-national regions of the UK, Canada and Australia considered here, allow for conscientious objection in regulations on abortion except where necessary in an emergency. Some specify mitigating measures including the requirement for health professionals to inform the person seeking abortion quickly and to refer them to a provided doctor.

Among the 37 countries, including the 23 sub-national regions of the UK, Canada and Australia, only five jurisdictions (Japan, South Korea, Bulgaria, Finland and Sweden) do not specifically provide for conscientious objection, while Finland explicitly states that a health professional is not entitled to refuse

a request for abortion. Sweden allows facilities to prohibit their staff from objecting to participating in abortions, which was upheld by the European Court of Human Rights (see *Grimmark v Sweden*, 2020 and *Steen v Sweden*, 2020).

Where conscientious objection is not provided for or permitted, this constitutes no exceptionalism. If provided for but facilities may prohibit their staff from objecting to participating in abortions this is low exceptionalism. If provided for but with requirement to refer, this is moderate exceptionalism, while provided for with requirement only to assist in emergencies constitutes high exceptionalism.

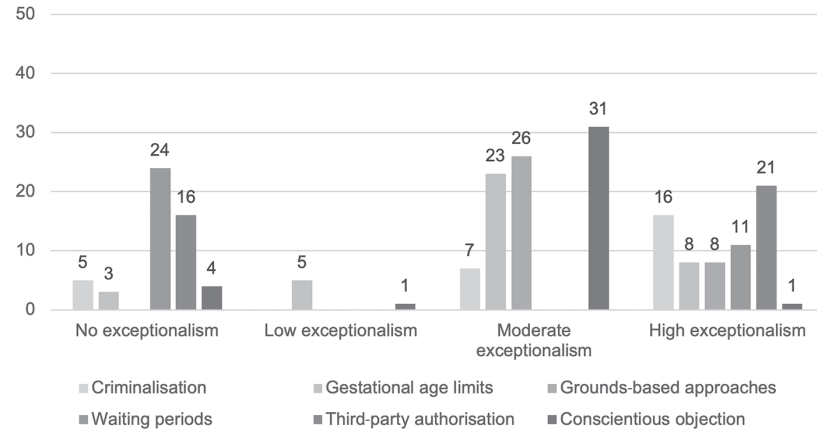
Variants of Exceptionalism

The categorisation of the six regulatory instruments of abortion considered into low, moderate or high exceptionalism allows us distil variants of exceptionalism among high-income countries from the synthesised information. Figure 6.1 shows the number of high-income countries using a specific regulatory instrument by the level of exceptionalism. Given the complexity of the dimension, grounds-based approaches are assessed overall in terms of whether they are consistent with international human rights law either to a moderate or low level. While the theoretical maximum number of countries per category is 57, the count does not capture countries that do adhere to human rights standards.

One finding is that high exceptionalism is marked by the use of the full range of regulatory instruments, making abortion a highly exceptional healthcare service, while moderate exceptionalism is marked by the use of criminalisation, application of grounds at 16 weeks gestational limit or higher, and conscientious objection with requirement to refer, and low exceptionalism contexts mostly use gestational age limits as a tool. Another finding is the high number of countries overall using conscientious objection and grounds-based approaches (after 12 weeks gestation) compared with other regulatory tools, and the relatively widespread use of criminalisation of abortion seekers and providers even among this group of countries.

Contrasting Levels of Abortion Exceptionalism within Countries

In this final step of the analysis, Italy and Canada are discussed as two contrasting example cases for demonstrating how exceptionalism varies within countries. As an example of high abortion exceptionalism, Italy does not allow abortion on request for any gestational stage and, moreover, applies lower- and higher-order grounds of qualification before and after 90 days gestation. Up to 90 days gestation, abortion is permitted where there is serious risk to mental or physical health, economic, social or family conditions or in the case of foetal



Notes: Bars show the numbers of countries using the regulatory instrument as specified in Table 6.1. Sub-national regions (one or more) of Australia, Canada and the UK are counted as "country" in this figure. "No exceptionalism" includes five countries without criminalisation, three with no gestational age limits, 24 without waiting periods, 16 with no third-party authorisation and four with no conscientious objection. "Low exceptionalism" includes gestational age limits in five countries, conscientious objection in one. "Moderate exceptionalism" includes seven countries criminalise, 23 apply gestational age limits, 26 grounds-based approaches, and 31 conscientious objection. Under "High exceptionalism", there are 16 countries with criminalisation, eight apply gestational age limits, eight grounds-based approaches, 11 waiting periods, 21 third-party authorisation, and one conscientious objection.

Figure 6.1 Number of high-income countries by abortion regulation instrument and level of exceptionalism

developments labelled as "abnormalities". In addition, providing doctors have discretion to impose a mandatory seven-day waiting time for abortion before 90 days gestation. After 90 days gestation, abortion is permitted in the case of serious threat to life or significant foetal "abnormalities" jeopardising the psychophysical health of the woman or pregnant person. At all gestational ages, parental consent is expected for anyone under 18 years. Criminal sanctions apply to the person seeking abortion and care provider for abortion outside of these regulations. Conscientious objection is invoked by gynaecologists extensively in Italy, making abortion access very difficult. Caruso (2023) depicts abortion in Italy as subject to hyper-regulation. Canada, by contrast, serves as a case for no exceptionalist treatment of abortion since 1988, when the Supreme Court of Canada ruled that Canada's abortion law was unconstitutional. The judgment held that the law was violating Section 7 of the Charter of Rights and Freedoms infringing a woman's right to life, liberty and security

of person. The effect of the ruling is that abortion was struck from the criminal code, leaving Canada with no criminal law restricting abortion, and abortion since then has been treated like any other medical procedure. Despite efforts by private members' bills and a government bill since to introduce new criminal sanctions, no laws were passed. By now, Canadian provinces are considered generally to have supportive regulations and policies supporting equitable, accessible, state-provided abortion services (Shaw & Norman, 2020).

DISCUSSION

Safe, legal abortion as a human right is well established in international conventions, but abortion regulation happens at national (and sub-national) level through legislation, penal codes and regulatory instruments, which differentially shape abortion access, acceptability and quality. Recent WHO 2022 abortion guidelines set out abortion healthcare standards underpinned by a rights-based approach. This chapter mapped the regulatory abortion landscape in settings that are generally viewed in the global context as economically and politically stable, culturally relatively liberal and expected to have well-developed frameworks respecting international human rights obligations. It demonstrates the wide heterogeneity in abortion regulation even among these countries.

Abortion exceptionalism was employed as a key construct for this mapping. Abortion exceptionalism refers to how abortion as an area of healthcare is subjected to different, unique more stringent and burdensome rules than other comparable medical procedures, constitutive of over-regulation arising from the politics of abortion rather than any medical issues entailed in the procedure. Previously this exceptionalism has been applied to analysis of case law (Borgmann, 2014) or a single country context (Joffe & Schroeder, 2021; Millar, 2023). In this chapter, exceptionalism was employed as a template against which abortion regulation was mapped across and within countries.

Comparative analysis was conducted of how six regulatory instruments of abortion laws, policies and regulation feature in abortion provision in 37 high-income countries comprising 57 jurisdictions, evaluating each in terms of the levels of exceptionalism. The analysis revealed variations in exceptionalism with reference to their alignment with WHO recommendations *within* regulatory dimensions among these countries. For example, high-income countries showed strong variation in their degree to use criminalisation of abortion as a barrier to healthcare with more than 15 countries criminalising abortion seekers, providers and assisting persons. In addition, the analysis shows that, within a given high-income country, the level of exceptionalism varies *across* regulatory dimensions.

Three main findings emerge from the analysis. First, the evaluation of abortion policy approaches shows that a high proportion of these countries treat abortion as exceptional, and none of the countries complies fully with WHO regulations across all dimensions. Second, criminalisation, third-party authorisation for minors and gestational age limits for abortion on request are the main regulatory instruments by which high exceptionalism is implemented. Third, within countries, the combination of regulatory instruments ranges between no provision for abortion without grounds at any gestational stage, physician discretion to impose a seven-day wait, criminal sanctions and high levels of conscientious objection making for hyper-regulation in Italy, to abortion being unregulated by law and a matter solely of healthcare between women and their healthcare provider in Canada.

This mapping shows that, in many high-income contexts where frameworks respecting international human rights obligations are expected to be in place *and* regulation of abortion is expected to be well settled, abortion continues to be treated as exceptional in the arena of healthcare. Exceptionalism is practised in a variety of ways, with countries often deferring the decision over abortion to the provider (conscientious objection) but also creating regulatory obstacles and barriers between the abortion seeker and the service, such as politically determined waiting periods and gestational age limits. Even in contexts adhering relatively well to international healthcare standards, low exceptionalism still often applies by laws specifying grounds for gestational ages above 16 weeks. Overall, considerable policy review and reform are needed to align high-income country abortion laws with human rights frameworks referred to in the WHO 2022 abortion care guidelines.

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PART III

Cross-policy comparison

7. The reciprocal relationship between public attitudes and reproduction policy: an agenda for an uncharted research field

Rohan Khan

PUBLIC ATTITUDES: A MISSING PIECE IN COMPARATIVE REPRODUCTION POLICY RESEARCH

Governments must be responsive to public attitudes for policies to gain acceptance (Brooks & Manza, 2007). Simultaneously, policies shape people's attitude-formation by impacting their lived experience (Pierson, 1993). These links have rarely been studied in the context of reproduction policy. However, they are crucial for understanding dynamics of liberalization and backlash in this policy domain across fields, countries and over time. Reproduction policy consists of all state interventions in the biological and social processes of human reproduction. States employ diverse instruments to regulate reproduction. These include legalizing and actively providing certain services, as well as criminalizing and not regulating others. Exemplary reproductive services are the provision of abortion and medically assisted reproduction treatment (Griessler et al., 2022; Levels, 2011). Policies in this domain affect citizens' ability to realize individual decisions regarding whether, when and how to procreate (Jackson, 2001). They are also relevant to social stratification, because state support for reproductive decision-making varies across social groups (Becker, 2023).

Given the impact of this policy domain on people's lives, a systematic analysis of the reciprocal relationship between public attitudes and reproduction policy is overdue. Public attitudes refer to views held by citizens, which impact processes of policymaking, and vice versa (Busemeyer, 2022). They function as input in the policymaking process by conveying demands for regulatory action on a subject and subsequently holding governments accountable. For example, citizens' growing acceptance of abortion procedures was a key driver in enacting more permissive abortion regulations (Camobreco & Barnello,

2008). At the same time, public attitudes are also an outcome of policies, as they are shaped by policies' resource allocation and signalled norms. For instance, women's higher support for abortion can be attributed to them being the primary recipients of abortion services (Lizotte, 2015). Furthermore, the designs of reproduction policies communicate various norms, including norms about ideal reproductive life-courses, the extent of women's reproductive autonomy and the ethical status of foetuses (Joffe & Reich, 2015).

Public attitudes can be distinguished into values and policy preferences. Values denote people's normative beliefs on how different aspects of life should be structured (Inglehart et al., 2017). Policy preferences result from these values and reflect citizens' ideas on how concrete policies should be designed (Busemeyer et al., 2020: 6). This distinction is often neglected in research but it is of particular importance in the domain of reproduction policy. Considering this difference helps to investigate multidimensionality in citizens' views regarding how different values are impacted by (contradictory) normative signals of reproduction policies. Furthermore, the distinction also allows one to examine how different values people hold on reproduction-related matters translate into specific policy preferences.

Investigating the reciprocal relationship between public attitudes and reproduction policy requires a comparative perspective for three reasons. First, cross-policy comparison helps to illuminate how the same attitudes can drive policymaking in similar or contradictory directions across policy fields. For example, individuals emphasizing the importance of motherhood might advocate for decreasing abortion accessibility while simultaneously supporting the expansion of pregnancy care. Second, a comparative angle allows one to investigate how different reproduction policies jointly shape citizens' views on reproduction-related matters. One question could be how topics covered in sexuality education and coverage of costs for contraceptives influence adolescents' conceptions of sexuality. Third, cross-country and over-time comparisons also accentuate how differences in political systems, state/market configurations and historical legacies impact the relationship between citizens' attitudes and reproduction policy.

In this chapter, I provide a research agenda for the systematic analysis of the reciprocal relationship between public attitudes and reproduction policy. First, I summarize existing research on attitudes towards reproduction policies and show how it neglects the policy context. Subsequently, I outline how public attitudes are conceptualized in the morality policy, social policy and family policy literatures. I describe how research on attitudes towards reproduction policy differs from these bodies of research and highlight their beneficial insights. Second, I explain the theories of government responsiveness and policy feedback. Together they provide a holistic framework to analyse the reciprocal relationship between public attitudes and policy context. Studies on

government responsiveness analyse under which conditions public attitudes impact policymaking. Policy feedback literature investigates how policy contexts impact citizens attitude-formation. Third, I use the case of Germany to illustrate the potential of these theories for explaining the role of public attitudes across reproduction policy fields. I look at the fields of sexuality education, contraception, abortion, medically assisted reproduction (MAR) and pregnancy care. The chapter closes with an outlook on how this research agenda can be expanded.

PUBLIC ATTITUDES IN MORALITY POLICY, SOCIAL POLICY AND FAMILY POLICY RESEARCH

Research on attitudes towards reproduction policy has mainly been undertaken in two ways. Health policy scholarship has concentrated on describing variation in citizens' attitudes towards sexuality education in school (Barr et al., 2014), contraceptive usage (Rocca & Harper, 2012), abortion permissibility (Learman et al., 2005), MAR procedures (Bangsbøll et al., 2004) and prenatal testing (Seror et al., 2019). In contrast, public attitudes researchers have focused on how socio-demographic traits and ideological positions impact citizens' views on abortion (Adamczyk et al., 2020; Osborne et al., 2022) and MAR (Mohamed, 2018; Szalma & Djundeva, 2020). In which ways attitudes relate to the reproduction policy context has thus far only been investigated for the field of abortion. Studies provide evidence for associations between citizens' support for abortion and the permissiveness of abortion regulations (Loll & Hall, 2019). For the US, literature also indicates that governments respond to the abortion preferences of voters (Kreitzer, 2015). This research field is lacking a systematic analysis of the reciprocal relationship between public attitudes and the policy context beyond abortion, considering the broader domain of reproduction policy. The conceptualization of public attitudes in research on morality policy, social policy and family policy holds beneficial insights for addressing this gap from a comparative angle.

Morality Policy

The morality policy literature investigates policy fields in which value judgements are more relevant for policymaking than socio-economic considerations (Heichel et al., 2013). Examples include the fields of euthanasia and prostitution. The main interest of morality policy scholarship is on how different political systems regulate these policy fields (Knill et al., 2015). Abortion and MAR policy are central subjects of morality policy research because they concern questions of life and death (Engeli, 2009). Most studies view diverging values within the public as an indication for which topics are contested

(Budde & Heichel, 2015; Nebel, 2015). The assumption is that public contestation necessitates government action. Scholars primarily focus on institutional features to explain how political systems respond to value conflicts. Findings suggest that the number of institutional veto players (Schwartz & Tatalovich, 2009), the relevance of Christian democratic parties (Adam et al., 2020), and the specific church–state relationship (Minkenberg, 2002) contribute to explaining differences in the regulation of abortion and MAR.

The role of public attitudes in morality policy scholarship draws attention to how the legitimacy of certain reproductive procedures is challenged based on people's values. However, the contribution of this scholarship is confined to policies that face public contestation. In the domain of reproduction policy this mainly applies to regulations in the fields of abortion and MAR. Furthermore, morality policy scholarship does not investigate which concrete policy preferences follow from the values citizens hold. An exemplary question would be, what are the abortion or MAR policy design preferences among people who believe in the importance of parenthood.

Social Policy

The most extensive research on the reciprocal relationship between public attitudes and policy context has been conducted in the field of social policy. This policy domain comprises benefits that are intended to support citizens in economic risk situations (Häusermann, 2023), such as pensions and unemployment benefits. Social policy is to a large extent based on redistribution of resources between different societal groups. Thus, social policy scholars are primarily interested in citizens' attitudes regarding what the welfare state should provide and which social groups deserve state support (Mau, 2004). The government responsiveness literature focuses on what citizens consider to be responsibilities of the welfare state (Brooks & Manza, 2007). For instance, whether people expect the state to provide for a certain standard of living to the unemployed. These studies indicate that states adjust their welfare spending according to citizens' social policy attitudes (Kang & Powell, 2010).

The complementary policy feedback literature consists of two strands. One strand revolves around how social policy designs generate support or opposition among the public towards them. Support for social policies is explained by material benefits that certain societal groups gain from specific social policies (Gingrich & Ansell, 2012). For example, people benefiting from policies that lend economic support to students are also most in favour of it (Garritzmann, 2015). Support for social policy designs also results from individuals adapting their attitudes to the normative signals of the welfare state in which they grow up (Lindh, 2015). Mirroring these explanations for social policy support, studies on citizens' opposition to policies highlight that people disapprove of

policy designs if they experience socio-economic losses from them, or if the design is contrary to their pre-existing attitudes. For example, progressive tax systems primarily receive opposition from high-income earners and people with fiscally conservative opinions (Roosma et al., 2016). Another strand of policy feedback literature examines how social policies impact citizens' attitudes on deservingness to state support of different social groups. This research argues that the way social policy designs address target groups signals to citizens how deserving they are of institutionalized solidarity. In turn, people adapt their views on these target groups (van Oorschot & Meuleman, 2014). Studies demonstrate for instance that workfare policies, which install a work-first logic, lead to more negative positions towards unemployed people (Horn et al., 2023).

The conceptualization of attitudes in terms of what the welfare state should provide and which social groups deserve state support is an underdeveloped perspective in research on reproduction policies. Adopting this angle accentuates the question of which reproductive services are viewed as a responsibility of the welfare state. Further, the concept of deservingness draws attention to citizens' attitudes towards whose reproductive decisions are considered worthy of state support. Finally, social policy research also often fails to distinguish between values and policy preferences, which can brush over complexities and contradictions in citizens' attitudes towards policy matters.

Family Policy

Reproduction policy is closely related to family policy, as both address aspects of family dynamics. Family policy structures the relationship between paid and unpaid work by (not) providing people with support to manage their care responsibilities (Daly, 2021). Examples of family policies are parental leave and care allowances. Family policy also shapes gender relationships because care work is mainly done by women. Owing to this gendered nature of family policy, scholars have focused on how citizens' attitudes towards the division of paid and unpaid work between men and women relate to policy contexts (Davis & Greenstein, 2009). Studies on government responsiveness in this context have mainly looked at citizens' values rather than preferences. They indicate for example that people's beliefs regarding maternal employment are a driver of childcare expansion (Ferragina & Seeleib-Kaiser, 2015).

The policy feedback literature regarding family policy follows two main strands. First, studies on policy preferences suggest that the affordability of childcare influences citizens' support or opposition to these policies on the bases of their socio-economic positions (Neimanns & Busemeyer, 2021). There is also evidence for preference adaptation in that citizens' preferred family policy designs correspond to current childcare schemes (Chung &

Meuleman, 2017). Second, policy feedback has been investigated in its impact on citizens' values regarding the division of paid and unpaid work. This research demonstrates, for example, that the expansion of policies fostering a dual-earner/dual-caregiver model affects gender egalitarianism values (Jozwiak, 2022).

Reproduction policy research benefits from the insight of family policy scholars that citizens' attitudes towards gender, sexuality, and family are interrelated with policy contexts. However, even though both policy domains deal with intimate lives, their foci diverge. A family policy focus presupposes the presence of family relationships and subsequently concentrates on gender role attitudes regarding the division of paid and unpaid work within families. In contrast, reproduction policy addresses processes of conceiving and not conceiving children, which highlights different sets of attitudes, such as the importance of family formation. Overall, family policy research operates most consistently with the distinction between values and policy preferences, which helps to uncover multidimensionality in citizens' gender attitudes.

PUBLIC ATTITUDES AS INPUT AND OUTCOME IN THE POLICYMAKING PROCESS

In democratic political systems, governments are supposed to adhere to public attitudes; simultaneously, policy contexts also shape citizens' attitudes by allocating resources and communicating social norms (Busemeyer, 2022). Two connected strands of literature deal with the reciprocal relationship between public attitudes and policy contexts. First, government responsiveness research investigates under which conditions citizens' attitudes function as input in the policymaking process. This work highlights the relevance of issue salience and congruence of public attitudes. Second, the literature on policy feedback examines how individuals' attitudes are an outcome of policy contexts. Central concepts in this body of work are resource feedback and normative feedback. Neither strand of research specifies the distinction between values and policy preferences.

