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Illegal abortion and reproductive injustice in the Pacific Islands: A qualitative analysis of court data

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Abstract

The Oceania region is home to some of the world's most restrictive abortion laws, and there is evidence of Pacific Island women's reproductive oppression across several aspects of their reproductive lives, including in relation to contraceptive decision-making, birthing, and fertility. In this paper we analyse documents from court cases in the Pacific Islands regarding the illegal procurement of abortion. We undertook inductive thematic analysis of documents from eighteen illegal abortion court cases from Pacific Island countries.

Using the lens of reproductive justice, we discuss the methods of abortion, the reported context of these abortions, and the ways in which these women and abortion were constructed in judges' summing up, judgements, or sentencing. Our analysis of these cases reveals layers of sexual and reproductive oppression experienced by these women that are related to colonialism, women's socio-economic disadvantage, gendered violence, limited reproductive control, and the punitive consequences related to not performing gender appropriately.

KEYWORDS

court cases, Illegal abortion, Pacific Islands, reproductive justice, unsafe abortion

1 | INTRODUCTION

Access to safe and legal abortion is severely limited in Pacific Island countries and this form of reproductive oppression results in women resorting to illegal and, therefore, usually unsafe terminations.[1]

In this article, we use the lens of reproductive justice to analyse documents from eighteen illegal abortion court cases from Pacific Island countries. The aim of this research is to understand the contexts and methods of illegal abortion, and how women and abortion are constructed in judges' summing up, judgements, and sentencing. We argue that Pacific women encounter layers of sexual and reproductive oppression that have links to colonialism, and socioeconomic and gendered inequity. There is a deficiency of data on abortion in the Pacific Islands,[2] and there has been no analysis of illegal abortion court

[1]World Health Organization. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems (2nd ed.). Geneva: World Health Organization; United Nations. (2014). Abortion policies and reproductive health around the world. Geneva: United Nations.

cases from the region. Thus, this research provides further insights into the lengths Pacific women go to access abortion in legally restrictive contexts, while paying attention to the broader historical, socioeconomic, and gendered environments in which these women are navigating their sexual and reproductive health and lives.

2 | REPRODUCTIVE (IN)JUSTICE IN THE PACIFIC ISLANDS

The Pacific Islands is a diverse region of islands spread across 15 percent of the world's surface, and includes a combined population of over 10 million.[3] There is a lack of data on contraception, abortion, and reproductive coercion from Pacific Island countries, particularly related to unmarried women, people with disabilities and those who do not identify as cis-gender or heterosexual.[4] However, available data suggest high rates of gender-based violence, partner control over contraceptive access or use, and unplanned and unwanted pregnancies alongside high unmet need for contraception.[5] In 2020, only half of all women of reproductive age in Oceania (excluding Australia and New Zealand) who wanted to avoid pregnancy were using a modern contraceptive method.[6] In this same year, an estimated 28 percent of all women aged 15 to 49 were using a method of contraception (modern or traditional), which is among the lowest rates of contraceptive use in the world.[7]

Reproductive justice is a framework that critiques narrow conceptions of reproductive choice, recognising 'that "choice" is a meaningful concept only under certain conditions.'[8] Reproductive justice requires analysis of intersecting factors that influence people's sexual and reproductive lives.[9] As Loretta Ross describes, 'Reproductive justice is rooted in the belief that systemic inequality has always shaped people's decision-making around childbearing and parenting, particularly vulnerable women. Institutional forces such as racism, sexism, colonialism, and poverty influence people's individual freedoms in societies.'[10] Reproductive justice incorporates the right to have a child, to not have a child, and to parent one's children in a safe and healthy environment.[11] Reproductive justice advocates campaign for people to be free from oppression and interference in making reproductive decisions, as well as corresponding duties on other parties, such as the state, in relation to the rights holder.[12]

Alongside women's limited access to contraceptive services, and the high rates of gender-based violence, there is also evidence of Pacific women's reproductive oppression across several aspects of their lives, including contraceptive decision-making, birthing, and fertility.[13] Many of these aspects of reproductive oppression contain echoes of colonial and missionary policies and programs in Pacific Island countries in the mid-19th and early 20th centuries.[14] These policies and programs targeted maternal behaviour, for example to increase birth rates, influence mothering practices, and shift birthing from Indigenous to biomedical practice.[15]

This extended period of colonial and missionary engagement could also be understood as influencing idealised motherhood as central to feminine identity. This idealisation may be seen in the programs of missionaries to 'domesticate' Pacific women;[16] in ethnographic accounts that were produced into the 1980s that romanticised Indigenous motherhood;[17] and the 'fixation on the mother-child dyad' in biomedical and demographic practice and policy 'reflected in the very concept of maternal and child health'.[18] The domain of reproduction may be claimed and valued by women as central to their purpose and worth in their communities, and in

[2]Dawson, A., et al. (2021). How do Pacific Island countries add up on contraception, abortion and reproductive coercion? Guidance from the Guttmacher report on investing in sexual and reproductive health. *Reproductive Health*. *18*(1), 68.