Government Responsiveness: Issue Salience and Congruence of Public Attitudes

Government responsiveness is about how issue salience and congruence of public attitudes are relevant factors affecting whether and how policymakers react to citizens' demands. Issue salience refers to citizens attributing substantial importance to a topic and demanding government action on it (Burstein, 2003). The concept implies that, via elections, citizens hold governments accountable on policy questions that matter to them. Following from these

assumptions, the prediction is that governments are particularly responsive to salient issues because they want to prevent electoral losses. If an issue lacks salience, governments are less inclined to address it, as it is not electorally important.

According to this literature, if an issue is salient, congruence of public attitudes predicts *how* governments react to citizens' demands by considering how uniform the public is on the issue (Busemeyer et al., 2020: 42). High congruence of public attitudes entails that a majority of the public holds the same interests on an issue. Low congruence, on the other hand, suggests that citizens have diverging perspectives. The argument is that policymakers most closely follow the demands of the public in cases of issue salience and high congruence of public attitudes. This is because it is electorally the most effective way to gain support from a majority of the population. In contrast, if issue salience is high but congruence of public attitudes rather low, governments become partisan and respond to the demands of their core voter base, because they are the most relevant for their re-election.

The regulations of abortion in Ireland and the US serve as a useful illustration for the theoretical assumptions of government responsiveness theory. In both countries, abortion is a very salient issue. However, in Ireland, the outcome of the 2018 abortion referendum indicated high congruence of public attitudes for a more permissive abortion regulation, which was then closely implemented by the government (Field, 2018). In contrast, the salience of abortion goes along with the low congruence of public attitudes in the US. Consequently, Democrats and Republicans act in a partisan way in the state legislatures and regulate abortion according to the presumed policy preferences of their core voter base (Kreitzer, 2015).

Policy Feedback: Resource Feedback and Normative Feedback

The majority of policy feedback research concentrates on how policies impact citizens' attitudes towards supporting or opposing them. Another strand of literature examines how policies' normative underpinnings influence people's beliefs on different topics. Two mechanisms through which policies affect public attitudes can be distinguished: resource feedback and normative feedback. The concept of resource feedback is based on the premise that policies benefit specific groups of citizens and disadvantage others (Pierson, 1993). For example, states may regulate access to MAR treatments inclusively by making them available to all people with a wish to have a child or they can restrict it to specific groups. Referring to individuals' material self-interest, resource feedback suggests that citizens benefiting from a policy will support it, whereas people experiencing disadvantages from the policy will oppose it (Jacobs & Weaver, 2015). For instance, if MAR treatments were exclusively

accessible to heterosexual couples, primarily these couples would support this policy, while same-sex couples would likely oppose it.

Normative feedback presumes that policies contain norms about which services are legitimate and how societies should be structured (Svallfors, 2012: 11). For instance, permissive abortion policies are grounded on the normative bases that abortions are legitimate procedures and women should have the possibility to pursue their reproductive preferences. Normative feedback suggests that policies signal their norms to citizens, which they adapt to (Campbell, 2012). The assumption is that people develop support for existing policies because they are signalled as legitimate and the policy context is perceived as normality. However, the degree of adaption is dependent on people's life-stage (Svallfors, 2010). Younger people are considered to be more receptive to policy signals because they are still in the life-stage where attitudes are formed. Older individuals on the contrary might disregard normative signals or react with opposition to policies if the communicated norms are conflicting with their existing attitudes.

PUBLIC ATTITUDES ACROSS REPRODUCTION POLICY FIELDS IN GERMANY

The regulation of reproduction policy differs strongly across countries and over time. In the following, I use the case of Germany since 2010 to illustrate the potential of government responsiveness and policy feedback theories in explaining the reciprocal relationship between public attitudes and reproduction policy. In a comparative perspective between reproduction policy fields, I consider political events, such as particular parliamentary debates, to explain issue salience and congruence of public attitudes in each field. Furthermore, I also consider how potential normative feedbacks impact attitudes regarding state support for different reproductive decisions. Each section ends with describing how the respective reproduction policy field in conjunction with other fields might shape citizens' values on reproduction-related matters.

Sexuality Education

Sexuality education in Germany is provided by the federal states. Curricula are developed by commissions consisting of stakeholders such as bureaucrats and experts (see Chapter 3 by Kluge and Chapter 5 by Ivanova et al. in this book). These curricula differ greatly regarding covered topics and how often they are updated (see Chapter 3 by Kluge). New sexuality education curricula have recurrently been met by protests from parents (Speit, 2015), building on assumptions that the new curricula entail topics that are not suitable for children. However, policymakers have tended not to respond to the demands

of the protesters and implemented the new curriculum. This demonstrates that, overall, sexuality education is not a salient issue in Germany. One reason could lie in potential normative feedbacks. In Germany, sexuality education has been provided since the 1960s (Sielert, 2007). This could imply that, over time, citizens have adopted the view that the state is co-responsible for adolescents' development of reproduction knowledge. As sexuality education teaches students about other reproduction policy fields such as contraception and abortion, it socializes them into the state's reproduction regime.

Contraception

A variety of contraceptive methods is available in Germany, such as, for example, permanent (e.g. sterilization), long-acting reversible (e.g. intrauterine devices) and user-dependent contraceptives (e.g. contraceptive pill) (Deutsche Gesellschaft für Gynäkologie und Geburtshilfe et al., 2020). Health insurance covers the costs of prescribed contraceptives for women under the age of 22, making coverage dependent on gender and age. In 2018, the Greens and the Left party introduced a proposal in the German parliament on expanding the cost coverage to more social groups (Bundestag, 2018). However, the proposal was not accepted by the necessary parliamentary majority and the topic has not been discussed since. This example illustrates that coverage of contraceptives is not a salient subject in Germany. One possible reason for the lack of public engagement regarding contraception could be normative feedback of existing policies on the belief that preventing pregnancy is a private matter for adults. Congruent with the policy, only adolescents might be considered in need of public services because they are just beginning with their first sexual encounters. In conjunction with sexuality education, contraception policy shapes citizens' attitudes towards how people's early reproductive life-stages should look. By providing sexuality education in school and covering costs of contraceptives only for women under 22, the German state signals that adolescents are expected to be sexually active, but that pregnancies and hence parenthood is not viewed as desirable at this life-stage.

Abortion

Germany's regulation of abortion is largely based on a cross-party compromise from 1992 (Budde & Heichel, 2015). Terminating a pregnancy is a criminal offence, which is not penalized if certain conditions are met. Abortion on request is permissible, if it is performed within the first 12 weeks of the pregnancy, if a mandatory counselling session is attended, and if the pregnant woman waits three days after counselling for the procedure. The costs of abortions on request are not covered by health insurance in most cases. Until 2022, the law

also prohibited medical professionals from providing information on abortion procedures publicly. The governing centre-left coalition lifted the ban because this was an important issue for their voter base, even though the second-largest party of Christian Democrats voted against it (Bundestag, 2022). This change illustrates that abortion is a salient issue with moderate congruence of public attitudes in Germany. Abortion policy being regulated in the criminal code and not covered by health insurance potentially functions as normative feedback. Citizens might adapt to these policy signals by developing the value that terminating a pregnancy is not a reproductive decision worthy of state support. Abortion policy is related to the fields of contraception, MAR and pregnancy care, as it functions as a last resort for women in situations where the other three fields have led to undesirable results. Examples include contraceptives not working successfully, medically assisted reproduction (MAR) treatments resulting in risky multiple pregnancies (see Chapter 10 by Tamakoshi in this book), or prenatal tests indicating foetal anomalies. Therefore, all four of these policy fields jointly shape citizens' values and policy preferences on how women should be able to pursue individual reproductive decisions.

Medically Assisted Reproduction

In Germany, the regulation of medically assisted reproduction (MAR) is dispersed across different legal documents (Geyken, 2022). MAR treatments, such as IVF, are permitted and a certain level of cost coverage for a limited number of MAR treatments is granted. The Embryo Protection Act from 1990 prohibits research on embryos, egg cell donations and any form of surrogacy. In particular, the latter two issues have recently entered public debate, as LGBTQ+ organizations have advocated for better access to MAR treatments for sexual minorities. Egg cell donations allow lesbian couples to split motherhood, whereas surrogacy makes having a child with their own gametes more accessible to gay couples. In 2023, Germany's centre-left government appointed a commission to explore under which conditions egg cell donations and altruistic surrogacy could be legalized (Bundesgesundheitsministerium, 2023). The conservative CDU already expressed opposition to any potential liberalization of surrogacy (Ärzteblatt, 2023). This example highlights how the government is responding in a partisan way on an issue that is substantial for their voter base but also opposed by other parts of society. However, this case also demonstrates how the legalization of MAR treatments and coverage of their costs have generated normative feedbacks, creating support for the idea that people's wishes to have a child should receive state support. Against the backdrop of expanding LGBTQ+ rights, citizens are now potentially extending this belief to encompass same-sex couples as well. MAR with abortion are the two reproduction policy fields that jointly shape citizens' attitudes towards

the ethical standing of embryos and foetuses. Ethical implications are also the reason why these two policy fields belong to the most contested ones in the domain of reproduction policy.

Pregnancy Care

Germany has a preventive care programme for pregnant women that aims to maintain safe and healthy pregnancies. Part of the programme is ultrasound tests in a fixed interval, check-ups for infections and diseases as well as prenatal tests (e.g. amniocentesis) for risk pregnancies (Gemeinsamer Bundesausschuss, 2023). In 2019, the German parliament had an orientation debate about whether non-invasive prenatal testing (NIPT) should be added to the preventive care program (Bundestag, 2019). Across partisan lines, politicians stressed that NIPT helps to inform women about foetal anomalies early in their pregnancy. At the same time, allowing NIPT would pose the risk that an increasing number or pregnancies might be terminated due to better detection of foetal anomalies. The debate did not result in concrete legislation, which shows that NIPT is a very salient issue but congruence of public opinion is low, so it does not map on partisan conflicts. This example demonstrates that, in rare cases, issue salience can go along with the government not responding to a matter because no legislation would receive support from the overall public or one specific voter base. Germany's elaborate preventive care programme suggests that, in this case, normative feedback has led to citizens viewing the maintenance of pregnancy as a reproductive decision deserving particular state support. Pregnancy care in conjunction with abortion and MAR policy potentially influence citizens' values around ideal pregnancies. These three policy fields together are grounded in norms around desired pregnancy trajectories.

PUBLIC ATTITUDES IN COMPARATIVE REPRODUCTION POLICY RESEARCH: AN UNFINISHED AGENDA

Reproduction policy has a fundamental impact on people's reproductive life-courses by shaping their ability to realize individual reproductive decisions. However, to date, our knowledge is limited as to how public attitudes impact reproduction policymaking and vice versa. This is a crucial omission because examining the reciprocal relationship between citizens' attitudes and reproduction policy is necessary to investigate changes in this policy domain. Examining these dynamics requires a comparative perspective that considers variances across policy fields, countries and over time. With this chapter, I suggest a research agenda to fill this gap.

First, I presented insights from research on morality policy, social policy and family policy regarding public attitudes. Each provides a useful angle for investigating attitudes towards reproduction policy. Studies on morality policy highlight that the domain of reproduction policy entails regulations that are highly contested. Their policymaking processes might diverge from policies that are not the subject of public conflicts. Adopting a social policy perspective emphasizes attitudes towards which reproductive services are considered to be within the government's responsibility and which social groups are seen as deserving of state support for their reproductive decisions. The family policy literature underscores how reproduction policies contain norms regarding gender, sexuality and family. Citizens' attitudes around these topics are not only input into the policymaking process, but also have to be analysed as the outcome of reproduction policy contexts.

Second, I outlined the theories of government responsiveness and policy feedback. Together they provide a holistic view on the reciprocal relationship between public attitudes and reproduction policy. The domain of reproduction policy shows how important the conceptual difference between values and policy preferences is to grasp the multidimensionality of citizens' attitudes. The government responsiveness literature highlights that people might hold potentially conflicting values on reproduction-related matters. This poses the question of which policy preferences result from the values. Policy feedback theory highlights how contradictory normative signals shape the values and in turn policy preferences of different societal groups.

Third, I illustrated the potential of these literatures for making sense of links between public attitudes and reproduction policy by exploring the issues comparatively across reproduction policy fields in Germany. The explorative analysis suggests that public attitudes impact reproduction policymaking particularly in instances in which women's reproductive autonomy and the ethical status of foetuses are potentially in contention. Furthermore, the examination indicates a pattern regarding citizens' attitudes towards state support for different reproductive decisions across social groups. First, adolescents seem to be considered worthy of state support in line with the prevailing norm that their sexual encounters shall not result in pregnancies. Second, reproductive decisions of adults are viewed mainly as private matters and state involvement as undesirable. Third, pregnant women are regarded as particularly deserving of state support, arguably because their position is considered vulnerable. Taken together, these tentative findings point to a normatively ideal trajectory of reproductive life-courses shared among the German public. Further comparative research on public attitudes and reproduction policy could take this as a starting point for cross-country comparisons and investigate whether other societies express different ideals.

This research agenda lays the groundwork for systematic analysis of the reciprocal relationship between public attitudes and reproduction policies. It is intended to be expanded in different directions. Possible avenues could be the inclusion of political actors. For instance, one question could be how different interest groups such as medical associations impact government responsiveness on issues such as the regulation of NIPT. Another question is how interdependencies between reproduction policy and other policy domains such as family policy shape citizens' attitudes. For example, how does the availability of MAR treatments for same-sex couples affect family attitudes in contexts where adoption policy is restrictive? Addressing these and other questions will extend the scope of comparative reproduction policy research. This proposed research agenda is the first step in illuminating the politics of reproduction policy in the twenty-first century.

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8. A comparative analysis across reproduction policy fields in Hungary

Ivett Szalma and Alexandra Sipos

INTRODUCTION

This chapter gives a comparative overview on the trajectories and interactions of reproduction policies in Hungary starting from 1989, after the democratic reform, with a focus on the changes that took place after 2010 during the second Orbán government. We focus our analysis on this period, which had particular relevance to how reproduction is regulated across different policy fields. Notably, and as described by others (Szikra, 2018), the Orbán government has pursued a strongly pronatalist approach to family policy. It has been an explicit aim of the Orbán government to reach replacement-level fertility. As for the desired effects of these efforts, there was no increase in the number of births (90,335 live births in 2010, and 88,491 in 2022), and only a small increase of the total fertility rate (from 1.25 to 1.52) (HCSO, 2023a), which can be attributed to the growing number of reproductive women in the period. What this rather shows is the strong orientation in Hungarian politics towards pronatalism as an ideological and political project that aims to promote childbearing, assuming it is conducive to the wellbeing of society.

The pronatalist approach of the post-2010 Orbán government has been analysed extensively in the domain of family policies. For example, Szikra investigated the (in)consistencies of the ideological pattern in the Orbán government's approach to family policy (Szikra, 2018). Others examined gendered policy approaches to work–life reconciliation in the pronatalist context (Glass & Fodor, 2022; Inglot et al., 2022). According to Cook et al. (2023), neo-familialist ideologies that are dominant in Hungary emphasise traditional values encouraging women's roles and responsibilities in the private sphere, particularly in reproductive labour. They identify similar discourses on the relationship between family policies and the so-called demographic "crises" in Hungary, Russia and Poland, but distinguish different strands within the pronatalist discourse. Conservative discourses emphasise traditional values, whereas nationalist discourses highlight the survival of the nation and the

outside "threat" of immigrants. It is precisely these cross-ideological discourse coalitions that allow many citizens with different views to identify with the pronatalist perspective. Moreover, in Hungary, pronatalism discriminates against poorer families, that is, better-off families are even more advantaged, and the poor are even more excluded from state transfers (Cook et al., 2023).

Beyond that research, Hungarian pronatalism has not systematically been examined across different fields of policies regulating reproduction. Previous studies focused on single policy fields or specific issues. For example, Takács (2018) examined how policies limit queer reproduction in Hungary, Szalma (2021) examined the access of individuals to medically assisted reproduction (MAR), and Neményi and Takács (2015) focused on the issue of adoption. This chapter is the first to comprehensively examine policies related to reproduction in the post-2010 era, including abortion, MAR, contraception, adoption, and sexual education. Through these policies, we aim to understand the broader policy landscape and point out interactions, biases, and potential (lack of) coherences in their goals concerning the Hungarian pronatalist approach.

CONCEPTUAL PERSPECTIVES

Pronatalism is often criticised for being a vaguely defined concept (Bergenheim & Klockar Linder, 2020). It has different conceptual meanings and connotations across social science disciplines. From the perspective of demography, all policies that encourage childbearing are pronatalist policies (Gietel-Basten et al., 2022). However, sociologists often point out that explicitly pronatalist political programmes imply antinatalist messages by othering those whose procreation is deemed undesirable (Hašková & Dudová, 2020; Szalma et al., 2022). In this context, pronatalism, which is "built on selective, heteronormative, and exclusionary measures can be called fragile" (Szalma et al., 2022, p. 83). In political science, pronatalism is considered as a political discourse that promotes and glorifies parenthood (Yuval-Davis, 1997). According to the feminist critiques of pronatalism (Graham et al., 2018), pronatalist policies amount to controlling and influencing women's reproductive decisions and thus limiting women to their role as mothers.

We understand pronatalism as an ideology and related policy measures implemented to reach certain ideological objectives. The ideology involves the understanding of gestational motherhood as valuable and as a social role of women. Increasing the fertility rate, which is seen to guarantee the survival of the nation and the continuity of the state, is viewed as desirable. The literature recognises "coercive pronatalism", which is aimed at regulating the sexual and reproductive health of individuals and couples (Heitlinger, 1991, p. 345), including the control over reproductive choices to influence fertility and birth rates, current and future demographic trends (Blake, 1972).

We use the term "selective pronatalism" (Hašková & Dudová, 2020) to note that the universal pronatalist approach is selective as to which groups' fertility is prioritised and deemed deserving (Herke & Janky, 2023). The concept of "selective pronatalism" recognises that certain policies, in line with the pronatalist ideology, are not necessarily coercive per se, but may still be restrictive. We further differentiate heteronormative selective pronatalism, following Warner's (1993) definition of heteronormativity as normative heterosexuality, which orders biological sex, gender and sexuality in ways that appear natural and conform to heterosexual norms. These aspects often apply to the institution of marriage (Sipos, 2023), which may be a key ideological orientation in reproduction policy.

POPULATION POLICY IN HUNGARY

A strong pronatalist orientation prevails in Hungarian politics. Pronatalism is politically legitimised by invoking the ageing populations in European societies and the increasing old-age dependency ratios. It is frequently highlighted that the high share of the population aged 65+ years puts pressure on the working population (e.g. speech by Viktor Orbán at the Second Budapest Demographic Forum – Miniszterelnok.hu, 2017). Accordingly, family policy promotes fertility based on the assumption that the population's size or its growth is insufficient, which is argued to put the welfare and the very existence of the population at risk (Spéder et al., 2020). In this political discourse, women's bodies serve to an end, namely, to procreate for national development and survival, while at the same time pursuing an anti-immigrant Islamophobic political agenda (Bíró-Nagy, 2022).

However, the government does not evenly distribute the funds to encourage childbearing. Research on family policies shows that the Hungarian government does not follow a "universal" pronatalist population policy. Rather, single parents, same-sex couples, Roma, and low-income families are frequently excluded from the group incentivised to have children, or the policies place explicit barriers to their parenting (Szalma et al., 2022). In this so-called "selective pronatalism" there is now a well-defined target group: "white, cisgender, straight(-acting), affluent middle-class people whose procreation is worthy of encouragement with legislative frameworks, tax, and other benefits" (Takács, 2018, p. 78).

Moreover, "anti-gender" discourses are growing in Hungary. These discourses are commonly constructed in opposition to the liberalisation of policies abroad or globally towards abortion, gender-affirming care for transgender and intersex individuals. The "anti-gender" discourses also oppose comprehensive sexuality education, and "gender studies" in secondary and tertiary education (Vida, 2019). Additionally, these discourses threaten the recognition of sexual

and reproductive health and rights as human rights and of their significance for achieving gender equality. It is important to examine the role of reproduction policies in these discourses, particularly the developments since 2010, to understand the scope of pronatalist politics in Hungary.