[3]The World Bank. (n.d.). The World Bank In Pacific Islands.

[4]Dawson, et al., op. cit. note 2.

[5]UNFPA, UNESCO, & WHO. (2015). Sexual and Reproductive Health of Young People in Asia and the Pacific. Bangkok: UNFPA; Republic of the Marshall Islands. (2014). Republic of the Marshall Islands National Study on Family Health and Safety. Majuro: Ministry of Internal Affairs, Republic of the Marshall Islands; Fiji Women's Crisis Centre. (2013). Somebody's Life, Everybody's Business! National Research on Women's Health and Life Experiences in Fiji (2010-2011): A Survey Exploring the Prevalence, Incidence and Attitudes to Intimate Partner Violence in Fiji. Suva, Fiji: Fiji Women's Crisis Centre; Kennedy, E., et al. (2013). The Case for Investing in Family Planning in the Pacific: Costs and Benefits of Reducing Unmet Need for Contraception in Vanuatu and the Solomon Islands. Reproductive Health. 10(1), 30; Kennedy, E., Gray, N., Azzopardi, P., & Creati, M. (2011). Adolescent Fertility and Family Planning in East Asia and the Pacific: A Review of DHS Reports. Reproductive Health. 8, 11; Vanuatu Women's Centre. (2011). Vanuatu National Survey on Women's Lives and Family Relationships. Port Vila, Vanuatu: Vanuatu Women's Centre; Secretariat of the Pacific Community. (2009). Solomon Islands Family Health and Safety Study: A Study on Violence Against Women and Children. Noumea, New Caledonia: Secretariat of the Pacific Community.

[6]United Nations Department of Economic and Social Affairs, Population Division. (2020). World Family Planning 2020: Highlights (ST/ESA/SER.A/450). New York: United Nations.

[7]Ibid.

[8]Shotwell, A. (2013). Aspirational Solidarity as Bioethical Norm: The Case of Reproductive Justice. *IJFAB: International Journal of Feminist Approaches to Bioethics*. *6*(1), 103–120.

[9]Bhakuni, H. (2021). Reproductive Justice: Non-Interference or Non-Domination? Developing World Bioethics. Special Issue, 1–6.

[10]Ross, L.J. (2017). Reproductive Justice as Intersectional Feminist Activism. *Souls*. 19(3), 291.

[11]Bhakuni, op. cit. note 9, pp. 1–6; Ross, L.J., & Solinger, R. (2017). Reproductive Justice: An Introduction. Oakland: University of California Press.

[12]Ibid: (a).

[13]Fiti-Sinclair, R. (2002). Childbirth in Papua New Guinean Villages and in Port Moresby General Hospital. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond Tradition and Modernity? (pp. 56–78). Honolulu: University of Hawai'i Press; Jolly, M. (2002). Birthing Beyond the Confinements of Tradition and Modernity? In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond Tradition and Modernity? (pp. 1–30). Honolulu: University of Hawai'i Press.

[14]Jolly, M. (1998). Other mothers: Maternal 'insouciance' and the depopulation debate in Fiji and Vanuatu, 1890–1930. In K. Ram & M. Jolly (Eds.), Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific (pp. 177–212). Cambridge: Cambridge University Press; Jolly, M. (1991). 'To Save the Girls for Brighter and Better Lives': Presbyterian Missions and Women in the South of Vanuatu: 1848-1870. *The Journal of Pacific History*. *26*(1), 27–48.

[15]Lukere, V. (2002). Native Obstetric Nursing in Fiji. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond tradition and modernity? (pp. 100–124). Honolulu: University of Hawai'i Press; Jolly, op. cit. note 14(i), pp. 177–212; Jolly, op. cit. note 14(ii), pp. 27–48.

[16]Ibid: (a), (b), (c); Bayliss-Smith, T. (1974). Constraints on Population Growth: The Case of the Polynesian Outlier Atolls in the Precontact Period. *Human Ecology*. 2(4), 259–295.

[17]Jolly, M. (2002). From Darkness to Light? Epidemiologies and Ethnographies of Motherhood in Vanuatu. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond Tradition and Modernity? (pp. 148–177). Honolulu: University of Hawai'i Press; Mallett, S. (2002). Colonial Impregnations: Reconceptions of Maternal Health Practice on Nua'ata, Papua New Guinea. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond Tradition and Modernity? (pp. 125–147). Honolulu: University of Hawai'i Press.

[18]Jolly, op. cit. note 13, p. 23.

accordance with indigenised Christianity.[19] However, this narrow construction of Pacific women as mothers obscures the realities of birthing and childrearing, especially where women are compelled to assume roles as primary caregivers.[20]

3 | UNSAFE AND ILLEGAL ABORTION IN THE PACIFIC ISLANDS

Abortion has been identified as a fertility and population control practice, and as a way for women and their families to preserve their health and social standing in the Pacific Islands throughout its history, alongside other fertility control methods such as the separation of men and women after birth and prolonged breastfeeding.[21] The Guttmacher Institute estimates the abortion rate in Oceania (excluding Australia and New Zealand) at 34 abortions per 1,000 women aged 15 to 49.[22] About one third of abortions in Oceania between 2010 and 2014 were estimated to be unsafe (administered by untrained providers and/or using unsafe methods and unsterile equipment).[23]

Several qualitative studies in Pacific Island countries reveal various methods used by women to end unwanted pregnancies.[24] In three qualitative studies on adolescent unplanned pregnancy in Vanuatu, Tonga, and Chuuk, study participants reported several methods of abortion that had been used or were known about. These included applying force to the lower abdomen (by, for example, having friends walk on the pregnant woman's stomach or back, or uterine massage); putting boiling water on the stomach; jumping from a height or belly-flopping into water; having sex while pregnant; drinking large quantities of lemon juice or other acidic drinks, kava, 'blue bleach,' strong alcohol, strong tea and coffee, or eating soap; heavy lifting and extreme physical exertion; taking large quantities of pharmaceuticals, such as paracetamol or antibiotics; and accessing herbal abortifacients.[25] Participants reported that these methods did not usually work.

Studies in the Cook Islands, Kiribati, the Autonomous Region of Bougainville (ARB) and Papua New Guinea (PNG) reported similar methods to induce abortion, with the addition of squatting over a half coconut shell that is placed over a fire and forcing sharp objects into the uterus.[26] The studies in ARB and the Eastern Highlands of PNG also report the availability of the drug misoprostol, a synthetic prostaglandin that can be used to induce labour, induce an abortion, and prevent and treat postpartum bleeding. This drug was accessed through sellers operating illegally and taken by women without medical supervision.[27] Most of the methods found to be in use in these studies are unsafe and have the potential to cause severe health outcomes such as infection, haemorrhage, and death.[28]

4 | ABORTION AND THE LAW IN THE PACIFIC ISLANDS

Access to abortion is significantly restricted in most Pacific Island countries, with the majority only allowing abortion to save the woman's life, and few for physical and mental health reasons. The legal context of abortion in the Pacific Island region is summarised in Table 1.[29] More specific to the cases analysed in this article, only Fiji allows abortion for socioeconomic reasons. Papua New Guinea, the Federated States of Micronesia, Kiribati, and the Solomon Islands only permit abortion to save the woman's life. Vanuatu allows abortion to preserve the woman's physical health and Samoa to preserve the woman's mental and physical health. In Fiji, Papua New Guinea, and the Solomon Islands, young women under the age of 16 also require parental consent to access legal abortion services, however, in Fiji young women can apply to the Magistrate for that information to be withheld.[30]

Pacific Island countries are largely common law jurisdictions often relying on colonial or foreign case law.[31] Penalties for

[19]George, N. (2010). 'Just Like Your Mother?' The Politics of Feminism and Maternity in the Pacific Islands. Australian Feminist Law Journal. 32(1), 77–96; Christine, S. (2002). Obligatory Maternity and Diminished Reproductive Autonomy in A'jië and Paicî Kanak Societies: A Female Perspective. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond Tradition and Modernity? (pp. 79–99). Honolulu: University of Hawai'i Press.

[20]Dureau, C. (1993). Nobody Asked the Mother: Women and Maternity on Simbo, Western Solomon Islands. *Oceania*. 64(1), 18–35.

[21]Brewis, A.A. (1995). Fertility and Analogy in Pacific Palaeodemography. Asian Perspectives. 34(1), 1–20; Cambie, R.C., & Brewis, A.A. (1997). Anti-Fertility Plants of the Pacific. Collingwood: CSIRO Australia.

[22]Guttmacher Institute. (2020). Unintended Pregnancy and Abortion Worldwide. Retrieved October 20, 2021, from https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide

[23]Singh, S., et al. (2018). Abortion Worldwide 2017: Uneven Progress and Unequal Access. New York: Guttmacher Institute.

[24]Linhart, C., et al. (2020). Adolescent Unplanned Pregnancy in the Pacific: Tonga. Sydney: School of Public Health and Community Medicine, UNSW. https://doi.org/10.13140/RG.2.2.11227.80168; McMillan, K., et al. (2020). Adolescent Unplanned Pregnancy in the Pacific: Vanuatu. Sydney: School of Public Health and Community Medicine, UNSW; McMillan, K., et al. (2020). Adolescent Unplanned Pregnancy in the Pacific: Chuuk (p. 52). Sydney: School of Public Health and Community Medicine, UNSW. Retrieved October 20, 2021, from http://unsworks.unsw.edu.au/fapi/datastream/unsworks:73685/bin7a4299a5-9b2f-42a9-8eac-58e42d5ed94b?view=true&xy=01; White, A.L., Mann, E.S., & Larkan, F. (2018). 'You just have to learn to keep moving on': Young women's experiences with unplanned pregnancy in the Cook Islands. *Culture, Health & Sexuality*. *20*(7), 731–745. https://doi.org/10.1080/13691058.2017.1371336; Drysdale, R. (2015). SRMH-related vulnerabilities for young women in the Autonomous Region of Bougainville. CARE International, Papua New Guinea; Vallely, L.M., Homiehombo, P., Kelly-Hanku, A., & Whittaker, A. (2015). Unsafe abortion requiring hospital admission in the Eastern Highlands of Papua New Guinea - a descriptive study of women's and health care workers' experiences. *Reproductive Health*. *12*(1), 22. https://doi.org/10.1186/s12978-015-0015-x

[25]Ibid: (a), (b), (c).