REPRODUCTION POLICY SINCE 2010

Abortion Policy

Access to abortion in Hungary has a long history in relation to women's health and self-determination. Gal (1994) identified three periods of abortion regulation in Hungary. The first period was a highly restrictive one (1949–1954), which is known as the "Ratkó period", where abortion was mostly banned to achieve an increase in birth rates. The second period was marked by the liberalisation of abortion (Council of Ministers Decision No 1047/1956 (VI. 3.)), which was followed by another more restrictive period starting between 1973–1974 that established so-called "abortion committees". The latter policy change granted access to abortion for particular groups of women, including the unmarried, those with at least two children, and those facing housing, financial, or health problems. These restrictions were rightly described as "unfairly privileging some social groups" (Gal, 1994, p. 264).

After regime change, Act LXXIX of 1992 on the Protection of Foetal Life, which is still in force today, was passed whose section 'Termination of Pregnancy' sets out the legal conditions for abortion. According to Article 6, a pregnancy may be terminated up to 12 weeks into pregnancy, if one of the following conditions is met: "the pregnancy is a serious threat to the pregnant woman's health, the foetus is medically diagnosed as suffering from a severe disability or other impairment, the pregnancy is the result of a criminal offense", or the pregnant woman is in a "serious crisis situation causing physical or mental distress or social incapacity" (Act LXXIX of 1992). After the 12th week, different rules apply to access to abortion. Until the 18th week, the procedure can be performed in case of previously not detected pregnancy beyond the pregnant woman's control or due to her limited capacity or incapacity.[1] Between weeks 20 and 24, abortion can be carried out only if serious health risks of the foetus are detected. Termination of pregnancy can take place irrespective of the pregnancy week, if there is a serious medical reason that endangers the life of the pregnant woman or if there is a foetal abnormality incompatible with life after childbirth.

As of 2010, a stricter abortion policy strengthened the pronatalist orientation and traditional views on gender roles – although the basic regulation of access to abortion has been retained as set out in the 1992 Act. The new approach aims to define no less than the beginning of life, the beginning of the capacity

to act as a person, and the balance between women's right to self-determination and the foetus' right to life.[2] On 25 April 2011, the legislator took a step towards recognising the foetus as a legal entity. The Fundamental Law of Hungary formulated the right to life and the state's obligation to protect it in Article II as follows: "Human dignity shall be inviolable. Everyone shall have the right to life and human dignity; the life of the foetus shall be protected from the moment of conception." This was reiterated in Act CCXI of 2011 on the Protection of Families in Article 3 paragraph (1): "From the moment of conception, the foetus is entitled to protection, respect and support as provided by law" (Act CCXI of 2011). The Act and especially its preamble contains the pronatalist approach. It states that families are the most important national resource in Hungary, and they serve as a guarantee for the survival of the nation as well as a natural environment for the development of human personality.

This approach indicates a shift to limit the reproductive self-determination of women, which went beyond regulative changes in abortion law. For example, in 2011, a pro-life campaign was launched by the government using the following headline with a picture of a foetus: "I understand if you're not ready for me, but I'd rather you give me up for adoption and let me live!". In May 2012, there was an unsuccessful attempt within the Hungarian Parliament to make medication abortion (commonly known as the "abortion pill") available in Hungary. In both instances, adoption was presented as the better alternative to abortion, and the right to reproductive self-determination was questioned and/or denied.

Another crucial moment in the trajectory of abortion policy in Hungary was Decree No 29/2022 (IX. 12.) of the Minister of the Interior, amending Decree No 32/1992 (XII. 23.) on the implementation of the 1992 Act on the protection of foetal life. This became known as the "foetal heartbeat" amendment, introducing another requirement for the termination of pregnancy, namely that the pregnant woman be shown "foetal vital signs". After the news of the proposed amendments came out, protests were held in Budapest in front of the Hungarian Parliament (Kovács, 2022).

At the time of writing, abortion is accessible on request, considering the time limits set forth by the law, counselling sessions with a member of the Family Welfare Service, a waiting period after the first session and the latest restriction, the clear indication of foetal vital signs to be presented to the pregnant woman. All these obstacles contribute to restricting women's and pregnant people's self-determination by following a pronatalist approach. Access to abortion varies in who is able to use services in other countries (Vida, 2019, p. 14) as well as regarding the decision to access abortion procedures. Those with lower education levels and those residing in areas where a higher percentage of people face substantial material and social hardships within Hungary are

more prevalent among those who have chosen to undergo an abortion (HCSO, 2023b).

The policy shift was in stark contrast with actual trends in the number of pregnancy terminations, which had been declining between 2010 and 2022 (HCSO, 2023b). This reveals the exclusively pronatalist objective behind the reforms, and the ideological stance of women as mere instruments of population policy. Notwithstanding, Hungary's population size is declining despite the government's "pro-family" family policy and economic initiatives (see Inglot et al., 2022). No serious long-term projection on the trends in population size and number of terminated pregnancies can be made following the recent decree from 2022.

Adoption

The regulation of adoption is considered in this chapter as a policy field that reflects the selective approach to supporting families in Hungary similar to other reproduction policies. Adoption was first regulated by Act IV of 1952 on Marriage, Family, and Guardianship (hereinafter: the Family Act) in the socialist context, then by the Hungarian Civil Code. The related procedures of adoption are further regulated in Act XXXI of 1997 on the Protection of Children and Guardianship Administration. The main goal of both the 1952 and 2013 Civil Code regulation was to establish a "family unit" through the adoption of those minors whose parents are unable or unwilling to raise them. With the Convention on the Rights of Children being the first international instrument adopted in Hungary after the state-socialist period – in addition to this decision's symbolic nature – the best interest of the child should be also considered.

Currently, Hungary allows both open and closed adoption (Civil Code Section 4:125–126) with the latter prohibiting contact between birthparents and adoptive parents and child. Regarding open adoptions, nine NGOs are officially authorised to facilitate the process under Government Decree 72/2014 (13.III.), whereas closed adoptions go through the state system (*Adoption in Hungary*, 2014). In both cases, applicants face several rounds of examination: psychological, medical, home study and income checks. Section 4:121 and 4:122 of the Civil Code defined several requirements regarding the adopter: full capacity to act, minimum of 25 years of age, the age difference between adopter and adoptee (minimum of 16 and maximum of 45 years), appropriate circumstances and a valid decision of suitability issued by the competent guardianship authority. Most of these remained in place, but the compulsory preparation course is now only recommended for prospective adoptive parents. Furthermore, the age gap has been raised to fall between 16 and 50 years in case the adoptee is more than 3 years old.

In October 2020, the 35/2020 (X. 5.) Decree[3] amended several other decrees related to – amongst others – child protection institutions, surrogate and foster parents. Following this, priority shall be given to married couples over single applicants for adoption. In addition, following a legislative amendment in December 2020, the conditions for adoption by single persons became stricter, as the eligibility certificate issued by the guardianship authority requires the specific consent of the Minister responsible for family policy (Sipos, 2021, p. 13). On the surface, these amendments only seem to support married couples, but considering that only different-sex couples can marry, it further restricts same-sex couples' access to adoption. In summary, these changes adhere to selective pronatalism tied to the ideal of marriage and heteronormativity.

Regarding the selectivity inherent to the adoption system, several issues are at stake. Neményi and Takács (2015) find that, in the process of adoption, public and civil actors as well as potential adopters identify several forms of discrimination. For example, in the "redistribution" of children from disadvantaged families towards well-off ones, or in the length of the adoption procedures. Interviewees reported their impression that the longer children are placed and kept in foster care or a childcare home, the less likely they are to be adopted. Another aspect was the "waiting time" for adoptive parents: those who were willing to adopt older or Roma children or children with treatable medical conditions, seemed to adopt faster (Neményi & Takács, 2015, pp. 87, 92). Furthermore, adopters often indicate preferences regarding the age, gender, health, and other characteristics of the adoptee.

Overall, among the actors involved in the adoption procedure, family is seen to be marriage-based, including heterosexual couples with children. This is in line with attitudes in the population more generally and the ideas reflected in the legislation of adoption. In our focal period after 2010, several changes have been made to the adoption system which strengthened this selective pronatalist approach to adoption in Hungary. Apart from the different amendments to the Fundamental Law in 2013 and 2020 regarding the protection of family in Article L), the eligibility criteria and requirements were modified, for example as noted before the difference in age, removing the compulsory nature of the preparation course or "speeding up" the process of declaring children adoptable.

Contraception

Overall, contraception is a reproduction policy field considered of much less interest to the state in Hungary. However, from the perspective of selective pronatalism, the regulation of female sterilisation and vasectomy are of interest. State regulation differentiates between access to and funding of sterilisation

for health reasons or family planning reasons respectively. Artificial sterilisation is regulated under Act CLIV of 1997 on Health Care and the related Decree 25/1998 (VI. 17.) on Artificial Sterilisation for the implementation of Act CLIV. Paragraph 1a of Article 187 of the Health Care Act covers the legal requirements for sterilisation. If sterilisation is requested for reasons of family planning, that is, to prevent having further children, the applicant must be at least 40 years old or should have at least three blood-related children. Here, the law treats women and men formally equal and implements a strongly pronatalist norm. Another requirement for sterilisation for family planning is mandatory counselling on alternative contraceptive methods, the sterilisation procedure and possible reversal, as well as a six-month waiting period. Even if the law is formally equal, the requirements are implied to be different for women and men (for example having three blood-related children), and indeed other contraceptive methods place more burden on women (e.g. hormonal contraception: dosage of hormones, cost, time, and regularity).

If sterilisation is requested for health-related reasons, there are different conditions. First, the law stipulates that surgical sterilisation can be performed in case a pregnancy would severely affect the health of the woman or the child born out of said pregnancy, and in case other contraceptive methods are not available (Act CLIV of 1997, 7. § a-b). In this case, the law concerns women's (and the foetus') health and body. Second, for people placed under custodianship by the court, resulting in limited capacity or no capacity, the law provides a set of requirements before artificial sterilisation can be performed, that is, no other contraceptive method is available, the procedure is done with the consent of the person, the person would suffer from serious health issues due to the pregnancy, there is a high likelihood of the prospective child having severe health issues, or there is a high likelihood of the person being unable to take care of the prospective child.

As for the coverage of costs for contraception in Hungary, regulations differ between different methods, although, in general, coverage is very limited. Hormonal contraceptives – including the so-called "plan B" pills – are prescription-only products that are currently not publicly funded. The state does provide funding for sterilisation, but given its pronatalist approach, sterilisation for non-medical reasons (e.g. family planning) is not covered by a public health care scheme (Act LXXXIII of 1997, 18. § (6) h)). To circumvent the challenges of the Hungarian system, people with the necessary financial means and information often travel to neighbouring countries (e.g. Slovakia) to access contraceptives, such as over-the-counter "emergency pills", which are not available in Hungary.

The different approaches to covering the costs of contraception and abortion for people with low incomes in Hungary reflect inconsistencies in state regulation of how unwanted parenthood may be avoided. According to an infor-

mation leaflet from the Hungarian Civil Liberties Union, the costs for abortion can be partially or fully covered for people living in social institutions, minors who are in temporary or foster care, young adults who are in aftercare, people with disability allowances, and in case the pregnancy was the result of sexual violence (TASZ, 2023). This contrasts with the low generosity in covering contraception.

Medically Assisted Reproduction

In Hungary, MAR treatments were regulated by the state for the first time in 1981. Decree No. 12/1981 (IX. 29.) of the Ministry of Health stated that MAR can be performed upon request on a married woman under the age of 45, who has full capacity to act, a Hungarian citizen residing permanently in Hungary, and provides medical proof that she is unlikely to conceive a healthy child "naturally". This was a strict regulation, which reflected pronatalist principles in that it made MAR conditional on marriage and citizenship. After that, MAR policy did not see substantial changes, which can partly be explained with MAR being less common in the 1980s and 1990s than today, because the various types of in vitro fertilisation were not yet available (Szijártó, 2023), and because, overall, people became parents at a younger age and needed it less (Williamson et al., 2014).

With Act CLIV of 1997, which is still in force today, the Ministry of Health dealt with the MAR procedures in detail. It changed the previous legislation so that the procedure could now be performed not only on married, but also on heterosexual persons in a cohabitation relationship, provided that either party has been diagnosed with a medical condition (infertility), which means that a healthy child cannot be born spontaneously from the relationship. While the selectivity based on marriage ended, same-sex couples were still excluded.

The Act regulated the financing of MAR treatments for the first time. Until the system changed (after 1990), financing regulations were obsolete because the entire health care system was statutory. Act CLIV of 1997 states that MAR treatments are free of charge only if a medical indication is certified by a health service provider, who is financed for this purpose from the Health Fund. In addition to the actual treatment, the financing also covers the necessary medical examinations. A maximum of five cycles of in vitro fertilisation and six cycles of insemination can be financed by the Health Fund. If at least one child is born alive as a result of any treatment, then four additional cycles will be financed by the Health Insurance Fund. Compared with what is covered in other European health care schemes, this financing can be considered generous.

The next major amendment was Act CLXXXI of 2005, which extended the group of people with access to MAR. The amendment allowed access to

treatment for single adult women who were not married or in a civil partnership at the time of the MAR procedure. Importantly, this was only available to single heterosexual women, but not lesbians. There was a grey area: women concealing their same-sex partnership could get MAR treatment, although any child born as a result of the treatment would only have a legal relationship with the gestating woman.

In 2020, the government moved further in its pronatalist agenda also in this policy field. A new law nationalised six fertility clinics and made both the cycle and the medication treatment costs state-funded (1011/2020 (I. 31.)). Previously, the medication treatments were not state-funded (only the cycles), and they were expensive. This amendment also means that only state funded fertility centres can operate, not private ones (Act CI of 2021 on certain property management issues and amendments to enhance the coherence of the legal system). Thus, financing the treatments themselves is not an option to reduce the long waiting lists. This is likely one of the reasons why many Hungarians choose to go abroad for MAR treatments, especially to Czechia (Serdült, 2021).

The bill argued that "the demographic challenges require a state role, so in the future, the performance of special procedures aimed at human reproduction will be the sole responsibility of a state-run health care provider and a clinical centre" (Justification of the Government Decision 1011/2020 (I. 31), 2021, p. 1327), which reflects that nationalisation was driven by pronatalist goals. More specifically, these are heteronormative pronatalist goals since homosexual couples are still excluded from access.

The latest reform has further increased funding, but this is selective too. While five cycles are fully covered and the necessary medication is provided free of charge, the clients of fertility centres are mostly better-off couples, who are now supported by the state. Treatment costs are not the only items that are to be taken into consideration (Bauer, 2022), but travel costs and time off from work can pose significant burdens. Additionally, all fertility centres are situated in urban centres, which means that they are less accessible for people living in more rural areas. Fertility treatments are time-costly, which is more reconcilable for people with teleworkable jobs, but not for blue-collar workers (Bauer, 2022). Knowledge about fertility treatments, which may be unequally distributed, is another factor. Knowledge deficits may originate in education, for example, our own ongoing research shows that secondary or vocational school curricula in Hungary do not include MAR.

Sexuality Education

While the introduction of school-based sexuality education in Western Europe started during the 1970s and 1980s, in the Central-Eastern European region,

this development took off after the state-socialist period (WHO Regional Office for Europe & Federal Centre for Health Education (BZgA), 2010, p. 12). Furthermore, the content of sexuality education differs significantly in post-socialist Europe. In Hungary and Poland, so-called "family life education" became dominant, which aimed at teaching children "traditional" gender and family norms. In 2012, Orbán's FIDESZ government incorporated the concept of family life education into the national curriculum, which prescribed that children should be taught about family life in ethics as well as in Hungarian language and literature classes, environmental or nature studies, history, and biology (*National Framework Curriculum*, 2013). Family life education has remained the framework of sexuality education in Hungary until today (Pető & Kováts, 2017).

In 2020, the core curriculum for the education system was renewed so that family life education appears as a separate subject in the new National Core Curriculum. It aims to prepare school-age children for independent adult life, responsible relationships, and family life in order to have a "significant positive impact on unfavourable demographic and social processes" (Pusztai & Csók, 2022, p. 110). With this, family life education clearly reflects the government's pronatalist goal, that is, for Hungarians to have more children. In addition, family education also serves to reinforce traditional gender roles by teaching pupils that the main role of women should be to care for children, while men should be breadwinners. Overall, children are expected to adhere to traditional gender roles and to be prepared for parenting roles.

However, family life education reflects *selective* pronatalism in promoting a heteronormative family idea and excluding other family forms. This is also shown in the symbolic politicisation of sexuality education. Coinciding with the parliamentary elections in Hungary, a national referendum was held on LGBTQI issues. The referendum contained four questions[4] on whether sexual orientation and gender reassignment should be taught at public schools, insinuating a risk for children being exposed to these contents. Although the referendum was not valid because the participation quorum of 50 per cent was not reached, it is noteworthy that more than 92 per cent of the votes did not support classes on sexual orientation in public educational institutions. In summary, these developments show that the regulation of sexuality education has taken the direction of selective (heteronormative) pronatalism since 2010 in Hungary.

COMPARATIVE SUMMARY

Changes in reproduction policies have taken a general pronatalist turn since 2010 in Hungary, but they did not follow a coherent pattern across different reproduction policy fields. While some fields saw some liberalisation (e.g.

Table 8.1 Ideological motives pursued in reproduction policies in Hungary

	Abortion	Adoption	Contraception	MAR	Sexuality education
Universal pronatalism	X	–	–	X	X
Selective pronatalism: marriage based	–	X	–	–	–
Selective pronatalism: heteronormative	–	X	–	X	X
Selective pronatalism: socio-economic status	(X)	–	–	X	X
Support of traditional gender norms	X	X	X	X	X

Notes: Assigns policy orientations to five reproduction policies in Hungary, that is, abortion, adoption, contraception, medically assisted reproduction, sexuality education, differentiating universal pronatalism from variants of selective pronatalism based on marriage, heteronormativity, socio-economic status, and from support of traditional gender norms.
Source: Based on Sipos and Szalma (2023).

MAR), others have clearly become more restricted (e.g. adoption, abortion). In terms of the ideological direction, the ruling government has followed a pronatalist agenda not only in the family policy domain as shown by previous research, but also in the domain of reproduction policy. However, as has been shown in previous research (Takács, 2018; Szalma et al., 2022), pronatalist policies are rarely universal in nature, but rather two-edged: while some groups are encouraged to have children, other groups may be discouraged. Table 8.1 shows which reproduction policies follow universal pronatalist principles and along which dimensions each policy can be considered to be selectively pronatalist.

Our analysis indicates that the policy fields have not followed the same pronatalist principles. What we refer to as "universal pronatalism" was reflected in the fields of abortion, MAR and sexuality education. Here, with the changes in legislation since 2010, the government's intention was explicitly to increase the number of births. However, all the examined fields of reproduction policy contain some selective elements. Abortion policy reinforces traditional gender

roles by allocating the responsibility for reproduction to women. Similarly, contraception policy reaffirms the "reproduction responsibility" of women who are seen as citizens primarily responsible for reproduction. Adoption policy reinforces traditional gender roles by making it more difficult for unmarried couples and single people to adopt a child from 2020 on. Making it conditional on marriage, which is only legal between a man and a woman in Hungary, also hinders same-sex couples' adoption. The same can be said for MAR policy, which is limited to heterosexual persons. In sexuality education, the "family life education" curriculum introduced in 2012 reinforces "traditional families" and teaches children traditional heteronormative gender roles. With this, traditional gender norms are the only element that equally applies to all reproduction policy fields we examined.

However, there are also conflicting principles in reproduction policies. While adoption is almost impossible for singles, MAR is allowed for single women through anonymous sperm donation. Another contradiction is that, while MAR is generously subsidised by the Hungarian state, knowledge on MAR is only available to certain groups of students in Hungary. For example, individuals trained in vocational schools may be at a disadvantage, because here MAR issues are not part of the curriculum. It is also a glaring contradiction that costs for contraceptives are not subsidised based on social need, but costs for abortion are.

The current Hungarian government's political agenda on reproduction policy is informed by both nationalism and conservativism. Hungarian women are viewed primarily as wives and mothers, considered as reproductive citizens of the nation to help overcome the "demographic deficit" of the country or to reinforce traditional family values. Through the recreation of a nationalist, conservative, heteronormative, discourse supporting the patriarchal family, which is explicitly "anti-gender" and anti-LGBTQI rights, the government seeks to undermine liberal democratic values, as well as the global and European human rights agenda.