[26]White, et al., op. cit. note 24; Drysdale, op. cit. note 24; Vallely, et al., op. cit. note 24; Brewis, A.A. (1994). Reproductive Ethophysiology and Contraceptive Use in a Rural Micronesian Population. The Journal of the Polynesian Society. 103(1), 53–74; Brewis, A.A. (1992). Age and Infertility: An Ethnodemographic Study from Butaritari Atoll, Kiribati. University of Arizona, Tucson, Arizona.

[27]Ibid: (b); (c), p. 22.

[28]World Health Organization. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems (2nd ed.). Geneva: World Health Organization; Sanga, K., Costa, C.D., & Mola, G. (2010). A Review of Maternal Deaths at Goroka General Hospital, Papua New Guinea 2005–2008. Australian and New Zealand Journal of Obstetrics and Gynaecology. 50(1), 21–24; Grimes, D.A., et al. (2006). Unsafe Abortion: The Preventable Pandemic. The Lancet. 368(9550), 1908–1919.

[29]Centre for Reproductive Rights. (2021). The World's Abortion Laws. New York: Center for Reproductive Rights.

[30]Fiji Crimes Decree, 2009, Section 234 (10-11).

[31]Faerua, A.V. (2004). Police v Apelu and Police v Apelu (Case Note). *Journal of South Pacific Law*. 8(2).

TABLE 1 Legal context of abortion in Pacific Island countries, including a list of each country and the circumstances in which women can legally access abortion.[32]

	Prohibited altogether (no explicit legal exception)	To save woman's life	To save woman's life and preserve physical health	To save woman's life and preserve physical/mental health	To save woman's life, preserve physical/mental health, and socioeconomic reasons	Without restriction as to reason, with gestational and other requirements
FSM (Micronesia)		■				
Fiji					■	
Kiribati		■				
Marshall Islands		■				
Nauru				■		
Palau	■					
Papua New Guinea		■				
Samoa				■		
Solomon Islands		■				
Tonga	■					
Tuvalu		■				
Vanuatu			■			

unlawfully procuring or attempting to procure an abortion by drug or instrument is seven to 14 years' imprisonment, or three years' to life imprisonment for women who unlawfully procure or attempt to procure their own abortion.

5 | METHOD

The aim of this research was to examine documents from illegal abortion court cases in the Pacific Islands to analyse abortion methods used and health outcomes, contextual details of women's lives, and how gender, maternity and abortion were constructed in court narratives. We acknowledge in undertaking this analysis that, although we each have close working or familial relationships with Pacific Island countries, we do not identify as Pacific Islanders so write as cultural outsiders.[33]

All court documents used in this analysis are publicly available through the Pacific Islands Legal Information Institute.[34] The cases analysed in this paper were found using the key word 'abortion,' including two cases where the defendant was charged with 'killing an unborn child.'[35] We excluded cases where abortion was raised but was not a criminal charge, for example, in rape and adultery cases, and cases involving physical assault causing spontaneous abortion. We identified 18 illegal abortion court cases from 1960 to 2017 (see Table 2). A summary of each case along with the defendants' convictions and sentences are summarised in Appendix 1. We identify cases by the date only, omitting the formal citation of cases, the defendants' names, the locations of their trials, and the currency in which any transactions for abortion services occurred, using Australian dollar (AUD) instead. While these details are publicly available, we have made this choice on ethical grounds to minimise risk of re-publicising these cases, and to avoid any possibility of retraumatising the people concerned given the small communities in which these cases occurred.

The documents we identified include summing up, judgement and sentencing from judges. These documents incorporate summaries of the stories of the accused and their conduct constructed by prosecution and defence counsels, as well as reference to community norms and standards of behaviour to assess the conduct of the accused.[36] We undertook an inductive thematic analysis, that is, we developed themes based on the content in these documents.[37] We took a social constructionist approach to our analysis, to understand both the descriptive information and the underlying socioeconomic, political, and cultural narratives regarding gender, maternity and abortion raised in these cases.[38]

[32]Centre for Reproductive Rights. (2021). The World's Abortion Laws. New York: Center for Reproductive Rights. Retrieved from https://maps.reproductiverights.org/sites/default/files/WALM_2021update_V1.pdf

[33]Hesse-Biber, S.N., & Leavy, P. (2006). In-Depth Interviewing. In S.N. Hesse-Biber & P. Leavy (Eds.), The Practice of Qualitative Research (pp. 119–147). Thousand Oaks: SAGE Publications; Ritchie, J. (2001). Not Everything Can Be Reduced to Numbers. In C.A. Berglund (Ed.), Health Research (pp. 149–173). Melbourne, Victoria, & Oxford: Oxford University Press.

[34]University of the South Pacific School of Law. (2020, November 27). Pacific Islands Legal Information Institute.

[35]Case 17, 2017, and Case 14, 2006.

[36]Heffer, C. (2010). Narrative in the Trial: Constructing Crime Stories in Court. In M. Coulthard & A. Johnson (Eds.), The Routledge Handbook of Forensic Linguistics (pp. 199–217). London, United Kingdom: Taylor & Francis Group; Gurevich, L. (2008). Patriarchy? Paternalism? Motherhood Discourses in Trials of Crimes Against Children. Sociological Perspectives. 51(3), 515–539; Tsing, A.L. (1990). Monster Stories: Women Charged with Perinatal Endangerment. In F. Ginsburg & A. Lowenhaupt Tsing (Eds.), Uncertain Terms: Negotiating Gender in American Culture (pp. 282–299). Boston: Beacon Press.

[37]Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic Analysis. In C. Willig & W. Stainton Rogers (Eds.), The SAGE Handbook of Qualitative Research in Psychology (pp. 17–36). London: SAGE Publications Ltd.; Pope, C., & Mays, N. (1995). Reaching the Parts Other Methods Cannot Reach: An Introduction to Qualitative Methods in Health and Health Services Research. BMJ: British Medical Journal. 311(6996), 42–45.

[38]Terry, et al., op. cit. note 36, pp. 17–36; Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*. 3(2), 77–101.

TABLE 2 Illegal abortion court cases from Pacific Island countries, including who was charged with the offence, and the dates of the hearings.[39]

Individual charged	Medically trained abortion provider	Untrained abortion provider	Woman seeking abortion
Cases (18)	7	5	6
Country A (7)	**Case 1**, 1980	**Case 4**, 2011, 2014	
	Case 2, 2006–8	**Case 5**, 2016-17	
	Case 3, 1976	**Case 6**, 1992	
	Case 7, 1992		
Country B (3)	**Case 8**, 2004		**Case 10**, 2009
	Case 9, 2010		
Country C (3)		**Case 11**, 1967	**Case 12**, 2005
			Case 13, 1960
Country D (2)	**Case 14**, 2006		**Case 15**, 2007
Country E (1)			**Case 16**, 1970-1
Country F (1)			**Case 17**, 2017
Country G (1)		**Case 18**, 1997	

6 | FINDINGS AND ANALYSIS OF DOCUMENTS FROM ILLEGAL ABORTION COURT CASES IN THE PACIFIC ISLANDS

6.1 | Abortions performed by medical practitioners

Illegal abortions were performed by three main groups: medical practitioners, untrained individuals, or the women themselves. Most of the medical practitioners were doctors or specialists accused of illegally performing surgical abortions. In both Case 7 (Country A, 1992) and Case 3 (Country A, 1976), the key matter debated by the courts was whether the doctors had in good faith formed the belief that the women's pregnancies were of sufficient danger to their physical or mental health for the abortion to be lawful. In cases 1 (Country A, 1980), 2 (Country A, 2006) and 14 (Country D, 2006), however, the key matter of debate was whether the abortion was spontaneous, the medical practice was routine, and the health outcomes (including death in Case 2) were accidental, or whether an illegal abortion was performed. In cases 1 and 14, the defendants maintained that they only performed routine vaginal examinations on their patients who later spontaneously aborted. In Case 2, the doctor maintained he performed a curette procedure on his patient who retained tissue after a spontaneous abortion.

Case 8 (Country B, 2004) involved a nurse who admitted to performing abortions on 20 to 30 women and was charged with 16 individual counts of procuring the abortion of a woman between March 1999 and January 2003. This defendant was convicted again under a later charge for procuring the abortion of another woman (Case 9), who was also charged and convicted (Case 10).[40] This nurse had observed surgical abortions administered by doctors in a hospital and a private clinic with a duck speculum and uterine sound. She was charged with using these same instruments to administer abortions on women at their request. The abortions were performed at the hospital, the homes of the 'victims' (as the women were referred in these documents), public housing, or motels. Women paid between AUD $16 and $160 for the procedure. Fifteen of these pregnancies ended in abortion, and one pregnancy continued. However, one abortion required two attempts, and one woman went to hospital nine days after the procedure with bleeding and pain.

Available information on the situations leading the women to seek abortions are discussed below, but this case demonstrates how women utilise their networks to access abortion services in legally restrictive environments.[41] Many of the women who accessed abortion through this nurse worked in the Ministry of Health, had close connections working in the health system, or were involved in nurse training so were able to access the defendant through word of mouth. Although the defendant in this case apologised in her cautioned statement to police and said she felt she had done wrong, she also appears to have made an ethical choice in providing abortion services to the women who approached her. The judge summarised a letter written by the defendant to the principal nurse of the hospital, in which she wrote that she 'had saved the lives of many young females who were attending school. She did not care about the money which counsel for the accused submitted is confirmed by the fact that the accused did not chase up on her unpaid or partly paid fees. The accused also says in the same letter that she was worried about the common problem of committing suicide.'