With this chapter, we have contributed to understanding how reproduction policies are aligned and how they can contradict each other at the same time within a country. Our chapter also demonstrated a case of intensive selective pronatalism in Central-Eastern Europe. Some important topics remain for future research, such as the issue of forced sterilisation of Roma women, which should be further explored as a question of selective pronatalism.

NOTES

1. Incapacity or limited capacity to act is indicated in the Hungarian Civil Code, for example in the case of young ages (0–14, 14–18), or being placed by

the court under legal custodianship (due to, for example, mental disorder, serious addiction).

2. The Constitutional Court of Hungary interpreted these rights related to the regulation of abortion in the following decisions: Decisions 64/1991 (XII. 17.) and 48/1998 (XI. 23.) and highlighted that it is within the Parliament's competence to determine whether the foetus is or not a legal person.
3. *2020-as jogi változások az örökbefogadásban* (2020, October 12). Örökbe.hu. https://orokbe.hu/2020/10/12/2020-az-orokbefogadasban/
4. Originally, the National Election Commission approved five questions, including the following: "Do you support the promotion of gender reassignment treatments for minors?" This question was excluded by the Curia, the highest judicial authority in Hungary, relying on the Fundamental Law of Hungary and the legal rules related to referendums in its reasoning (Decision Knk.II.40.646/2021/9. of the Curia).

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9. A world of contradictions: biopolitics and the post-1989 reproduction policies in Poland

Monika Ewa Kaminska

INTRODUCTION

In the past three and a half decades, reproduction policy in Poland has shown an almost unwavering continuity – despite changing political constellations – in the attempts to control female bodies and their reproductive possibilities. Below, this consistency in the Polish post-1989 reproduction policy is discussed, relying on Foucault's concept of biopolitics which is here understood as a comprehensive discipline of bodies and regulation of populations (see Gros 2016: 264) to which the state aspires with the goal of controlling the biological aspect of society (Foucault 2003: 247; Albert and Szilvasi 2017: 25). According to Foucault, with the emergence of the modern state, sexuality and reproduction have been transformed into means of production (Foucault 2003; Albert and Szilvasi 2017: 25): the population should procreate to produce human resources for the state's purposes (Foucault 1978; Albert and Szilvasi 2017: 25). This chapter argues that the Polish reproduction policy framework has been driven by the political intent to turn female bodies into objects of what Foucault terms as "disciplinary power" (Foucault 2003: 242; see Albert and Szilvasi 2017: 24). In the post-1989 Polish context, the state's disciplinary power has been embedded in the agenda of the Catholic Church (Mishtal 2009) and exercised with the declarative goal of ensuring a perpetuation of the Polish "dying nation" (Mishtal 2012). Crucially, the concept of the "nation" has been clearly specified as pertaining to "an ethnic-Catholic vision of the nation" (Kozłowska et al. 2016: 834). This agenda has defined the Polish framework for reproduction policies in different fields, both in their de jure and de facto dimensions and has set the limits for what can be deemed as "acceptable" reproductive behaviour.

In the Polish context, religion must be "conceptualized in an actor-centred way" (Fink 2009: 78), with the Catholic Church acting as a societal veto

player in everyday policymaking (Calkin and Kaminska 2020: 87–89). Here, Catholicism has been historically "intertwined with nationalism" (Calkin and Kaminska 2020: 92). During the period of loss of Polish autonomy to Russia, Prussia and Austro-Hungary (1795–1918), Catholicism served as "a unifier of the nation in opposition to German Protestantism and the Russian Orthodox Church" (Calkin and Kaminska 2020: 92–93; see Zubrzycki 2006), resulting in an "ethnic-centred fusion of 'the Pole' and 'the Catholic' into a single Polish Catholic national identity" (Kozłowska et al. 2016: 831). After the Second World War, with the communist regime imposed by the Soviet Union, the Catholic Church was again perceived as "the only legitimate institutional counterpart to the state" representing the interests of Poles (Kozłowska et al. 2016: 832; Zubrzycki 2006). Having struggled during the post-war Stalinist decade, since the mid-1950s, the Church was gaining political strength as a supporter of the anti-communist opposition (Caytas 2013: 66). After 1978, its position was bolstered by the election of a Pole, Karol Wojtyła, as Pope John Paul II, whose extremely conservative approach to sexuality found its clear expression, inter alia, in his 1995 encyclical "Evangelium Vitae" where abortion was condemned as a manifestation of a "culture of death" and "contraceptive mentality" was opposed to responsible parenthood (Population and Development Review 1995: 689).

The growing political power of the Polish Catholic Church culminated in it playing an official role in the 1989 Round Table talks between the opposition movement and the communist government that eventually ushered in democracy in Poland. Since 1989, the Catholic Church has continued to "formulate norms of acceptable behaviour in the political arena", exerting "palpable authority" on political parties across the political spectrum (Heinen and Portet 2010: 1011). That influence has been institutionalized by a concordat signed by Poland and the Vatican in 1993 that effectively gave the Polish Catholic Church control over moral and sexual education and undermined the secular character of the Polish state (Heinen and Portet 2010: 1009). Between 1989 and 2015, the alternating liberal–conservative and centre-left governments have surrendered to the interference of the Church in the state's functioning. The 2015 electoral victory of the populist-nationalist Law and Justice Party marked a turn towards a regime that, while dismantling the rule of law and steeping the country in corruption, adopted the most conservative version of Catholicism in policy processes.

Consequently, since 1989, the ethnic-centred fusion of "the Pole" and "the Catholic" increasingly became a reality also in policymaking processes, particularly the field of sexual and reproductive health and rights. The policy outputs across different reproduction policy fields have been formulated within heteronormative conservative boundaries defined by the Polish Catholic Church that have prescribed who, with the help of which technological means,

and in which family constellations, should reproduce. Thus, in contrast to the declarative pronatalist intention, the actual emphasis in the Polish post-1989 context has been on "the morality of reproductive conduct" (Mishtal 2009: 164). In other words, these policies have been used to discipline reproductive bodies of Poles, in particular Polish women and individuals defying heteronormative prescriptions.

As a result, a regulatory framework has emerged leading to, on the one hand, virtual lack of sexual education (Izdebski et al. 2022), very poor access to contraception, as well as restrictions and eventually a virtual ban on abortion. Coupled with perinatal care of declining quality (Mastylak et al. 2023) and barriers in access to prenatal diagnostics (Orzechowski et al. 2021), these policies have had a chilling effect on reproduction intentions of Polish women. On the other hand, barriers in access to medically assisted reproduction have directly prevented scores of potential parents from achieving reproductive goals. This reproduction policy framework has manifestly failed to increase fertility rates in Poland. On the contrary, fertility rates have been dropping since the late 1980s, and since 2018 each consecutive year has been marking a historical low: in 2022 and 2023 Poland registered the lowest birth rates since the Second World War (GUS 2024). Decreasing fertility rates result from a confluence of several factors and obviously must be interpreted against the overall fertility patterns in Central and Eastern Europe (Grzenda and Frątczak 2018), as well as the contingencies of the Covid-19 pandemic (Sienicka et al. 2022). However, experts increasingly point the finger to limitations on reproductive rights imposed over the past three and a half decades (Kostrzewski 2023).

The chapter follows up on this premise and takes stock of the de jure and de facto changes in reproduction policy framework in Poland within the context of post-communist transition. It maps the developments in three reproduction policy fields (abortion, contraception, and medically assisted reproduction) and their interaction since 1989. It explains the de jure and de facto policy outputs in these policy fields as embedded in the moral governance defined by the Polish Catholic Church and adopted by a large majority of Polish political elites and healthcare providers. The chapter concludes that, first, the de jure and de facto outputs of these reproduction policies are mutually contradictory and that, second, their interaction has produced a regulatory reproductive regime whose content effectively contradicts the declarative goals of pronatalism professed by the conservative political and religious actors in Poland.

REPRODUCTION POLICIES DURING THE COMMUNIST REGIME AND THE 1989 WATERSHED

The post-1945 communist system in Poland promoted a vision of women who were meant to be independent of and equal to men in their civil and social

rights, and actively participating in the labour market. While the communist gender equality rhetoric did not quite extend to domestic chores, it did produce "greater reproductive and sexual autonomy", reflecting the secular ideology of the communist regime (Mishtal 2009: 162). The newly installed communist government instated a universal healthcare system that gradually endorsed family planning (Mishtal 2010), with some groundbreaking policy changes adopted already in the 1950s. A 1956 law introduced the right to abortion in cases of "difficult living conditions", thus legalizing social indications in addition to medical and criminological indications as grounds for abortion (Czajkowska 2012: 145). In 1957, a Polish Family Development Association was founded, soon running medical clinics and youth centres, prenatal training schools and family planning counselling centres that offered advice on contraception (Kozakiewicz 1990: 15). The abortion law was further liberalized in 1959, whereby upon-request abortion was effectively introduced (Kula 2012: 9). Abortion care was fully subsidized in public hospitals (Mishtal 2010: 56). With no conscientious objection clause existing in the Polish legal framework during the communist period, doctors could not refuse to perform an abortion, although the Catholic Church consistently exerted pressure on physicians to refuse compliance with the law (Fuszara 1991: 118). The 1959 law also introduced an obligation for physicians to offer advice on contraceptive measures to women after a delivery or abortion; soon, the healthcare system was also covering 70 per cent of the cost of contraceptive pills and intrauterine devices (Mazur 1981).

However, this legal framework was not matched by practical availability: shortfalls in national production and limited import possibilities resulted in extreme shortages in the supply of all types of contraceptives. Moreover, the Catholic Church in Poland consistently advocated against the use of contraceptives (Mrugala 1991) and, with ca. 95 per cent of Polish society identifying as Catholic in that period, a substantive share of the population followed the Church's teaching on that matter. Within this context, although ca. 60 per cent of Polish women did resort to some form of family planning in the 1980s, most of them relied on "the least effective methods (withdrawal and rhythm)", and only 2 per cent would use contraceptive pills or intrauterine devices (Mazur 1981: 195). As a result, abortion remained the main method of family planning during the communist period (Okólski 1983).

In the 1980s, as its political position was strengthened by its involvement with the anti-communist opposition and the support of the Pope, the Church and the emerging "pro-life" organizations that it sponsored launched anti-abortion campaigns (Jankowska 1993) to which the imploding communist regime partially yielded by introducing additional procedural requirements in access to abortion (Caytas 2013: 66). In an attempt to counter the pressure of the Church, at the end of the 1980s, the Family Development Association

was still actively promoting planned parenthood with five youth centres, 25 premarital and family counselling centres, six prenatal training schools, and 89 medical clinics. In total, it was serving 140,000 patients per year (Kozakiewicz 1990: 15).

The collapse of the communist regime in Poland triggered an anti-communist backlash in many policy fields (e.g., Kaminska et al. 2021). In the reproduction policy, this was manifested in the adoption by state institutions of moral governance based on "Christian values" proclaimed by the Church and a gradual tightening of the disciplinary power grip on Polish women. The first post-communist government halted subsidies for non-governmental organizations, which undermined the activities of the Family Development Association (Kozakiewicz 1990). Crucially, the new Health Ministry issued a regulation that introduced a "conscientious objection clause" allowing doctors to refuse to perform abortions and deny any other medical services (including prescription of contraceptives, prenatal diagnostics, etc.) "citing conscience-based objections" (Mishtal 2009: 161). In 1991, the re-instated National Chamber of Doctors adopted a Code of Medical Ethics that incorporated the conscience clause and defined performing an abortion based on social indication as a violation of medical ethics, possibly leading to suspension of one's medical licence (NIL 1991). The right to invoke conscientious objection was legalized for physicians, nurses and midwives by the Polish medical law in 1996 (Czekajewska et al. 2022).

What followed was a massive rollback on women's reproductive rights, in compliance with the Church's perception of woman as "a mother […] whose body should serve the national aims of procreation" (Heinen and Portet 2010: 1012). In the media, official documents, penal code, and national legislation, the words "female patients", "pregnant woman", "embryo" and "foetus" were replaced with, respectively, "mother" and "unborn or conceived child" (Heinen and Portet 2010; Król and Pustułka 2018). On the one hand, de jure (legislative and regulative) changes in the following decades posed restrictions on access to abortion, contraception, and medically assisted reproduction. On the other hand, de facto restrictions followed from the massive reliance by healthcare providers on the "conscientious objection clause". While a growing number of individual doctors yielded to "social, clerical and media pressures" (Caytas 2013: 68) and applied the clause to refuse to perform legal abortions or prescribe contraception, soon "conscientious objection" was being used structurally across the healthcare system by entire hospitals and "facilitated the withholding of medical services on a systemic scale" (Mishtal 2009: 163).

DEVELOPMENTS ACROSS REPRODUCTION POLICY FIELDS

Abortion

The first reproduction policy field that was dramatically restricted through this biopolitics was abortion. The Polish Episcopate submitted a draft bill banning abortion to the new Parliament – now dominated by Christian Democrats – as early as 1989. A string of similarly draconian draft bills followed. However, they met with massive street protests led by women's organizations who eventually collected 1.3 million signatures in support of a referendum on abortion. Yet, as polls indicated that 70 per cent of voters would oppose a ban on abortion (Caytas 2013: 69), the President, as well as the legislature and the executive, both dominated by Christian Democratic parties, rejected the referendum initiative under direct pressure from Polish bishops (Szelewa 2016). Instead, as a result of a legislative process controlled by a Christian Democratic majority and based on a 1992 draft bill proposing to ban abortion, contraception and access to IVF treatment, a Family Planning Act was adopted in 1993. The new law was tagged "abortion compromise" as it criminalized abortion following the Episcopate's will without completely banning it: termination of pregnancy became illegal except for three cases: (1) a threat to life or health of the woman; (2) high probability of a severe foetal impairment; (3) pregnancy resulting from an unlawful act (until the 12th week). Performing illegal abortions became punishable by up to two years of incarceration; forcing a woman to undergo abortion, with up to eight years. The Act did not criminalize women obtaining illegal abortions.

When a centre-left coalition established a government for the period of 1993–1997, it tried to amend the Family Planning Act in 1994 and, again, in 1996, by introducing a socio-economic indication as grounds for legal abortion. These liberalization attempts met with staunch opposition of the Church who openly equated abortion to the Holocaust, Nazi eugenics policies, and infanticide (Szelewa 2016: 751). Under the pressure from the Church, the 1994 amendment was rejected by the right-wing President of the country (Caytas 2013), while the 1996 amendment was declared unconstitutional by the Polish Constitutional Tribunal, also dominated by Christian Democrats (Szelewa 2016: 752). When the left-wing coalition returned to power (2001–2005), it was cautious not to approach the topic of abortion fearing the Church's retaliation in the form of a veto on the 2004 referendum on Polish EU-accession (Caytas 2013). In the following ten years, the liberal-conservative coalitions, despite their "modern" image, also shied away from attempts at liberalizing the 1993 "abortion compromise". After the 2015 electoral victory of an extremely

conservative coalition led by the Law and Justice Party, numerous attempts to further restrict access to abortion followed, including a 2016 draft bill that proposed to unconditionally ban abortion, criminalize women seeking abortion, and effectively halt any prenatal diagnostics (Król and Pustułka 2018: 373–374). These attempts met – again – with massive protests. In 2016, hundreds of thousands of people across the country marched against the proposed abortion ban (Król and Pustułka 2018). Despite protests, further restrictions on access to abortion did materialize: in 2020, the Constitutional Tribunal of Poland (unlawfully appointed by the Law and Justice Party) declared abortion on the grounds of foetal impairment as unconstitutional. Following that ruling, the current (as of May 2024) legislative framework only allows for a legal abortion if the pregnancy constitutes a threat to life or health of the woman or results from an unlawful act (rape, incest). Poland has currently the most restrictive abortion law in Europe (together with Malta, Andorra, Lichtenstein and Monaco) (CRR 2024).

The situation has been exacerbated by de facto barriers in access to legal abortion. As already mentioned, since 1989, individual doctors as well as entire hospitals have massively invoked the conscientious objection clause to refuse legal abortions (Mishtal 2009; Frugalska and de Londras 2022). Furthermore, public prosecutors who are responsible for issuing prosecutorial certificates that qualify the pregnancy as resulting from an unlawful act, thus allowing for legal abortion, manifestly delay processing of such cases, which leads to exceeding the 12-weeks time limit and rendering an abortion illegal even in such circumstances. In addition, pregnancies resulting from unlawful acts are notoriously underreported (Kaminska 2024 forthcoming).

These de jure and de facto restrictions have led to a radical decrease in the number of legal abortions in Poland, from 105,333 in 1988 to 685 in 1993 and later around 1,000 per year between 2015 and 2020 (Rada Ministrów 2022). Since the entry into effect in early 2021 of the ruling of the Constitutional Tribunal, the annual figures dropped to 107 in 2021 (Rada Ministrów 2022) and 161 in 2022 (Rynek Zdrowia 2023).

The actual abortion figures are significantly higher. In the first two and a half post-1989 decades, Polish patients seeking abortion outside of the legal framework relied on underground domestic abortion or abortion travel abroad. According to feminist organizations, between 80,000 and 190,000 illegal terminations were performed annually (Federa 2013). The last ten years have seen a growing reliance on self-managed medication abortion (Calkin 2023) often accessed through pro-choice organizations located both in Poland and globally and operating on digital platforms (Kaminska 2024 forthcoming). While hard data are impossible to obtain given the grey-zone character of these activities, similarly high numbers can be estimated: for example, between October 2020 and October 2023, only one of the pro-choice organizations,

Abortion Without Borders (Aborcja Bez Granic) helped ca. 125,000 persons to access (mainly medication) abortion (ADT 2023; Federa 2023).

Despite a growing reliance on medication abortion and the mobilization of pro-choice organizations, not all individuals in need of an abortion are able to access it. Between January 2021 and December 2023, at least six women died in Polish hospitals because they were refused a life-saving abortion (Pamula 2023); this figure seems to be constituting "only a fraction of the actual number of fatalities arising from the extreme restrictive abortion framework" (Kaminska 2024 forthcoming).

Contraception

Immediately after 1989, the opposition of the Church against contraception was – as in the case of abortion – channelled into a legislative process in an attempt to ban contraceptives. The already-mentioned draft bill proposing respective measures was accepted by the Parliament for deliberation in 1992 (Caytas 2013: 69). While a ban on contraceptives was eventually not written into the 1993 Family Planning Act, de facto barriers in accessing contraception have been erected through other regulative and non-regulative measures. Prescription requirements, the pricing and cost reimbursement policies, as well as the conscientious objection clause invoked by doctors and pharmacists alike have gradually restricted access as part of the biopolitics framework.

Oral contraceptives remained prescription drugs after 1989 but, since 2002 (following a regulation by the Health Ministry issued under the pressure of the Church, Mishtal 2010: 57), only obsolete hormonal pills of one type have been (partially) reimbursed by health insurance (Federa 2020). Widespread use of conscientious objection by gynaecologists has made obtaining prescriptions for any contraceptives from public healthcare providers extremely challenging. Patients may turn to private providers but in this case, they must also pay a full price for the visit, and cost barriers are insurmountable for a large share of women (Mishtal 2009; Caytas 2013). Finally, the conscientious objection clause has also been increasingly invoked by pharmacists, which has made purchasing contraceptives – even against a prescription – even more difficult. While reliance on conscientious objection by pharmacists is missing legal grounds in the Polish medical law, a 2017 decision by a conservative Minister of Health made official that possibility (Ministerstwo Zdrowia 2017). Additionally, a large majority of healthcare providers refuse to install intrauterine devices.

Consequently, in 2006, Poland had "one of the lowest rates of use of modern contraceptive methods in Europe – only 19 % compared with 81 % for Great Britain, 38.9 % for Italy and 29.5 % for Romania" (UN 2010). A decade later, little had changed in the reliance on contraceptives in Poland. According

to a representative 2017 study, 27 per cent of respondents did not use any contraception, and of those who did – less than 30 per cent used oral contraceptives (Izdebski and Wąż 2017). The remaining most preferred methods were condoms (66 per cent) as well as coitus interruptus (21 per cent) and periodic abstinence (13 per cent) (Izdebski and Wąż 2017; multiple answers were possible).

In May 2017, the government led by the Law and Justice Party imposed further restrictions – this time on emergency contraception. After 1989, emergency contraception was available on prescription only, and was very rarely used because of virtual impossibility to obtain a prescription within 72 hours (due to a combined effect of very long waiting times and the conscientious objection practised by doctors and pharmacists), and stiff prices (Izdebski and Wąż 2017). In early 2015, following the implementing decision of the European Commission to qualify the emergency contraception based on ulipristal acetate as a non-prescription drug across the EU territory, the liberal-conservative government made it directly available from pharmacies in Poland. That regulation was reversed when the Law and Justice government was installed later that year: since July 2017, all emergency contraception in the country has again been available only upon prescription.

As a consequence of these different measures, between 2017 and 2019 Poland was among the countries with the worst contraception access in Europe according to the European Parliamentary Forum's Sexual & Reproductive Rights "Contraception Atlas"; since 2020, it has established itself as "the only country going backwards in terms of contraceptives access" and ranked "worst in Europe" (EPF 2020).

Medically Assisted Reproduction

Medically assisted reproduction (MAR) was the last of the policy fields discussed here to be regulated with the effective aim to exercise disciplinary power over reproductive bodies in Poland. While the first successful in vitro fertilization (IVF) procedure in Poland dates back to 1987, it was not until the mid-1990s that MAR in general, and IVF in particular, established themselves in Poland. However, after the first clinic for medically assisted reproduction opened its doors in Warsaw in 1994, other clinics mushroomed, reaching the figures of 15 in 2000, 31 in 2009 and 44 in 2019 (Smeenk et al. 2023). In the first post-1989 decades, MAR remained unregulated in Poland. Instead, access was governed by the rules of the free market. While ultra-conservative politicians and the Polish Catholic Church had traditionally opposed access to MAR, the debate did not erupt until 2007, when the liberal-conservative government proposed introducing state financing to cover (partial) costs of MAR procedures. This proposal met with a vehement backlash of the most

conservative sections of the Polish political spectrum and the Episcopate itself, and opened a violent discussion on "whether IVF should be allowed in Poland at all" (Radkowska-Walkowicz 2018: 980). The argument was based on the Church's approach to reproductive citizenship, materialized in the defence of "foetal citizenship" (referring to embryos as "unborn children" and protecting their "right to life") and – at the same time – in the exclusionary logic presenting the "IVF children" as a threat to the Polish nation (Korolczuk 2016). Despite a brutal war of words in which the Church equalled IVF to murder and the Holocaust and claimed that "IVF children" are doomed to suffer from mental and physical impairments (Radkowska-Walkowicz 2018), in 2013 the government introduced a scheme for reimbursement of IVF treatment with the declarative aim "to boost fertility rates in Poland and to ensure the safety of embryos and patients" in the absence of a legal framework (Korolczuk 2016: 128).

The public debate on access to MAR and the legislative process aiming at its regulation continued as Poland was under the obligation to regulate this policy field following the European Union Directive (2004/23/EC) "On setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage, and distribution of human tissues and cells" and its two associated Technical Directives. The "Law on Infertility Treatment" that was eventually adopted in 2015 was another "compromise" that emerged in circumstances similar to those surrounding the adoption of the "abortion compromise" two decades earlier. The draft bill – prepared by the ultra-conservative parties and the Church – which postulated banning IVF and criminalizing doctors for applying the procedure was rejected. However, the adopted law has introduced a conservative and strictly heteronormative framework which allows for fertilization of a maximum of six oocytes and provides for a possibility of treatment only for heterosexual couples, thus discriminating against single women and homosexuals. Following the adoption of the law, single women have not only lost the possibility to receive treatment in Poland, but those of them who had already initiated the treatment and had their embryos cryopreserved in Polish clinics found themselves banned from continuing the treatment and using these embryos; the only possibility for them to access their own biological material has been by literally "evacuating" the embryos to clinics in countries with more liberal MAR laws (Sussman 2019).

In the meantime, the IVF financing scheme was proving extremely popular and, in 2015, the government announced an extension of the programme until 2019. Yet, following its 2015 ascent to power, the Law and Justice-led government closed the scheme. Until 2023, only a few municipalities in Poland decided to fund IVF treatment locally. As a consequence, access has been severely limited for low-income individuals.

The restrictiveness of these policies has been mirrored in the statistics on MAR births. Since 1987, at least 100,000 children have been born following MAR treatment, including ca. 22,000 in the years 2013–2016 when it was (co-)financed from the public scheme. In 2019, between 6,200 and 6,500 MAR births were registered, which corresponds to ca. 1.7 per cent of all 2019 national births (Smeenk et al. 2023). These figures are very low in comparison with countries such as Spain, where MAR births constitute 8.9 per cent of all births, Greece (7.5 per cent) or Denmark (6.3 per cent) and some Central and Eastern European countries such as the Czech Republic (6.2 per cent) and Estonia (5.7 per cent). The European Atlas of Fertility Treatment Policies ranks Poland as third worst in Europe (together with Ireland) in terms of access to MAR, ahead only of Armenia and Albania (Fertility Europe 2024).

CONCLUSION

Poland, with a population of 40 million (the fifth largest in the EU), emerges from this overview with the worst scores across the continent on all three policy fields, thus holding the worst reproductive rights record in Europe. The outcome is attributable to the approach to reproduction policy adopted in Poland under the massive influence of the Catholic Church and – as shown in the discussion above – actually aiming at disciplining female bodies and their reproductive options.

Having produced the lowest historical fertility rates (and one of the lowest in Europe), this policy has effectively contradicted its declarative pronatalist goals. That failure is consistent with the existing literature. Research on the possible negative impact of abortion decriminalization on fertility rates finds no such straightforward effects (Sedgh et al. 2016) and, rather, indicates "an average, negligible effect" of abortion liberalization on fertility levels (Fernandez and Juif 2023). Abortion and contraception restrictions in historical contexts (in non-democratic regimes with closed borders, before the widespread use of medication abortion) produced only short-lived increases in fertility rates that within a few years would level out to reach fertility levels only slightly, if at all, exceeding the pre-ban levels (Stephenson et al. 1992 for Romania; Hajdu and Hajdu 2021 for Hungary). As the Romanian case shows, the societal costs of abortion and contraception bans were enormous in terms of maternal mortality (after their introduction in 1966, abortion-related maternal mortality in Romania soared to a level ten times that of any other European country) and the legions of children born from unwanted pregnancies who were literally warehoused in public institutions in extreme conditions (Stephenson et al. 1992). In the current EU context characterized by open borders allowing for free movement of persons and goods, and in the face of the increasing reliance on medication abortion, abortion restrictions will not

stop women from having abortion. Instead, they will either push individuals in need of abortion into the underground of illegal abortion within the national borders, or into the grey-zone of self-managed abortion with the use of pills, or into cross-border travel to jurisdictions with more liberal abortion laws. Obviously, restrictive regimes will generate inequalities in access to abortion and contraception, with individuals of lower socio-economic status facing financial, communication and health literacy barriers, as in the case of all healthcare services not reimbursed by the public healthcare system (Kaminska and Wulfgramm 2019). Finally, as Matysiak and van der Velde show, the 2020 abortion law change in Poland "resulted in a fall in overall fertility of around 4 per cent of the previous mean", as "[m]ore women opted to 'terminate' pregnancy by never starting it, than what would have resulted if the option to abort would have been available at a later stage" (Matysiak and van der Velde 2023: n.p.). Moreover, the authors also indicate that the 2020 policy change "resulted in an increase in mortality among newborns" because among women who could not access abortion, some of them gave birth to children unable to survive (Matysiak and van der Velde 2023: n.p.).

The discussion of the parallel developments and outcomes of the de jure and de facto policies in the three fields reveals that, considered from the pronatalist perspective, they are mutually contradictory. While the restrictive Polish abortion and contraception policies aim at protecting the so-called "unborn life", MAR, which could effectively produce more births, is also regulated in a restrictive way, thus undermining its pronatalist potential. The policy outputs in these three fields have clearly worked against each other, and have effectively shown to be counterproductive to boosting fertility rates in the country.

While the reproduction policy framework in Poland has proven incongruous with the official pronatalism, it has been perfectly coherent with the "disciplinary power" of biopolitics that governs and excludes (see Hanafin 2013: 45). By restricting reproductive choices and creating a framework of coerciveness, the Catholic Church and Polish politicians of different political leanings have engaged in what in the Italian context has been termed as *vitapolitics*, an ideology that "valorizes the abstract notion of life over the actual rights of living citizens, particularly women" (Hanafin 2013: 54). Faced with a loss of the ability to control and govern their reproductive bodies, and with their "voice" being ignored despite massive protests against growing restrictions (Korolczuk 2016; Król and Pustułka 2018), women seem to have literally "rebelled" against the biopolitics framework and adopted the only "exit" strategy (see Hirschman 1970) left to them, that is a refusal to procreate.

In October 2023, the Law and Justice Party lost the elections, mainly due to votes cast by women and young people for the opposition. One of the first legal acts adopted by the new governing coalition (this time composed of an unlikely panoply of conservative, liberal-conservative, and left parties) re-introduced

public funding for MAR (without, however, changing the restrictive conditions of the 2015 Law on Infertility Treatment). In a next step, the new government attempted a liberalization of the access to emergency contraception (and was stopped by the President of the Republic, who is a close associate of the Law and Justice Party and will remain in office for at least another year). Another point on the electoral programme of the winning coalition has been liberalization of abortion access, which is being debated in the Parliament as this book goes to print. After three and a half decades of growing restrictions, these might be the first steps towards relaxing the state's disciplinary power over reproductive bodies in Poland in favour of reproductive autonomy.

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PART IV

Policy interactions

10. The regulatory environment of multifetal pregnancy reduction: a comparative case study of Italy and Japan

Mio Tamakoshi

INTRODUCTION

Abortion and medically assisted reproduction (MAR) are vital components of the politics of reproduction. They are medical interventions that are intended to serve opposite reproductive outcomes; whereas abortion is performed to terminate pregnancy, MAR is utilized to initiate pregnancy and achieve live birth. The social science literature on these two topics has mostly explored these topics in isolation from each other (van de Wiel, 2022). Whereas abortion politics has a long history, which has been extensively studied in its own right, MAR is a relatively new subject; after all, the first "tube baby" was only born from in vitro fertilization (IVF) in 1978. The socioeconomic profile of MAR and abortion clients may also have contributed to how the two fields have been researched; the abortion rate is higher among women of lower socioeconomic status than among their affluent counterparts, while MAR is more often utilized by members of the middle class, who can afford the expensive treatment (Bell, 2014; Dehlendorf et al., 2013). However, both abortion and MAR can be understood as part of reproduction, that is, "the biological and social process of having or not having children" (Almeling, 2015, p. 430).

Looking at both abortion and MAR regulations together can illuminate a broader context of reproduction policy as a regulatory domain. Because both abortion and MAR involve the same legal and ethical issues – including the beginning of life, the status of the unborn and the state's responsibility for human life – regulations and regulatory debates on each of these interventions may pave the way for politicization of the other (van de Wiel, 2022). Existing debates on abortion can prepare the conceptual and political resources that actors utilize in the development of regulations on reproductive technologies. For example, comparing British, American and German regulations on embryo

research, Jasanoff (2011) highlights that preceding or concurrent abortion debates surrounding the origin of life, the foetal status and limits on abortion have influenced the framing of controversies that emerged in MAR regulatory discussions. Yet, MAR regulations, which are newer than abortion regulations in many countries, may trigger the re-emergence of previously settled abortion debates. Calloni (2001) observes that during the legislative discussion of IVF regulations in Italy in the 1990s, the subject of the legal and ethical status of embryos and the unborn was brought up in the parliament, and some legislators sought a restrictive amendment to the abortion law that had passed in 1978.

The cross-agenda reference between abortion and MAR regulations not only occurs in such a spill-over way, but also more directly. One showcase for their interrelations is the regulation of multifetal pregnancy reduction (MFPR), a procedure to reduce one or more live foetuses in multiple pregnancies. Multiple pregnancy can occur in spontaneous pregnancy, but the incidence has dramatically increased owing to the widespread use of reproductive technologies. As it is associated with higher risks to foetal and maternal health than singleton pregnancy, multiple pregnancy is considered to be one of the most important adverse outcomes of MAR (Olivennes, 2000). Thus, MFPR is usually regulated in the context of MAR; however, regulations on MFPR need to address the issue of abortion because the procedure involves, at least partly, voluntary termination of foetal development.

The present study compares the regulations and regulatory discussions on MFPR in Italy and Japan, following a most-similar systems design (Anckar, 2020; Przeworski & Teune, 1982); the two countries share socio-structural features relevant to reproduction, while showing a stark contrast in the MAR regulatory arrangement. By investigating the two country cases comparatively, this study addresses a two-sided question. First, what difference in MAR regulatory structures can empirically explain the different regulations on MFPR between the two cases? The chapter aims to explain the diverging responses to the issue of MAR-induced multiple pregnancy and the legality of MFPR by analysing the different regulatory arrangements that condition the level of professional autonomy of gynaecologists from legislative control. Second, how do the regulations of MFPR within the context of MAR refer to and interpret the abortion legislation in the respective country? In other words, the study investigates how the regulations of MFPR as part of MAR treatments have legalized or restricted the procedure of MFPR in relation to abortion. By answering these questions, the study aims to articulate how MAR and abortion regulations form part of a broader context of reproduction policy as a regulatory domain.

This chapter first gives a brief overview of multifetal pregnancy reduction. It then goes on to introduce the analytical and comparative perspective the study takes, drawing on science and technology studies (STS). After explaining the case selection and providing an outline of both abortion and MAR

regulations in Japan and Italy, the chapter reviews regulations and regulatory debates surrounding MFPR in both countries. Drawing on the comparison, it discusses how the different regulatory structures in the field of MAR have led to the divergent legal statuses of MFPR, as well as how the focus point of the respective abortion laws can be illuminated by the MFPR regulations in the two countries.

BACKGROUND: MFPR

Multifetal pregnancy reduction (MFPR) is a first-trimester or early second-trimester procedure to interrupt the development of one or more foetuses in multiple gestation. The standard procedure of MFPR is performed by a transabdominal injection of potassium chloride (KCl) to the heart of the foetus(es) (Berkowitz et al., 1996). Developed in the 1980s, the procedure has been used in order to reduce risks associated with multiple gestation, including foeto-maternal morbidity and mortality (Evans et al., 1996). While twin and triplet pregnancy can occur in spontaneous gestation, the increased use of medically assisted reproductive technologies (MAR) has led to the greater incidence of higher-order pregnancy. Multiple pregnancy following MAR is especially frequent with ovarian stimulation, which may produce multiple follicles. It is also common when in vitro fertilization (IVF) is carried out with more than one embryo transferred per cycle (Berkowitz et al., 1996; Maymon et al., 1995). Thus, the circumstances in which MFPR is performed are strongly associated with the use of reproductive technologies which seek to initiate pregnancy and achieve live birth. Meanwhile, MFPR shares a feature with abortion: both involve a voluntary interruption of the foetal development in an already-initiated pregnancy. MAR patients who undergo MFPR do not terminate the entire pregnancy, which is what occurs when abortion is conventionally performed, but instead carry the rest of the live foetuses conceived with MAR to term.

As it involves ethical and legal issues and puts a significant psychological burden on the pregnant person and their partner, MFPR is usually recommended by MAR experts "as a last resort only secondary to prevention of multiple pregnancy from the first place" (ESHRE Workshop Group, 2000, p. 1863). In fact, since the mid-1990s, technologies and practices have been developed to avoid multiple pregnancy following MAR. For example, ultrasound examination is utilized to inspect the number of follicles after ovulation induction and, when a high number of follicles is observed, the insemination attempt is postponed until another cycle. In several countries, medical guidelines have encouraged single or low numbers of embryo(s) transferred per cycle in IVF treatment. However, multiple pregnancy resulting from MAR

cannot be entirely prevented by these circumventory measures in today's medicine.

ANALYTICAL PERSPECTIVE

Drawing on the tradition of comparing policies in science and technology studies (STS), this study conducts interpretive analysis of MFPR regulations. Whereas comparative studies, especially in policy research, have conventionally aimed at identifying best practices to imitate in another context, the STS literature emphasizes the embeddedness of knowledge and policy in a specific context and suggests that a mere transplant of such best practices that pays little attention to cultural and other specificities may fail (Jasanoff, 2011; Markle et al., 2001). Inspired by this, the current study takes a comparative perspective to scrutinize differences in MFPR regulations between two countries and to observe how medical practices and regulations develop interactively in the field of reproductive medicine.

First, through a cross-country comparison of MFPR regulations, types and approaches in MAR and abortion policies respectively may be identified. On the one hand, MFPR is usually subject to MAR regulations, which vary strongly across countries (Pennings, 2009). Countries differ in what sorts of MAR treatments are permitted and prohibited, reflecting the ethical, religious and legal standpoints of the regulators. Moreover, the regulatory structure of MAR differs by country. Different actors, such as legislators, ministerial organs and professional associations of gynaecologists are involved in the making of such regulations on the use of MAR in different countries. On the other hand, MFPR regulation touches upon abortion regulations, which also vary widely across countries. Abortion laws convey cultural, religious and political meanings surrounding and assigned to reproduction. Thus, the cross-country comparison of MFPR regulations in the current study helps to identify variations in the policy fields of MAR and abortion simultaneously.

Second, because MFPR concerns both MAR and abortion, an analysis of regulatory landscapes surrounding MFPR contributes to understanding how these two different fields intersect and interact with each other. This provides a more comprehensive view of the regulatory domain of reproduction policy. By comparing how MFPR regulations within the MAR regulatory contexts refer to and interpret the abortion laws in each country, the study enables exploring the inter-policy dependencies in the realm of reproduction policy. Regulations of MFPR are a unique subject in a cross-country comparative analysis that seeks to understand interrelations among different sub-fields of reproduction policy.

CASE SELECTION

This chapter looks comparatively at MFPR regulations in Italy and Japan. The case selection resembles a most-similar systems design (Anckar, 2020; Przeworski & Teune, 1982), with both countries showing important structural commonalities but strong differences in the MAR regulatory arrangement. First, the two countries share certain societal features that are relevant to reproduction. Southern Europe and East Asia are often compared in terms of historical development and the organization of welfare states. Both regions are characterized by strong *familialism*, that is, a great emphasis on the family as a welfare provider, predicated on conservative teachings on family in Catholicism and Confucianism (Collier & Mahon, 1993; Naldini, 2004). Furthermore, both Japan and Italy are facing a lowest-low fertility rate while the populations are rapidly aging. This renders the matter of reproduction ever more pressing for policymakers in both countries. The high prevalence of infertility along with the societal change, including postponement of childbearing also adds to the importance of reproduction policy, especially in the field of MAR, to people in both societies.

Second, the abortion regulations in Japan and Italy are similar. Abortion remains in the Penal Code in both countries, while specific law exempts the criminality under certain circumstances. In Japan, abortion was criminalized in 1907 under the Imperial government (Articles 212–216 in the Penal Code). However, as part of the population control policies in the post-war period, the Eugenic Protection Law (優生保護法) passed in 1948 (renamed to Maternal Protection Act (母体保護法) in 1996). The law permits abortion up to the foetal viability, marked by the ability of a human foetus to survive outside the uterus.[1] This applies to cases in which the pregnancy may cause serious harm to the mother's health for physical or economic reasons as well as in cases of incest or rape.

In Italy, the abortion ban was included in the Penal Code under the Fascist regime in 1930 (Articles 545–551). Despite democratization in the post-war period, many pieces of Fascist legislation remained in place, including abortion prohibition. However, in 1978, Law no. 194 "Norme per la Tutela Sociale della Maternità e sull'Interruzione Volontaria della Gravidanza" (Regulations on the Social Protection of Motherhood and about the Voluntary Interruption of Pregnancy) was approved by the parliament. This law legalizes abortion within the first 90 days of gestation when pregnancy threatens the pregnant woman's physical or mental health, including economic, social or family conditions. As such, whereas several countries have completely decriminalized abortion, both Italy and Japan have kept abortion in the criminal code, but established certain conditions under which abortion can be legally performed.

Third, the countries exhibit great differences in the regulatory organization in the field of medically assisted reproduction. Italy used to be regarded as "the Wild West" in the fertility industry for a long time due to the absence of relevant regulations. After two decades of legislative attempts, Law no. 40 "Norme in materia di procreazione medicalmente assistita" (Regulations on Medically Assisted Procreation) passed in 2004, which was the most restrictive MAR regulation in Europe at the time (Robertson, 2004). The law established a ministerial guideline, which is updated every three years and binding for all the authorized fertility clinics that can perform MAR services. Meanwhile, Japan has no legislative regulation of MAR up to today. In Japan, MAR is primarily governed by organizational guidelines issued by the Japan Society of Obstetrics and Gynaecology (JSOG). The stark contrast in the regulatory structure in the field of MAR helps to empirically analyse the difference in MFPR regulations between the two cases.