6.2 | Abortions performed by untrained individuals

The untrained individuals used a variety of methods to try to end women's pregnancies. These methods include vigorous uterine massage, walking on the pregnant woman's lower back and inserting five sharpened casava sticks into her vagina (Case 5, Country A, 2016-17); inserting fingers then injecting a hot substance through a tube into three women's vaginas, and a yellow substance into their anuses (Case 18, Country G, 1997); and the preparation of concoctions to be drunk, such as strong tea, raw eggs, and rum mixed with milk (Case 4, Country A, 2011). Where these abortion providers were paid, the service charge ranged from around AUD

[39]Although the court documents analysed in this paper are available publicly, the cases in this paper are all de-identified to minimise unnecessary additional public exposure. References for these cases are available from the corresponding author upon reasonable request.

[40]Case 9, 2010; Case 10, 2009.

[41]Ross & Solinger, op. cit. note 11.

$98 to $182. The majority of these abortion methods were not successful, including Case 11 (Country C, 1967) in which the woman chose not to take the pharmaceuticals given to her by the father and his acquaintance. The method in Case 5 (Country A, 2016-17) did work but at significant risk to the woman's health; two women's pregnancies continued and one ended in stillbirth in Case 18 (Country G, 1997); and in Case 6 (Country A, 1992) the woman died as a result of the abortion, although the method was not detailed.

6.3 | Self-induced abortions

There were five cases of women who were charged with procuring their own abortions; the woman in Case 10 (Country B, 2009) was charged for an abortion that was performed by the nurse convicted in Case 8 and 9. In Case 15 (Country D, 2007), the pregnant woman's aunt inserted misoprostol into her vagina in her third trimester, causing premature labour and stillbirth. However, it was the pregnant woman who was charged and convicted. In Case 16 (Country E, 1970-1) and Case 13 (Country C, 1960), the method was not detailed. In Case 17 (Country F, 2017), the woman was accused of causing a late term abortion by living alone in her final month of pregnancy and by working hard collecting sea-worms every day. In Case 12 (Country C, 2005), the woman was similarly accused of intentionally causing her own abortion at 8-12 weeks' gestation by working in the garden and carrying heavy dishes and washing. Strenuous physical activity was also described as an abortion method in other studies in Pacific Island countries (although usually unsuccessful), and has been considered a cause of spontaneous abortion.[42]

7 | CONTEXT OF ABORTION: FEAR, SOCIOECONOMIC HARDSHIP, AND COERCION

7.1 | Fear of social reprisals

Fear of others' reactions to the pregnancy was a key motivator for women seeking abortions in many of these cases. The reaction of parents, spouses, family members and sometimes others in the community was a key recurring concern for the women who approached the defendant in Case 8 (Country B, 2004) for abortions, with this reason mentioned in 10 out of the 16 counts of abortion. For one woman who approached the defendant in Case 8, for example, the teasing and mocking by colleagues for being pregnant to a boy who would not marry her led her to contemplate suicide, as did another woman's fear of her mother's reaction to her pregnancy, aggravated by the fact her father was deceased. In Case 17 (Country F, 2017), the defendant, who was 40 years old at the time, was described as a single mother of three young children 'entirely dependent on her for support.' Furthermore, she reported fear of her father's reaction to the pregnancy, and anger over the failure of the man responsible for the pregnancy to inform her father that he had made her pregnant. It was in this context, particularly her fear of her father, that she went to an isolated islet during her final months of pregnancy, although this was constructed by the court as an intentionally malicious act toward the fetus. In Case 1 (Country A, 1980), the complainant, a 22-year-old, unmarried woman, consulted with a doctor about her pregnancy that she did not want her parents to know about. She described two visits to the doctor (the defendant) where he inserted a device that expanded her vagina, produced clicking sounds, and caused her discomfort and, she assumed, her later abortion.

7.2 | Socioeconomic factors

This fear over others' reactions to the pregnancy was compounded by women's socioeconomic circumstances, mentioned in six cases, sometimes alongside other concerns such as those related to the woman's health or her desire to continue education or training. For example, the defendants in Case 12 (Country C, 2005) and Case 15 (Country D, 2007) described both socioeconomic concerns and fear of family and social outcomes. Notably, these cases involve women who were charged with procuring their own abortions, in contrast to Case 8 where women were able to access a trained nurse through their networks which may suggest relative socioeconomic advantage.

In Case 12 (2005), the defendant was 29 years old at the time, educated to class six, lived alone with her 6-year-old son, and was unemployed and reliant on her parents for support. When the father of her son left her and had a child with another woman, she entered a relationship with another man with whom she conceived. As framed by the prosecution, however, the hope of restoring her relationship with the father of her son, and concerns over his reaction to her pregnancy to another man, underpinned her decision to try to end the pregnancy. Issues related to women's socioeconomic status, timing (e.g., the wish to delay or cease childbearing), and being too young or unmarried which can translate to fear of others' reactions to the pregnancy are recurring themes in women's motivations for accessing abortion in Pacific contexts and more broadly.[43]

7.3 | Coercion

In addition to socioeconomic concerns and fear of the reactions of others to the pregnancy, sexual and reproductive coercion from more

[42]Linhart, et al., op. cit. note 24; McMillan, et al., op. cit. note 24 (i); McMillan, et al, op. cit. note 24 (ii), p. 52; Jolly, op. cit. note 13, pp. 1–30; Helen, M. (2002). From Mā'uli to Motivator: Transformations in Reproductive Health Care in Tonga. In V. Lukere & M. Jolly (Eds.), Birthing in the Pacific: Beyond tradition and modernity? (pp. 31–55). Honolulu: University of Hawai'i Press.