MFPR REGULATION

In the following sections, the chapter provides an overview of MFPR regulations and regulatory discussions in the two countries. The data consist of legislation, constitutional litigations, government documents and official announcements by professional groups and stakeholders. Due to the difference in the regulatory structure in the field of MAR between the two countries, the weight given to different types of data in the analysis differs.

MFPR Regulation in Japan

In Japan, the incidence of multiple births increased between the 1960s and 2000s. With the implementation of IVF in clinical practice in the mid-1980s, the rate of increase further accelerated, especially of triplets and higher-order pregnancies (Imaizumi, 1995). Since its peak at 1.18 per cent in 2005, the proportion of multiple births to total deliveries has remained stable in recent years, with 1.05 per cent of all deliveries in 2020 (Ministry of Health Labour and Welfare, 2023). While there has been an organizational effort to reduce the incidence of multiple pregnancies resulting from MAR, the legal status of MFPR has not been settled, nor is there any medical guideline specifically on MFPR.

In 1986, the first case of MFPR in Japan, a reduction of quadruplets to twins, was reported by the gynaecologist Yahiro Netsu. The reported case provoked a heated debate both among physicians and in the wider public (Yomiuri Shimbun, 1987). The president of the Japan Association of Obstetricians and Gynaecologists (JAOG), the nationwide professional association, published a comment that physicians should restrain from performing MFPR until its

legality is established (Moriyama, 1988). In 1993, JAOG published a statement claiming that MFPR may violate the abortion ban. The definition of abortion in the Maternal Protection Act is "expulsion of the foetus from the mother's body" (Article 2(2)), whereas, in the procedure of MFPR, the foetus whose development is interrupted remains in the uterus until the delivery of the other fully developed live foetus(es), later than 22 weeks. Hence, abortion of all the foetuses in multiple pregnancy by 22 weeks is legal but foetal reduction may be illegal, as the "abortion" procedure in MFPR is technically completed later than the foetal viability threshold.

With the cautious attitude against MFPR maintained in the country, the JSOG, who publishes MAR guidelines periodically, sought to prevent multiple gestations from the mid-1990s. In 1996, JSOG issued an updated guideline on IVF, setting the maximum number of embryos (three) transferred at a time.[2] Meanwhile, other expert organizations started to acknowledge the necessity of MFPR in the 2000s. A report in 2003 by the expert committee on MAR of the Ministry of Health Welfare and Labour stated that MFPR "may be performed if, despite precautionary measures, the number of foetuses is four or more" (Subcommittee on Assisted Reproductive Medicine, Health Science Council, 2003). In 2004, the Japan Society of Fertilization and Implantation (JSFI) also issued a statement in favour of MFPR, proposing that the definition of legal abortion in the Maternal Protection Act be amended so that it includes the extinction of a foetus *inside* the mother's body (Japan Society of Fertilization and Implantation, 2004).

Despite these opinions, JSOG has insisted on preventing multiple gestation until the present day without solving the ambiguous legal status of MFPR. In 2008, JSOG updated the IVF guideline, reducing the maximum number of embryos transferred per cycle from three to one, except for women over 35 years old or those who have had two or more consecutive unsuccessful pregnancy attempts. The guideline also states that the infertile couple must be fully informed about the embryo cryopreservation technology, which allows for the use of surplus embryos in a later treatment cycle, so that patients do not request a treatment with higher risk of multiple pregnancy.

Yet, despite this discouragement by JAOG and JSOG, and the subsequent absence of clinical guidelines or physician's training in MFPR, the procedure has still been practised since the late 1980s. There is limited data on the number of such procedure and their outcome in the country. One of the rare studies on the issue shows that MFPR was performed in 21.7 per cent of higher-order pregnancies between 1994 and 1996, and 33.4 per cent between 1997 and 1999 (Irahara, 2002).

In sum, the legal status of MFPR has remained ambiguous in Japan. The Japanese regulatory body for MAR, JSOG, has regarded MFPR as semi-illegal, and focused on preventing multiple gestation from the start.

Meanwhile, the procedure is performed out of necessity to higher-order pregnancies in Japanese clinics.

MFPR Regulation in Italy

In contrast to the legal vacuum in Japan, Italy legalized MFPR in 2004. Under the Italian MAR law (Law no. 40/2004), MFPR is permitted on the condition that the procedure takes place in accordance with the abortion law (Law no. 194/1978). Article 14(3) of the MAR law states that "embryo reduction in multiple pregnancies is forbidden except in cases provided for by the law no. 194 of 22 May 1978." In other words, as long as the requirements for legal abortion are met like in singleton spontaneous pregnancy, MFPR can be performed in the case of multiple pregnancies that resulted from MAR.

This MFPR provision should be understood in the context of the legal status of embryos in the Italian MAR law. Strongly influenced by the Catholic Church's teaching, the MAR law grants a high status to embryos, viewing the moment of conception as the beginning of human life. Article 14(1)(2) prohibits creation of more than three embryos at once, as well as suppression and cryopreservation of embryos. Furthermore, it states that all of the embryos, once created, must be transferred to the uterus at once ("sole and simultaneous implantation"). The clause that mandates the transfer of all the created embryos has widely been criticized as "unacceptable on medical grounds" by both Italian and international MAR experts, because it increases the risk of multiple pregnancy (Benagiano & Gianaroli, 2004, p. 118).

As such, under the Italian MAR law, embryo protection is prioritized over the health of the person who received the MAR procedure as well as over the ultimate goal of achieving live birth of a healthy child. However, once the pregnancy has begun, the foetus(es) may be aborted, either entirely or partly (i.e., through MFPR), as long as it is legal under the abortion law (Riezzo et al., 2016). Although there are no data that comprehensively cover the number of MFPR cases, MFPR has been included in the standard MAR protocol in Italy (Società Scientifiche SIGO-AOGOI-AGUI, 2016). This is still the case even after the Constitutional Court ruling in 2009 against the MAR law regarding the maximum limit of three embryos produced, which effectively legalized cryopreservation of embryos and thus allowed IVF treatment with a transfer of fewer than three embryos (Riezzo et al., 2016). A recent study suggests that, in Italy, even twin-to-singleton MFPR is practised, for which the clinical benefit of foetal reduction is not as established as for higher-order pregnancies (Monni et al., 2020).

DISCUSSION

The comparison of the MFPR regulations between Japan and Italy gives rise to two observations. First, the comparison between the two countries with systematic similarity on crucial contextual dimensions reveals the interactive development between medical practices and regulations in different regulatory arrangements. Specifically, I show that the regulatory structure in the field of MAR can explain the legal status of MFPR. There is a stark difference in the level of autonomy of MAR practices from legislative control between the two countries. In Japan, MAR is entirely governed by autonomous regulations, which allows rules to be generated more spontaneously, that is, medical guidelines. Because MFPR involves abortion, which is subject to a legislative regulation in Japan, developing measures to prevent multiple pregnancies is politically a less costly solution to the adverse outcome of MAR than amending the definition of induced abortion in the Maternal Protection Act. In turn, by focusing on the circumvention of multiple gestation, the relevant actors have postponed the debate on MFPR, leaving the procedure in a legal vacuum. In contrast, in Italy, MAR is regulated by strict legislation. When Law no. 40/2004 came into force in 2004, with its considerable emphasis on embryo protection, MAR practices to prevent multiple gestation, such as transfer of the minimized number of embryos per IVF cycle, were prohibited, which rendered MFPR necessary and legal. This has made MFPR a more available and less controversial option for MAR patients in Italy; even after the Constitutional Court ruling in 2009, which enabled cryopreservation of surplus embryos, MFPR has been widely practised (Monni et al., 2020).

Second, the comparative analysis of how MFPR regulations refer to abortion legislation illuminates how the respective abortion laws govern the relationship between the state, embryos/foetuses, and the pregnant person. In the Japanese case, the JAOG's hesitation towards MFPR derives from the fact that, in MFPR, the foetus that is subject to reduction physically departs from the gestating body much later than the threshold for the foetal viability. This highlights the significance of the foetal (in)viability requirement in the Japanese abortion laws. The JAOG's concern that MFPR may not fall into the definition of legal abortion does not neatly align with the typical ethical debate about the beginning of life, including the question at which point "foeticide" becomes unethical. In MFPR, interruption of the foetal development occurs in the first or early-second trimester, much earlier than when the foetus can hypothetically survive outside the uterus. However, such an ethical debate on the beginning of life is irrelevant in the Japanese abortion law; instead, the emphasis is put on when the reduced foetus(es) is discharged from the gestating body.

In the Italian case, the MFPR clause in the MAR law points to the tension between the legal protection of embryos and abortion rights of pregnant people. Although embryos are regarded as human beings following Catholic doctrine, once embryos are gestated, they become part of the pregnant person's body and thus turn into a matter of abortion rights. In other words, in Italy, embryos *in vitro* have an immediate legal status as a human, embryos *in utero* are at the pregnant person's discretion within the first 90 days of gestation. Although embryos are granted the right to life under the Italian MAR law, pregnant people's rights in the abortion law override that of the embryo once it is transplanted to the uterus. Unlike the Japanese case, the Italian abortion law does not discuss the foetal viability outside the maternal body. Instead, voluntary interruption of pregnancy, either partly or entirely, is justified on the grounds of woman's autonomy as long as it takes place within the first 90 days of gestation.

By comparatively looking at MFPR regulations in terms of how they refer to and interpret the abortion laws, it becomes clear what the abortion laws in each country are all about. The abortion ban in Japan is centred on the timing at which the aborted or reduced foetus is discharged outside of the gestating body; the expulsion of the foetus and foetal tissues has to be prior to the foetal viability threshold. Meanwhile, the Italian abortion law permits abortion within the first 90 days of gestation based on the pregnant person's right to abortion. This overrides the right of the unborn, even though the MAR law grants it the right to life from the moment of conception outside of the gestating body, that is, prior to gestation. The comparison of MFPR regulations also highlights the significance of the physical location of the foetus in relation to the gestating body along with the gestational age in the abortion regulations.

CONCLUSION

By investigating regulations and regulatory debates on multifetal pregnancy reduction (MFPR) in Italy and Japan, this chapter has explored the interrelation between the two realms of reproduction policy, medically assisted reproduction and abortion. By comparing the country cases, the study has held two inquires. First, it has suggested that the difference in regulatory structures in the field of MAR is an explanatory factor for the divergent manifestations of the legality of MFPR in the two countries. In the Japanese case, the non-legislative organizational regulation of MAR has left the legal status of the procedure ambiguous until the present day; the gynaecologist associations have avoided the politically costly process of changing the definition of abortion in the abortion law. When it comes to dealing with the higher incidence of multiple gestation following MAR, the professional autonomy in the MAR regulatory structure has allowed gynaecologists to resort to the alternative

solution than MFPR; in the absence of legislative control on the status of embryo in vitro, the Japan Society of Obstetrics and Gynaecology was able to develop and standardize the practices to prevent multiple pregnancy in the first place. In the Italian case, the restrictive legislative regulation of MAR has limited such preventive measures and thus made MFPR legal and, paradoxically, less controversial in the country. This finding shows how medical practices and regulations develop interactively at the intersection of abortion and medically assisted reproduction.

Second, by comparing how the abortion laws are referred to and interpreted within the context of MFPR/MAR, the study has examined the focus of abortion prohibition and permission in the respective pieces of abortion legislation. On the one hand, the analysis of the MFPR regulatory debates in Japan highlights the importance of the expulsion of the foetus for interpreting the Japanese abortion laws. On the other hand, the high status of embryo in vitro in the Italian MAR legislation and the subsequent legalization of MFPR show that legal abortion in the Italian abortion law is framed as a matter of the pregnant person's autonomy as long as the embryo/foetus is in utero. The comparison has also indicated that the abortion laws in both countries put significant value on the physical location of the unborn in relation to the gestating body.

These findings provide analytical insights that are useful for comparative reproduction policy studies in two ways. First, examining more than one sub-field at the same time provides a fruitful perspective on reproduction policy as a broader regulatory domain. Instead of investigating a single reproduction policy field separately, such as abortion or MAR, we can seek to understand the links between them in order to capture how the regulator intervenes in people's reproduction more broadly by prohibiting and permitting both general and specific reproductive care procedures. Abortion and MAR are a particularly intriguing combination, because, despite the opposite reproductive outcome, both of these medical interventions are penetrated by the same legal-ethical issues. Crucially, questions of the beginning of life and the status of embryo/foetus in relation to the patient and their body are relevant for both. This means that legal and medical authorities attempt to maintain the coherence between the two policy realms. For example, regulations of MAR are not only conditioned by the preceding abortion laws, but may also be a useful tool for understanding the logics of abortion regulations more deeply.

Second, the findings of this chapter demonstrate the advantage of a cross-country comparison in the field of reproduction policy. Because reproductive health services involve ethical-legal issues, regulations on these services are embedded in the specific socio-cultural contexts. Even for the purpose of delving into a single country case, such specificity can be captured better with a comparative reference to other cases. This chapter shows how comparative analysis offers insights into, for example, how medicine and

policy interact with each other in the field of reproduction, and how different sub-fields of reproduction policy affect each other.

It is crucial to note that medical practices and technologies develop in interaction with relevant regulations. Such development plays out differently across contexts especially in the field of reproduction, because reproduction policy that conditions medical practices reflects the cultural and ethical understanding assigned to reproduction in a specific society.

NOTES

1. Under the Maternal Protection Act, the exact pregnancy week of foetal viability is determined by a ministerial decree. It has been moved forward according to the development of premature infant care. It is currently 23 weeks, which means abortion is legal up to 22 weeks and 6 days.
2. Around the same time, the cryopreservation technique was improved (Kasai, 1997). In 1995, the vitrification method was developed in Japan which significantly increased the survival rate of human embryo cryopreserved because, in contrast to the preceding slow-freezing procedure, it prevents the ice formation which causes physical and chemical injuries to the cell (Rezazadeh Valojerdi et al., 2009).

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11. Comparing surrogacy regulation in the UK and California

Zaina Mahmoud

INTRODUCTION

In the United Kingdom (UK) and the United States of America (US), the nuclear family has been 'the reality for which legislation should be made and the ideal norm which it should strive to enforce' (McCandless & Sheldon, 2010). This family is presented as natural and the most suitable environment for raising children (Fineman, 1999), notwithstanding the fact that there is nothing inherently natural about law's reliance on particular factors (heterosexuality, marriage, and biology). Instead, these factors have been identified as important within particular temporal and social contexts (McCandless & Sheldon, 2010). For this reason, legal frameworks cannot be (comparatively) analysed in isolation; instead, they should be analysed as social processes reflecting broader cultural ideas and values (Bell, 2021).

Law's reliance on these factors was challenged in the latter half of the twentieth century, with the rapid emergence and expansion of medically assisted reproductive technologies (MAR) (Zegers-Hochschild et al., 2017). These scientific advances occurred during a time of renewed political interest in 'the family'. In the US, then-President Ronald Reagan placed responsibility for society's welfare on the nuclear family, using the rhetoric of 'family values', with the traditional nuclear family established as vital to American success (Dowland, 2009). In the UK, then-Prime Minister Margaret Thatcher unironically advocated for a return to 'Victorian values', with traditional family values 'a leitmotif of the election campaign' (Samuel, 1992). Regulatory debates on acceptable MAR use hinged on the potential impact on the nuclear family, given the challenges posed to law and the traditional understanding of legal parenthood, particularly motherhood. Law, equipped with concepts and language not designed with scientific advances in mind, responded by reinforcing the nuclear family as 'law's family', especially when motherhood, the centre of the nuclear family, was challenged.

At the most basic level, law regulates relationships between individuals, supporting fundamental social institutions 'thought to serve desirable ends and [channelling] people into them' (Schneider, 1992). Without a single statutory (or indeed, common law) definition of 'family' (Diduck & Kaganas, 2012), law recognising certain relationships as 'families' attaches legal status, rights and responsibilities, 'validating their worth and confirming [their] positive benefit for wider society' (O'Donnell, 1999). Law's construct of a family is a particular idealised kinship structure: the nuclear family, consisting of a married man and woman with their biologically related children (Fineman, 1995). This structure emerges from the 'nexus of the conjugal relationship and the parent/child relationship' (Brown, 2019), with the mother at its centre. Recognising that family law 'grows and decays and shifts and fidgets in line with what is happening in the larger society' (Grossman & Friedman, 2011), comparing the legal constructs of family and motherhood within the two legal systems allows for an understanding of the jurisdictions' legislative differences when confronted with the social conflicts arising out of surrogacy.

This chapter compares the regulatory measures adopted by the UK and California in response to challenges posed by surrogacy, demonstrating how these jurisdictions remained wedded to the nuclear family. From here, the chapter draws on empirical research comparing surrogates' lived experiences in the UK and California, demonstrating similarities notwithstanding the different frameworks. This comparative exercise reveals how surrogates similarly understood motherhood and viewed surrogacy as a gift. The chapter concludes with a discussion on the need for surrogacy regulation to be more responsive to surrogates' experiences, focusing on reforms to legal motherhood in the UK, where there is active reform underway. The Law Commission of England and Wales and the Scottish Law Commission are responsible for 'taking and keeping under review all the law' (Law Commissions Act 1965, 1965), and between 2018–2023, they undertook a project on surrogacy law reform.

REGULATORY BACKGROUND

This section critically examines and analyses the different legal and policy approaches to surrogacy in the UK and California, in case law and statute. Recognising surrogacy as a pressing threat to the nuclear family, these jurisdictions adopted legal responses as minimally disruptive to their family law regimes as possible. *Prima facie*, their responses appear vastly different, although closer analysis reveals similarities: both ensured the 'right' families were formed following surrogacy.

United Kingdom

The rapid expansion of MAR was recognised as posing a threat to the nuclear family (Department of Health & Social Security, 1984), prompting the Thatcher government to establish the Committee of Inquiry into Human Fertilisation and Embryology (the Warnock Committee) in 1982. Two years later, the Warnock Report was published, recommending government policy for recent and potential developments in human fertilisation and embryology, based on an assumed 'common moral position' on the importance of promoting the nuclear family (Department of Health & Social Security, 1984).

Two assumptions underpinned the Warnock Report's recommendations: the legal principle *pater est quem nuptiae demonstrant* (the father is he whom the marriage points out) and the importance of 'a loving, stable, heterosexual relationship' for children (Department of Health & Social Security, 1984). Upholding *pater est* downplayed the importance of a genetic link between father and child, and attached more weight to the maternal relationship – the cornerstone of the nuclear family (Foxcroft, 2001). When children were conceived with the use of donor sperm, the Report proposed the husband of the woman receiving treatment be registered as the child's legal father, replicating the nuclear family. The Report explicitly called for legislation treating children born following artificial donor insemination as the legitimate child of the couple who benefited from successful treatment (Department of Health & Social Security, 1984); this call was answered three years later by section 27 of the Family Law Reform Act 1987.

The Report reflected an insistent focus on the maternal relationship, seen in their belief that 'the deliberate creation of a child for a woman who is not a partner in such a relationship [was] morally wrong' (Department of Health & Social Security, 1984). Critics pointed to the Report's privileging of the nuclear family, commenting how the Report's recommendation that MAR be accessible only by married and stable couples sent a 'deeply heterosexist' message: 'perfect babies for perfect couples' (Hamner, 1987). This insistence was not initially as salient in the Report's opposition to surrogacy; Baroness Warnock later clarified how concerns with surrogacy arose 'largely because of possible consequences for the child' (Warnock, 1985), aligning the opposition to surrogacy with the rest of the Report. The Committee posited that surrogacy distorted the maternal relationship, attacking 'the value of the marital relationship' through its introduction of a third party into procreation.

As the Warnock Committee finalised their recommendations, a London-based American commercial surrogacy agency arranged for Kim Cotton to receive £6,500 to act as a traditional surrogate[1] for an anonymous couple. She was artificially inseminated with the intended father's sperm, and following the birth in early 1985, she left the child in the care of the hospital until the

baby could be collected by the intended parents (IPs). However, the London Borough of Barnet issued a place of safety order, requiring the baby to be kept in a designated safe place until further inquiry, resulting in the baby becoming a ward of the court. The judgment in the so-called *Baby Cotton* case was in favour of the IPs, with the judge declaring that 'at the heart of the prerogative jurisdiction in wardship, is what is best for the child or children concerned' (Re C (Wardship), 1985).