[43]Vallely, et al., op. cit. note 24, p. 22; Bankole, A., Singh, S., & Haas, T. (1998). Reasons Why Women Have Induced Abortions: Evidence from 27 Countries. *International Family Planning Perspectives*. 24(3), 117–152.

powerful individuals featured in five cases. In two of these cases, the 14-year-old girls conceived as a result of sexual abuse from older men, which was followed by medical practices being performed on them with minimal explicit consideration of the young girls' understanding and consent over the procedures.[44] In Case 14 (Country D, 2006), the 14-year-old girl became pregnant after her uncle sexually abused her. The details of the case suggest she was then taken by her aunt (the wife of the man who abused her) to a doctor without a full understanding of why they were there. However, the girl's teacher reported that the girl's aunt and uncle planned to take her to get an abortion, and the aunt reported pressure from her husband to arrange an abortion. The defendant in this case, a medical practitioner, was acquitted as it was reasoned that a syphilis infection could have caused the girl's second trimester abortion. However, according to the teacher's testimony, the young girl had described that 'the doctor put something in me and broke one of the ropes in my tummy' which suggests she did not understand what was going on during the doctor's examination. Additionally, the judge's summary of the provincial welfare officer's testimony provides some evidence of the coerced and distressing nature of her doctor and hospital visits:

> She [the welfare officer] visited [the young girl who was pregnant] at the hospital on the evening of 1 June. [The young girl] was hungry, bleeding and crying. [The welfare officer] asked [the young girl] if she had consented to an abortion and [the young girl] cried and said that she had no idea about the arrangement. Her aunt had only told her that she was taking her to the doctor for help.

Similarly, in Case 4 (Country A, 2011), a 14-year-old girl had become pregnant as a result of sexual abuse by an older man who was paying for her education and thus had some level of financial control over her. She did not report the abuse because of his threats of physical harm. When she became pregnant, the accused then fed her different substances to end the pregnancy (as described above), although none of them worked.

In Case 5 (Country A, 2016), the woman's abortion was similarly coerced, and appears to be in the context of power imbalances between her and her male partner. The complainant in this case was 22 years old at the time and had entered a relationship with a 48-year-old man (the second accused). This man also employed her in one of his shops and, as she reported, would sometimes 'chase [her] out of the house'. When she was over two months pregnant, he arranged and paid the first accused AUD $130 to perform an abortion. From the available details of this case, the young woman was coerced into this abortion; she was taken by her partner's brother and his wife to the house of the first accused (whom she did not know) without explanation. There is other evidence of coercive methods that were used by the woman's partner and his family, including him giving her 'medicine made from some leaves and asked her to take the medicine saying her vomiting will stop'. This evidence of sexual and reproductive coercion echoes other reports of Pacific women's limited control over sexual and reproductive decisions such as those regarding contraceptive use, as well as the high rates of men's violence towards women including violence during pregnancy.[45]

8 | COURTS' CONSTRUCTIONS OF GENDER, MATERNITY, AND ABORTION

In some of these court documents, gender, maternity, and abortion were constructed in particular ways to appeal to social, moral, and religious standards.[46] In some cases, illegal abortions were framed as those solely motivated by the woman's desire to preserve her reputation (e.g., Case 10, Country B, 2009), for her 'convenience' (Case 8, Country B, 2004), or 'to please herself' (Case 12, Country C, 2005). In these examples, these motivations describe decisions based on socioeconomic constraints or because of other life circumstances, such as the hope of restoring a relationship and the fear of others' reactions and abandonment. By highlighting these motives as the reasons for these women's abortions, the court sets them apart from the 'norm of good motherhood',[47] which in the Pacific is influenced by missionary and colonial feminine ideologies of women as domesticated, middle-class, modest, Christian wives and mothers.[48] As such, these abortions are constructed as 'bad' abortions, falling outside socially and legally sanctioned reasons for choosing not to parent.[49] However, although not pursued by the judge, it should be noted that the counsel for the defence in Case 9 (Country B, 2010) did argue for the 'social need' for abortion related to, for example, parents' assessments of their ability to care for another child.

Motherhood, central to feminine identity in the Pacific,[50] was constructed in some of these cases as decontextualised from women's other experiences and challenges.[51] For example, the judge's framing of his sympathy for the defendant in Case 10 (Country B, 2009) appeared to be in the context that the abortion would have inherently caused her guilt and shame, and that with the right guidance, 'she would have reconsidered her decision and not trodden the painful road she has embarked upon.' Social and

[44]Helen, op. cit. note 40, pp. 31–55.