While *Baby Cotton* was not the first surrogacy case (A v. C, 1978), the British press was outraged by this perceived condoning of a 'baby-for-cash' deal (Inquiry over 'Baby-for-Cash' Deal, 1985). Surrogacy disturbed 'the calm waters of personal integrity, family life and national security' (Morgan, 1986), and the ensuing moral panic forced surrogacy onto the legislative agenda. Parliament implemented the Warnock Report's recommendations hastily and partially through the Surrogacy Arrangements Act 1985 (SAA 1985), resisting any demands for clarification as 'no delay could be brooked' (Serratelli, 1993).

The SAA 1985 was envisioned as a strictly time-limited measure, rather than a comprehensive piece of legislation, as the government intended to introduce 'comprehensive legislation as soon as practicable' (HC Deb 15 April 1985, vol 77 (Surrogacy Arrangements Bill), 1985). The Act aimed at restricting the development of commercial surrogacy in its pursuit of two distinct goals: discouraging surrogacy as a practice and protecting (presumed vulnerable) women and children (Jackson, 2001). Comprised of five sections, the SAA 1985 left many critical legal issues outstanding, for example the legal status of surrogate-born children and the acceptability of payments to surrogates, with the Human Fertilisation and Embryology Act 1990 (HFE Act 1990) addressing these two issues. The HFE Act 1990 adopted a firm policy decision on the importance of the nuclear family, introducing status provisions allocating parental status following MAR without the need for litigation (Montgomery, 1991). Section 27(1) of the HFE Act 1990 reflected the Warnock Committee's recommended codification of the *mater est* principle:

> The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and *no other* woman, is to be treated as the mother of the child.[2]

The person who gave birth was not 'a deputy or substitute mother, but [the] genuine and authentic mother to the child she [bore]' (Dickens, 1987). As legal motherhood was allocated based on gestation alone, traditional surrogacy and gestational surrogacy were treated identically in law. In both cases, the surrogate was the legal mother of the baby, and, in line with the now-codified *pater est*, her husband was the legal father, unless he had not consented to the fertility treatment.

Section 30 of the HFE Act 1990 introduced the Parental Order (PO), a bespoke court order transferring legal parenthood to IPs, if certain criteria were met: the IPs had to be a married couple domiciled in the UK and living with their baby, and this baby had to be genetically related to at least one IP. A PO could only be granted no earlier than six weeks after birth, and no later than six months after birth. Additionally, unlike adoption, the surrogate's consent was required, with no mechanism for dispensing with her consent, even if it was in the child's best interests, or consent was unreasonably withheld. This court order revealed acceptance of surrogacy only where the result replicated the nuclear family as far as possible.

Reforms proposed to the HFE Act in 2008 introduced minor amendments to the PO, in light of changing social and familial norms. Contemporary parliamentary debates revealed a view that two parents were necessary to handle surrogacy's 'additional responsibilities and burdens' (HC Deb 12 June 2008, 2008). The Human Fertilisation and Embryology Act 2008 (HFE Act 2008) extended PO eligibility to same-sex civil partners, and heterosexual and same-sex couples in an 'enduring family relationship'. The families formed via these 'new' couples performed the heteronormative family (Van Eeden-Moorefield et al., 2011), affirming the nuclear family's foundational requirement of a sexual relationship between the couple. As such, family remained legally as 'an entity, built on and arising from the sexual affiliation of two adults' (Fineman, 1995). In fact, single applicants' deliberate exclusion from PO eligibility was 'a key feature of the "pith and substance" of the legislation' (Re X, 2020), with this exclusion only lifted in 2019 through the 2018 Remedial Order insertion of section 54A into the HFE Act 2008.

The UK's regulatory response was drafted to discourage surrogacy, with moral panic institutionalised through legislation. The perceived threat to the nuclear family was disproportionate to reality – even at the time – and has had long-lasting repercussions. UK law focuses on preserving the traditional social meaning of 'mother' and promoting the nuclear family form, rather than the actual contingencies of care-taking relationships and dependency (Fineman, 1995). Law recognised the creation of families through surrogacy where these resembled the nuclear family, and reaffirmed the 'the idea that the biological experience of motherhood "trumps" all other considerations' (Shultz, 1990).

California

Prior to discussing California's approach to surrogacy, it is important to briefly explain why a single state, rather than the entirety of the US, is considered. Surrogacy law developed within a federal system and, without federal regulation, there are various legal regimes, ranging from criminalised entirely at one end of the spectrum, to legally valid and determining parentage at the other.

This diversity has resulted in fertility tourism, especially to California, one of the most surrogacy-friendly jurisdictions globally, regulating and permitting gestational surrogacy via statute (Cal Fam. Code (West 2021), 2021).

In family life, status relations are supposed to predominate. Indeed, law's construction of the family in most jurisdictions (including the UK) is status-based, rather than contract-based (Dolgin, 1990), and is matrifocal, understood in relation to the mother (Appell, 2001). However, in California, this is not the case following gestational surrogacy,[3] whereby regulation has been described as a 'free-market' approach, as contractual obligations are binding and enforceable (Scherpe & Fenton-Glynn, 2019). As such, California's distinct regulatory following surrogacy presents a useful comparator, especially when exploring the empirical data later.

California's legislature and judiciary built a legal kinship doctrine allowing for legal parentage outside of marriage (Kay, 1965). California adopted the Uniform Parentage Act (UPA) in 1975 (SB 347, 1975), later incorporated into the Family Code in 1994 (Fam. Code (West 1994), 1994), with this defining a parent–child relationship as 'the legal relationship existing between a child and his natural or adoptive parents incident to which the law confers or imposes rights, privileges, duties, and obligations' (Uniform Parentage Act 1973, 1973). Whereas, in the UK, legal motherhood is only established through gestation (Mahmoud & Romanis, 2023), California recognised 'natural' motherhood by: (i) offering proof of that she gave birth to the child, (ii) through adoption, or (iii) by fulfilling the requirements for establishing fatherhood[4] (Fam. Code (West 1994), 1994). Motherhood was imbued with notions of choice and negotiation – as opposed to biological destiny.

The Family Code curiously determined natural motherhood either via genetic consanguinity or gestation. This legal approach was under consideration in *Johnson v. Calvert* (Johnson, 1993), which questioned the definitive definition of 'natural' maternity. In this case, Anna Johnson entered into a surrogacy contract with the Calverts; as the pregnancy progressed, Johnson and the Calverts' relationship deteriorated and Johnson sought to retain custody. When deciding whether Johnson or Calvert should be recognised as the legal mother, the trial court judge invoked race and the doctrine of privacy and recognised Calvert as the mother; each of these is discussed in turn.

Within the American socio-cultural context, race is 'flexible enough to be manipulated in multiple and frequently contradictory ways, as required by the exigencies of the day' (Bridges, 2011). The 'one drop' rule, a legacy of miscegenation laws, maintained racial separation through 'blood', if a person was believed to have any Black ancestry, they were regarded as Black (Davis, 1983). Johnson, a Black woman, was likened to a 'Mammy' (Roberts, 1991), the original 'surrogate mother' – in the true sense of *replacement* mother – raising white children without any legal rights. Although the baby was

genetically white and Filipino, the judges forged a 'metaphysical and conceptual link' (Grayson, 1998) through repeated descriptions of baby Calvert's likeness to his parents and their 'blood' – otherwise put, their race. This link resulted in doubts over Johnson's claims of maternal–foetal bonding (Johnson (No X-633190), 1990), as describing baby Calvert as white rendered inconceivable Johnson's maternal rights over a genetically non-Black baby (Allen, 1991). The judiciary's determination that Calvert, a Filipina woman, was the 'natural', and hence legal, mother, was shadowed by the consequences of an alternative blurring of racial-familial boundaries. Race emerged from genes and not gestation, otherwise a supposedly white baby would be Black. Keeping the Calverts 'delineated as a unit anchored in shared substance' (Dolgin, 1993), genetics, allowed them to be tied together as a proper, nuclear family and preserved social (and racial) boundaries (Roberts, 1995). This approach promoted a 'traditional view about marriage, procreation, and family relationships' (Grayson, 1998) and adhered to the nuclear family.

Alongside race, the doctrine of privacy upheld the nuclear family in this case. In the US, family developed as an extension of autonomy principles on which the country was founded, geared at 'protection from the intrusion of the collective' (Nedelsky, 2012). The family is a private realm into which the State cannot enter (Moore v. East Cleveland, 1976), with this privacy guarding nuclear families and those resembling the ideal.

In *Johnson*, the Supreme Court found that Calvert and Johnson adduced adequate evidence of their respective 'natural' motherhood (Johnson v. Calvert, 1993), but distinguished between 'the ruling "head" and the labouring "body"' (Doyle, 1995), adopting a contractual intention-based approach. The Calverts' intent brought about the child and took precedence over Johnson's labour (Johnson v. Calvert, 1993). Johnson entered the surrogacy agreement to provide a service, and not to exercise her right to make procreative choices. Necessitating that the child has one 'natural mother', the Supreme Court relied on contractual intention, thereby promoting a 'traditional view about marriage, procreation, and family relationships' (Johnson v. Calvert, 1993). Finding Johnson not to be the 'natural mother' allowed for the enforceability of the surrogacy contract, as contracts releasing parents from their obligations are contrary to public policy (Bartlett, 1988).

California built a legal environment amenable to surrogacy, to create nuclear families that otherwise would not exist. Recognising a contrasting set of assumptions rooted in intention and lack of biological ties invalidated gestational surrogates' parental claims and recognised their service as delegated gestation.

Following surrogacy, *mater interdum incerta*. The jurisdictions addressed the challenge to traditional understandings of motherhood differently, although in both, law's reconstruction of the challenging external social reality brought

on by surrogacy was motivated by a desire to uphold the nuclear family ideal, as far as possible. The next section discusses surrogates' experiences of these very different regulatory frameworks.

EMPIRICAL EXERCISE

This section draws on empirical research exploring surrogates' experiences within the regulatory frameworks described above. This research compared the impact of the legal and health regulatory frameworks on surrogates' lived experiences (Mahmoud, 2023) and included interviews with 14 UK-based surrogates (July–September 2019) and ten Californian surrogates (July 2019–September 2021). Open-ended questions allowed for an understanding of the impact of regulation on surrogates' experiences. These questions were arranged to follow the progression of a surrogacy journey. Interviews were audio-recorded and transcribed verbatim. Qualitative data were analysed through Framework Analysis (Ritchie & Spencer, 1994). Of particular relevance here is how surrogates co-constructed their identities as mothers and treated surrogacy as categorically different to motherhood, with their understandings challenging the 'naturalness' of the nuclear family in law. All references to surrogates in the following sections should be understood as referring to those interviewed as part of the conducted empirical research.

Motherhood

Surrogates all described the central role motherhood occupied in their identities. With the exception of two UK surrogates, all had had their own children prior to undertaking surrogacy; one surrogate had her own child after, and the other was a stepmother. How surrogates described their role as mothers revealed it as 'an existentially changing event, reorganising values and what makes life worth living and [raising] questions about mortality and meaning of life' (Prinds et al., 2014). They described how becoming a mother was an important milestone, a defining dimension of their lives (O'Reilly, 2020), irrevocably changing their identity: 'I couldn't imagine life without being a mom, because it just gave life a whole new meaning' (Chelsea, California).

Identifying as a mother has often been observed as accompanied by internalised normative ideals about motherhood, for example self-sacrifice and generosity (Cannell, 1990), that underpin the interpretation of motherhood in the nuclear family context. Surrogates understood participating in surrogacy through the lens of motherhood, especially when discussing their empathy and sympathy for IPs. They described themselves as comparatively fortunate in terms of their fertility; their own journeys to motherhood were uncomplicated, motivating them to help. Surrogates juxtaposed IPs' desperation and devasta-

tion with their own pregnancies to describe their felt imperative to help: 'Why wouldn't I use my body to help other people?' (Bella, UK).

Surrogates understood surrogacy as contributing to – not challenging – cultural understandings of motherhood. They interpreted motherhood not as emerging out of gestation and birth, but rather as the result of caring and nurturing a child. They contributed to cultural constructions of motherhood (and parenthood) by *creating* parents, providing children for IPs to whom parenthood had been denied (Ragoné, 1994). This was an especially significant finding, demonstrating that surrogates – regardless of whether they were in receipt of compensation and of the regulatory framework in play – underscored their contribution to a loved one's motherhood project.

Generally, the transformation of a foetus into a baby – separate from the pregnant person – is culturally defined to develop during a pregnancy (Han, 2013); in surrogacy, the separation is ever-present. Surrogates reflected the dominant model of understanding surrogacy, implicitly instrumentalising their bodies, their wombs seen as semi-detached and used for others (Cooper & Waldby, 2014). They downplayed any potential maternal bond, embracing metaphors as receptacles for gestating foetuses and acting as the environment for foetal development. Their views reflected the dominant perception that surrogacy is a manifestation of a normative view of motherhood (Horsey, 2020); the qualities seen in surrogates, for example self-sacrifice, are assumed 'natural' to women, synonymous with 'good motherhood' (Weedon, 1997).

As described in the first section, aiming to preserve the traditional social meaning of 'mother', the UK codified the *mater est* principle, with gestation legally valued and privileged. This was seen as protecting surrogates from forcibly handing over 'their' babies. However, UK surrogates described how they consented to the IPs' parenthood *ab initio*: they became pregnant expressly intending to relinquish the baby to the IPs, 'It's why you go into it, it's, it's always for somebody else' (Brooke, UK). They embodied the view that 'maternity, bonding and kinship are not automatic outcomes of pregnancy, but a choice' (Teman & Berend, 2018). In California, surrogacy is framed as a service, delegated gestation, and surrogates are not recognised as legal mothers. Much like the UK-based surrogates, the California surrogates had not considered themselves as mothers at any point: 'I'm not a mother. I birthed these babies. I get it, cause that's like, conceptually… please, uh, no' (Chloe, California). They did not view their role as service-providers, with many decrying a sanitised approach of what is entailed in surrogacy: 'If it was just kind of like not really any kind of friendship, and just kind of, like, okay, whatever, give me my baby, and yeah, peace out, we're done… then, I think I would have been sad about that' (Charlee, California).

Comparing surrogates' experiences revealed how similarly both groups constructed their actions, never viewing themselves as mothers, regardless

of the legal framework, and based parenthood in intention – theirs and the IPs. They did not erase kinship ties ('de-kinning'), and instead actualised IPs' kinship ties through gestation (Berend & Guerzoni, 2019). Every surrogate saw surrogacy as completely different to motherhood; surrogacy allowed them to be pregnant without having to become a mother afterwards. Beyond this, as the next sub-section reveals, surrogates framed their participation as a 'gift', with this metaphor interpreted as serving multiple purposes.

Gifts

Surrogacy is frequently analysed through two frequently conflated lenses – gift-giving and altruism – especially in the realm of 'bodily gifting' (exchanges of organs, tissue, and fluids) (Berend, 2016). It is important to disentangle the two: surrogates were motivated by altruism, as they were involved in an intentional undertaking not motivated by external reward, and they viewed surrogacy as a gift, triggering a relational chain of reciprocal obligations (Mauss, 2002). Surrogates described their participation as a gift; this metaphor served two distinct purposes. First, this metaphor importantly differentiated their arrangements from baby-selling; any insinuation that they were involved in baby-selling necessarily challenged their altruistic motivations. In particular, California surrogates used the gift rhetoric to pre-empt such insinuations (Guerzoni, 2020). Second, construing surrogacy as a gift reinforced the importance of their relationships with IPs. Surrogates' description of their 'gift' to IPs echoed a Maussian approach to gift-giving, focusing on social bonds created between donors and donees.

All surrogates presented their contribution to IPs as a redistributive transfer from those with plenty to those without: they participated in surrogacy due to their proven fertility and to help IPs overcome their infertility. Crucially, surrogates had not viewed the babies as gifts, because they never saw the babies as theirs: 'you cannot give what belonged to someone else as a gift' (Berend, 2016). The significance of their 'gift' arose out of the value placed on their role as mothers in their own lives, and empathy for those who could not experience it without their help.

LESSONS LEARNED

With the regulatory frameworks in the UK and California described in the section titled 'Regulatory background', and surrogates' experiences within these frameworks described in the Empirical Exercise, this final section suggests reforms reflective of surrogate experiences, specifically reforming legal motherhood in the UK. As described in the Introduction, the Law Commission of England and Wales and the Scottish Law Commission concluded their

surrogacy law reform project in early 2023. Within their Final Report, they recognised the current approach to legal parenthood as not in the best interests of the child, in part because surrogates do not view themselves as the parent nor have any intention of parenting the child.

Law encodes relationships with meaning by describing individuals and their behaviour, and reproduces power structures. This is demonstrated in legal parenthood as a status of 'most fundamental gravity and importance' (Re HFEA (Parentage), 2016), cementing and securing rights to family life (X v. Z, 2022). Law may respect autonomy by supporting a person's ability to plan their lives and exercise self-determination. This was seen in the California cohort's discussion on their lack of parental rights following surrogacy, identified as an important regulatory aspect. Such legal labelling reflected surrogates' expressed understanding of their contribution to the IPs' parenthood project, mitigating any potential stress or tension emerging from IPs' change of mind. In this way, the doctrine of intention-based parenthood, as described above, brought about surrogates' visibility and reflected their understanding of their role in surrogacy. Legal recognition of their choices to act as surrogates is important, respecting their autonomy and valuing their altruism; such an approach was present in the California approach to surrogacy, described above. California IPs are recognised as legal parents of their baby via a pre-birth parentage order, imbuing them with immediate and sole access to, and control over, the baby, including postnatal care and medical treatment. The required documents are filed with the relevant court during the first trimester of the pregnancy, since processing may take up to nine weeks.

However, as described in the United Kingdom section of this chapter, following surrogacy arrangements, IPs and their children are in a legal limbo, requiring a PO for recognition of their familial status. Recent case law showed judicial adoption of a constructive and purposive analysis of the PO requirements enumerated in sections 54 and 54A of the HFE Act 2008, aimed at legal recognition of IPs as far as possible, mirroring lived reality. Legal motherhood describes the relational status emerging from a person's role in pregnancy and birth (Ampthill Peerage Case, 1977; Re G, 2006; In the matter of TT and YY, 2019), but recognising the surrogate as 'the legal mother even though she has no wish to be, it has failed to cater for surrogacy. This outcome was a deliberate measure to discourage people from entering into surrogacy arrangements' (Douglas, 1994).

The Empirical Exercise demonstrated that UK surrogates described the current regime of legal motherhood as an example of law failing to respect their autonomy. Automatic recognition as legal mothers was understood as a deliberate denial of their choice to become surrogates, their consent to IPs' parenthood from the outset; they carried pregnancies specifically intending to relinquish the baby. Recognising their consent as valid *ab initio* – rather than

after the fact through the PO – an intention-based approach to parenthood respects surrogates' autonomy and values their altruism.

In both jurisdictions, surrogates did not understand their relationship to the foetus/baby as maternal. Rather, they confirmed their role as helping actualise IPs' kinship ties through gestation (Teman, 2010; Berend & Guerzoni, 2019). UK surrogates desired recognition of their role in IPs' family formation, and so some UK surrogates worried birth registration reforms would erase their fundamental contribution. They desired some sort of formal recognition on the birth certificate, reflecting their role in giving birth, without the accompanying legal rights and responsibilities.

An intention-based approach challenges the definition of legal motherhood, currently held as the relational status emerging from pregnancy and birth. Additionally, in terms of the practical elements of reform, for surrogates to be named as 'birth' mothers/parents without the accompanying parental responsibilities requires a significant overhaul of the birth registration scheme.

Reforming birth registration to allow for long-form birth certificates to recognise surrogates not as 'mothers', but as 'gestational parents' or 'surrogates', appropriately recognises their gestational contribution, simultaneously allocating legal parenthood to those undertaking the parenting – IPs. Such an approach ensures surrogate-born children are not denied their right to know their origins, in line with safeguarding their best interests, an important principle in UK law.

As a practice continuing to attract controversy and growing in popularity, surrogacy will remain on any reproduction policy agenda for the foreseeable future. Rather than top-down legislation, where legislators enact general principles covering perceived future disputes based on general principles, regulation should adopt a bottom-up approach, using lived experiential knowledge to create, interpret, and enforce rules. Such an approach mitigates the likelihood of reforms resulting in poor legislative design. To be the most effective, law must be routinely re-evaluated and amended, bridging gaps between law in books and law in action. Reforms ought to be legitimate, ensuring those impacted 'believe it is worth engaging with and participating in the normative framework proposed' (MacDonald & Kong, 2006). The law's responsibility is in providing mechanisms by which people can organise their lives, allowing them to express their autonomy, and respecting their values and decisions. The pursuit of a bottom-up approach, informed by surrogates' experiences, ensures laws and policies are reflective of the needs of those directly affected.

NOTES

1. Traditional surrogacy involves the surrogate donating her egg to the intended parents (usually) without it leaving her body, and this egg is inseminated

with the intended father's sperm, either at home ('DIY' arrangements) or at a clinic.
2. Emphasis added.
3. Gestational surrogacy refers to the surrogate gestating a genetically unrelated foetus, usually genetically related to at least one of the intended parents, with the intended parents then raising that child.
4. §§ 7610 (d); The requirements for establishing fatherhood, outlined in Fam. Code §7611, outline that the presumption of fatherhood may be satisfied either through marriage to the mother at the time of birth or within 300 days if the marriage was terminated, or if the marriage was void or voidable and either consented to the birth certificate or he is obligated to support the child under a written voluntary promise or by court order, or if he welcomes the child into his home and openly holds out the child as his own. This last section was modified in 2000 to provide that 'for the first two years of the child's life, he resided in the same household with the child and openly held out the child as his own.'

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12. Discussion: reproduction policy in the twenty-first century

Hannah Zagel and Rene Almeling

INTRODUCTION

How should the state be involved in human reproduction? Reproduction scholars have typically viewed state interference with a great deal of suspicion, given the mass of historical and contemporary data they have collected about the nefarious effects of coercive policies and abuse of reproductive bodies (e.g. Browner & Sargent, 2011; Ginsburg & Rapp, 1991; Roberts, 1997). Similarly, international sexual and reproductive health (SRH) advocacy and reporting highlights states' shortcomings in securing SRH rights (UN, 2021; WHO, 2020). By contrast, taking a welfare state approach opens up the possibility that state support of reproduction – if pursued in a way that is inclusive of all forms of reproduction and humans in all their variety – may actually bolster health and well-being. Yet, comparative welfare state scholarship, which provides ample evidence and guidance to policymakers in other domains, has largely ignored the domain of reproduction.

This book has provided a framework for bringing together under one umbrella the range of policies that address whether, when, and how people biologically reproduce, but which has not previously been constituted as a cohesive policy domain, and thus has been missing from theoretical and methodological discussions about the welfare state (but see O'Connor, 1993; O'Connor et al., 1999). Insights from policy scholarship, for example on multidimensionality (e.g. Daly, 2020), and competing goals behind different policy instruments (e.g. Kaufmann, 2002; Palier, 2005), have been integrated into this new framework, as have various insights from literature on the politics of reproduction (for reviews, see Almeling, 2015; Gammeltoft & Wahlberg, 2014). Together, the analytical framework and contributions in this book seek to spotlight the power of a comparative welfare state approach to reproduction policy, particularly in terms of a more granular understanding of how regulatory processes shape the relationship between states and reproduction.

So far, showcased in historical case studies, state–reproduction relationships have largely been discussed in light of overarching paradigmatic ideas about how a particular 'national body' should reproduce. More than other policy domains, such as family policy or social policy, the regulation of reproduction tends to be described as a by-product of ideological projects such as nationalism or pronatalism. Despite the undeniably central role of normative ideas, this focus has somewhat obscured the view on the types and characteristics of particular policy instruments created to address the range of goals associated with reproduction policy. How do ideas translate into or align with goals, what instruments are used to achieve them, and how coherent are these instruments and goals?

Not addressing these and similar questions produces shortcomings in at least two ways. First, how states should (or should not) regulate reproduction is at the heart of several current societal conflicts and negotiations. For example, in the context of declining birth rates, many governments' political agendas today include the search for possible ways to increase reproduction (i.e. fertility). At the same time, advocates call out injustices in how states differentially bestow reproductive rights to different social groups. This can involve the lack of financing for reproductive services such as contraception or abortion care, but also selective legal access to medically assisted reproduction for singles or same-sex couples. While the literature on reproductive justice has spotlighted the significance of intersecting inequalities in shaping reproductive processes at the individual, meso, and macro levels (e.g. Luna & Luker, 2013; Ross & Solinger, 2017), there is more work to be done in disentangling everyday experiences from the regulatory processes that condition them. How precisely do different policies restrict or support reproductive processes and produce unequal outcomes?

Second, the question of 'what policy instruments will affect people's reproductive outcomes?', is often asked with demographic doomstate scenarios in mind, such as how shrinking populations threaten welfare state survival (Gietel-Basten, 2019). It is commonly answered with reference to family policies that address conflicts between paid work and care, such as parental leave and childcare provision. While the pressures of capitalist labour markets on families may justify this focus, it does fall short of a range of regulatory measures by which the state intervenes in reproductive decision-making, such as access to sexuality education, affordable contraception and abortion care. Centering reproduction as a policy issue must focus on these regulations, among others. Considering reproduction policy alongside family and social policy will provide a more comprehensive understanding of how welfare state settings affect reproductive outcomes.

RE-CONCEIVING THE FIELD OF REPRODUCTION POLICY

Building on the rich comparative welfare state literature, the first chapter in this edited book introduces a comparative framework for analysing reproduction policy. The aim of that framework was to set the scene for the contributions to the book, and to establish reproduction policy as a subject of welfare state research. The framework differentiates ideas, goals, and instruments of reproduction policy, which enables the comparative examination of policy configurations, underpinning ideas and goals, and different layers of change and stability in the policy domain. The chapter also suggests that two principal paradigms have set the tone for reproduction policymaking (Ratcliffe, 1978; Shalev, 2000). Here, paradigms do not dictate ideas and goals, but define what is thinkable, shape boundaries around how ideas can be expressed, and which goals seem desirable.

The chapters in this book make the relationships between specific ideas, goals, and policy instruments explicit by using comparison between countries and across policy fields. While many of the chapters clearly show the close links between ideas, goals, and instruments in reproduction policy (see chapters by Gietel-Basten, Szalma and Sipos, and Kaminska), the lack of an explicit policy goal that goes beyond just an ideological project (i.e. protection of unborn life) is particularly obvious in Penovic's chapter on the US anti-abortion movement. Looking beyond abortion, Khan's chapter suggests that ideas matter to different degrees for policymaking across different fields of reproduction policy.

Three chapters also cast light on the complexities in goal-setting and implementation of coherent sets of instruments in the idea-driven policy domain of reproduction (chapters by Kluge, Mahmoud, and Tamakoshi). Kluge's chapter shows that, in sexuality education, the connections between specific ideas, policy goals, and their translation into instruments appear to be driven more by processes than by strict determinism. Further, in her chapter contrasting abortion and medically assisted reproduction (MAR) policy, Tamakoshi points to the interdependencies between different fields of reproduction policy (MAR and abortion), and how potentially conflicting goals are worked around in designing policy instruments within particular countries (Italy and Japan). Mahmoud's study of kinship law in the context of surrogacy is an example of how instruments and ideas are in conversation with each other, not least through the individuals impacted by the policies, such as the surrogates she interviewed. Ivanova et al. build a case in their chapter around how to more successfully integrate the instrument of comprehensive sex education (CSE) in contexts normatively opposed to ideas underpinning CSE.

The chapters also speak to the broader paradigms in which reproduction policy is made today. Clearly, even within the rights-based paradigm, there is stark variation in the policy instruments by which countries and regions grant reproductive rights and how far those rights extend. The ongoing negotiations over ideas driving reproduction policies also reveal how the now-dominant rights-based paradigm can accommodate a range of normative motives, some of which may be conflicting or contradicting, such as in the case of pitting 'foetus rights' against those of a pregnant person (see also Morgan & Roberts, 2012). Conlon's chapter sheds light on this variance in showcasing the different degrees to which states diverge from a human rights approach to abortion care promoted by the WHO by over-regulating abortion with various policy instruments.

Bringing together the insights from the chapters against the background of the analytical framework leads to new questions that can inform future research on reproduction policy in the welfare state. An outward-looking question is about the wider institutional landscape in which reproduction policies are embedded; how do goals and instruments in reproduction policy align with goals and instruments in other policy domains such as family policy or health care policy? Such questions lead to a broader welfare regime thinking, and one route of future research will be to explore possible institutional complementarities between reproduction policy and other domains. However, some work still needs to be done to better understand the inner workings of this policy domain. For example, one question is how the two principal paradigms evolve and what their impact is on policymaking. What are their potential trajectories, and what other paradigms shaping reproduction policy may emerge? Another question is about the stakeholders involved both on the ideational side and on the policy formation side. Which actors matter within 'the state' and beyond it (e.g. social movements, church, professional associations), and how does their influence vary across reproduction policy fields?

HOW SHOULD THE STATE BE INVOLVED IN REPRODUCTION?

Detailing the precise relationships between ideas, goals, and instruments in the domain of reproduction policy – both within and between states – is crucial analytical work. It also invites the question we posed at the beginning of this chapter: how *should* the state be involved in reproduction? As empirically grounded social scientists, we are taking a step outside of our comfort zone in addressing a normative question such as this. However, we think it is important not only to document the pathologies of various reproduction policies but to engage in more creative and speculative thinking about what reproduction policy might be. Mobilising the approaches and results of social scientific

research in this book and beyond, we use this final section to explore what might constitute an ideal approach when it comes to how states might most fully support *all* people in *all* aspects of their reproductivity.

Imagine for a moment there are no constraints on the kinds or levels of resources that a state could provide when it comes to reproduction. And recall from the Introduction that reproduction is defined broadly as the processes around starting, carrying, or ending pregnancy and procreation, as well as efforts to avoid them altogether (see also Almeling, 2015). If there were no limits on money or technology or access to high-quality health care, then the ideal state reproduction policy would be to enable and fully support whatever reproductive decisions any particular individual would make for themselves. Compulsory comprehensive sex education that is non-discriminatory, inclusive of diverse genders and sexualities and reproductive desires, and provided by trained pedagogical staff would serve as a basis for knowledge and interactions around reproduction (and beyond). Those who wanted to become pregnant would be fully supported in terms of access to health care and any technologies necessary to achieve pregnancy, regardless of sex assigned at birth, gender identity, sexuality, marital status, and/or ability to pay. Those who did not want to become pregnant would have ready access to the contraceptive method of their choice. And those who are pregnant and do not want to be would have easy access to a range of abortion methods provided with care and without stigma. In short, not only would there be no restrictions on individual reproductive decision-making, but the state would provide resources to empower each and every individual to enact their reproductive desires, whatever they may be.

Returning to the real world, where even the prospect of basic reproductive autonomy is out of reach for so many, not to mention this more pie-in-the-sky vision of full reproductive welfare, there are a number of complexities that immediately present themselves. First, and most obviously, only some people can become pregnant. So if one's body cannot become pregnant, which can include people assigned male at birth (at least as of the time of this writing!) as well as people assigned female at birth who experience infertility, then they may need to rely on the bodies or bodily processes of others (e.g. eggs, sperm, gestation) in order to fulfil their reproductive goals. And we rely on a trove of historical, social, and clinical evidence in contending that, in all cases, reproductive decisions should be made by the individual whose body is (or could become) pregnant.

A second complexity is the limits inherent to narrating a vision of full reproductive welfare solely in terms of individual desires and decision-making. As reproductive justice scholars and advocates have powerfully argued (e.g. Luna & Luker, 2013; Ross & Solinger, 2017), individualist approaches to reproductive rights that are rooted in a framework of 'choice' elide the significant

and intersecting structural inequalities that constrain (and enable) any one individual's decisions. For illustrative purposes, we have written the preceding paragraphs from the perspective of any one individual engaged in any one reproductive process, but those individuals are always situated within particular communities at particular times and in particular places. And, of course, the range of reproductive processes considered in this book – from sex education to medically assisted reproduction – are inspired in part by the reproductive justice movement's injunction to examine not only efforts to avoid pregnancy but also efforts to become pregnant and to parent the children one has.

Returning to one of the central arguments of this book, the third complexity arises from the fact that, unfortunately, resources are never limitless. Indeed, the emergence and evolution of comparative welfare state research is rooted in the essential question of how best to collect and allocate resources. In the remainder of this section, we compare and contrast different institutional logics for providing welfare, asking: how would different kinds of welfare systems get involved in reproduction, if the goal was reproductive autonomy?

To address this question theoretically, we can postulate ideal-typical approaches to the provision of reproductive welfare by looking across different welfare state systems that have been described to follow distinct logics in setting policy goals and applying policy instruments. Comparing the ideal-typical systems will help to situate any real set of instruments, and reveals possibilities of and limits to different approaches to producing reproductive autonomy. For simplicity, we draw on the distinction famously outlined by Esping-Andersen (1990) and elaborated by many others, including welfare state scholars who focus on gender (e.g. Lewis, 1992; Orloff, 1993), that is the so-called conservative-corporatist, social-democratic and liberal models.[1] The comparative principles introduced in the Introduction to this book (based on Palier, 2010) serve as comparative categories across the systems, that is the rules and criteria governing eligibility and entitlement (who is entitled to access?), the types of benefits and services (what is being delivered?), the financial mechanisms (who pays and how?), and the organisation and management of the policy (who decides and who manages?). What could be the different institutional pathways to welfare state support of reproductive autonomy across these different systems?

The so-called liberal welfare system – typical examples of which are Australia, Canada, the UK, and the US – builds on the idea that the market is the main organising principle by which welfare should be achieved, and that the state should only intervene if the market fails (e.g. O'Connor et al., 1999). Key features of this system are its relatively strong legal safeguards for people to participate freely in markets, such as anti-discrimination laws, and that entitlement to state support is commonly reserved for those temporarily unable to participate in markets. In the realm of reproduction, where

markets are generally viewed with concern (Almeling, 2011), an ideal-typical perspective of a market-based system to reproductive autonomy would build on the premise that legal safeguards are functional and effective, and that the welfare state provides a last resort. Starting from there, a liberal model aiming to guarantee reproductive autonomy would provide for the flourishing of an education market accessible to all, in which providers offer comprehensive sex education without misinformation. A liberal welfare system would also legalise any procedure conducive to reproductive health of individuals regardless of sex assigned at birth or sexual orientation, provide legal safeguards against discrimination in access to reproductive services such as contraception, abortion, medically assisted reproduction, and pregnancy care. Provision would be organised through markets. In cases where people are unable to pay the market price and prove eligibility against a means-test, the state would provide a temporary and lower-bound solution to the limitation on reproductive autonomy, typically in the form of flat-rate monetary transfers financed through taxes and administered by the state.

By contrast, the main objective of the so-called social-democratic welfare system is to ensure equality among social groups with an explicit focus on gender equality. This model is typically said to prevail in the Northern European countries of Denmark, Finland, Iceland, Norway, and Sweden. State involvement is common, taxes are high and social protection is universal in this system. Another feature of the social-democratic model is that a large share of its public spending on welfare goes to the provision of services, although cash payments are also common. The ideal-typical scenario in which reproductive autonomy is the overarching policy goal does not seem far-fetched in a social-democratic system, which has often served as an ideal-case welfare regime in other policy domains. The well-resourced education system in the social-democratic model would provide compulsory inclusive and comprehensive sex education. In this system, people would be served by state-run and fully tax-financed health care infrastructures in which they would receive non-discriminatory access to the reproductive services, technologies and procedures in support of their reproductive autonomy. Individuals would be able to rely on the costs for any procedure to be covered by statutory health care systems, thereby balancing inequalities that typically restrict autonomy between socioeconomic groups.

The so-called conservative-corporatist welfare system, found in Continental European countries such as Austria, Belgium, France, Germany and the Netherlands, is oriented towards preserving status rather than relying on the market or creating equality (Palier, 2010). It commonly applies contribution-based mechanisms and involves social partners in managing insurance funds and welfare provision. Features of this system are the differential treatment of people based on their status (e.g. employment sector,

occupation), which extends to adhering to more traditional gender roles; contributions-based social protection; and a high share of welfare state activity being organised as cash transfers as opposed to a social-democratic service focus. In an ideal-typical conservative–corporatist welfare system whose goal is to install reproductive autonomy, the social partners would negotiate agreements that enshrine availability and accessibility of a range of reproductive procedures and services to the respective groups covered by the agreement. One example is the catalogue of services and procedures covered by the health care system, negotiated by representatives of health care insurances, health care providers and patients and overseen by the health ministry. Services would mostly be delivered through the third sector, which receives state funds. Cost coverage for reproductive services, technologies and procedures would be organised through contributions-based insurances.

Contrasting the three ideal-typical institutional scenarios highlights possibilities, but also potential challenges to how different welfare systems may support reproductive autonomy. Although these possibilities and challenges reflect to some extent those posed to the production of welfare more generally, some are specific to reproductive welfare. First, the liberal system has the desirable feature of providing legal safeguards against discrimination, which is a well-documented, real-world barrier to reproductive autonomy. However, there are strong downsides to the market-based approach, especially in the realm of reproduction, given that it involves the creation of the next generation and can involve the commodification of human bodies and body parts. In contrast, the conservative-corporatist system seems to offer the structural conditions for integrating different actors in the negotiations over the terms of reproductive welfare, hence allowing a less top-down approach of state involvement and dispersion of power. At the same time, this type of welfare system inherently serves to uphold differences in access between social groups, with those differences such as membership in a particular industry sector following economic logics rather than being related to particular reproductive needs. Thus, the likelihood of supporting reproductive autonomy seems to be clearest in the social-democratic system, whose institutions are geared most to equipping people with the necessary options and resources for realising their reproductive decisions. However, a possible challenge in this system is its heavy reliance on taxes to finance the universal provision of services, especially if these services are both expensive and morally charged such as medically assisted reproduction.

Our exercise of comparing ideal-typical institutional approaches to pursuing reproductive autonomy does not come without limitations. First, taking Esping-Andersen's three worlds of welfare as the starting point can be criticised for its limited view on the actual range of welfare state systems. An extensive body of literature names at least two additional welfare systems, and

narrowing the view on three can distort the conclusions that may be drawn from the comparison (Emmenegger et al., 2015). Our excuse above has been to refer to the space limitations of this chapter, but we must add that the goal was never to give a comprehensive account of all possibly existing types here. For theorising of what may be called 'reproductive welfare regimes', a broader range of institutions and actors must be considered, as well as the stratifying outcomes they produce. Finally, the prior on which we built this exercise is a bold one, i.e. that states would even pursue the goal of reproductive autonomy. Indeed, reproductive autonomy is not a policy goal earnestly stated and actively pursued by many (any?) governments at all. Even those governments that are generally committed to supporting reproductive *health* are often far from formulating reproductive autonomy as the desired goal and from designing reproduction policy instruments accordingly.

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Our reflections in this discussion underscore how there are no easy answers to the question of how states should be involved in reproduction. But we still think it is a question worth posing. To be sure, there are good reasons to approach such a question with trepidation, given the atrocious histories of various forms of state involvement in reproduction around the world. That is one reason why it is difficult to say bluntly what states *should* do in this regulatory domain, as compared with other domains more commonly discussed as part of the 'welfare' state. Indeed, even making the suggestion that state support of reproductive autonomy does, in fact, constitute an act of *welfare* seems provocative, as compared with, for example, reducing poverty. But that is exactly the kind of thinking we wish to encourage, not only amongst scholars of the welfare state or reproduction, but amongst policymakers.

In conclusion, our comparative exercise reveals that, despite the many pathways states could take, if the goal is to support reproductive autonomy, it would look very different from our current institutional arrangements, stated goals, and policy instruments. Aligning reproduction policy with the goal of reproductive autonomy would involve considering the role of the state much more comprehensively and enabling a range of supportive instruments, regardless of what individual reproductive goals may be. Creating true and full reproductive welfare would require going far beyond the basic question of legalising abortion to encompass a range of issues associated with sex education, pregnancy care, contraception, and medically assisted reproduction. It would involve a range of policy stakeholders, regulatory levels, and policy instruments, with the ultimate goal of a more reproductively just society for all.

NOTE

1. We do not consider other models here, due to space limitations (e.g. Southern European and post-transformation Eastern European models).

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Index