[45]Family Planning New Zealand. (2019). Planem Gud Famili Blong Yumi: Knowledge, Access and Barriers to Family Planning in Rural Vanuatu. Wellington, New Zealand: Family Planning New Zealand; Republic of the Marshall Islands, op. cit. note 5; Fiji Women's Crisis Centre, op. cit. note 5; Vanuatu Women's Centre, op. cit. note 5; Secretariat of the Pacific Community, op. cit. note 5.

[46]Heffer, op. cit. note 35, pp. 199–217; Gurevich, op. cit. note 35, pp. 515–539; Tsing, op. cit. note 35, pp. 282–299.

[47]Millar, E. (2020). Abortion Stigma as a Social Process. Women's Studies International Forum. 78, 5.

[48]George, op. cit. note 19, pp. 77–96; Jolly, op. cit. note 14 (i), pp. 177–212; Jolly, op. cit. note 14 (ii), pp. 27–48.

[49]Norris, A., et al. (2011). Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences. Women's Health Issues. 21(3), S49–S54.

[50]George, op. cit. note 19, pp. 77–96.

[51]Tsing, op. cit. note 35, pp. 282–299.

emotional support are undoubtedly important for women facing unplanned and unwanted pregnancies. However, the judge in this case appears to reinforce the pathologizing of abortion in relating the defendant's choice to terminate her pregnancy to innate psychological distress requiring 'guidance.' Thus, her abortion is decontextualised from her various life circumstances and her socioeconomic and gendered position in society.[52] This woman was serving a prison sentence at the time and was pregnant to a man other than her husband. The notion that she may have regarded the abortion as her safest and best option in her circumstances was scarcely considered by the judge, besides relating both the context of her pregnancy and her abortion to 'guilt and shame.'

In Case 15 (Country D, 2007), the defendant was 19 years old, single, and unemployed at the time of her pregnancy, which she did not discover until she was in her third trimester. She faced anger and threats of abandonment from relatives and her father tried to kill her after she attempted to disclose her pregnancy. An aunty of the defendant inserted misoprostol into her vagina (with little understanding of the drug on the defendant's part) and told her not to go to the hospital when she experienced labour pains. Yet, despite her experiences of threats, violence, and coercion, the defendant was constructed as failing in her 'duty of care to her child.' The judge further contended that she 'exhibited careless disregard for the life of the baby that she was carrying' in 'her original act of negligence (allowing the drug to be administered) [that] was exacerbated by her failure to take herself to the hospital or at least seek assistance of some kind, having felt labour pains.' In both cases 10 and 15, motherhood appears to be assumed as an essential and incontestable element of the women's identities, separate from the circumstances of their pregnancies, terminations, and births. Given this essentialising of motherhood, opting not to be a mother is constructed as a symptom of psychological illness or maternal degeneration in these women.[53]

While in the above cases idealised motherhood was invoked in the sentencing of these women to imprisonment, motherhood was also referenced in the judge's decision to suspend the defendant's prison sentence in Case 17 (Country F, 2017), in order that she not fail further in her duties to her other 'innocent children'.[54] Similarly, the defendant's status as a mother was cited in the judge's decision to grant her appeal against her sentence in Case 6 (Country A, 1992). The defendant in this case, who was convicted of manslaughter after a woman on whom she had performed an abortion died, was described as a 48-year-old single mother of four children, all of whom had been removed from her care due to financial hardship.

Abortion was also conceptualised in some cases as broadly in opposition to moral and Christian beliefs. For example, in Case 18 (Country G, 1997), the judge's summing up on abortion includes several references to the protection of 'innocent unborn children' from 'destruction,' and that those who do procure abortions must be 'treated severely.' In Case 12 (Country C, 2005), the judge described that the defendant 'gave birth to a child' when she had a first trimester abortion, and later that she 'intended to kill the child which was living in her womb.' The prosecution in this case further argued for 'the maximum term of imprisonment of 2 years as a warning to the community at large, girls and women especially that it is a serious offence to procure her own miscarriage.' The sentiment in the prosecution's case was supported in the judge's sentencing of the defendant to 3 months' imprisonment to 'mark the gravity of the offence,' 'emphasise and mark public disapproval,' 'service as a warning to others,' and 'protect the right of the child.'

The imposition of a deterrence sentence was also a key element of the judge's sentencing in Case 9 (Country B, 2010), to mark the 'sanctity of life,' the 'seriousness of this kind of offending,' and 'serve as a denunciation of such conduct by a society such as ours which professes to hold and follow Christian beliefs and principles.' This sentence was also intended to 'convey the proper message to young women, indeed all women of our community.' Notably, men as parents, or potential parents, families, communities, and the state are not conveyed similar 'messages'; the object of this 'public disapproval' appears to be solely female.[55] However, as noted, Pacific women are not permitted full autonomy over decisions regarding reproduction, and, under these constructions, their pregnancies are further decontextualised both from their bodies and their other life circumstances.[56]

9 | REPRODUCTIVE (IN)JUSTICE AND ILLEGAL ABORTION IN THE PACIFIC ISLANDS

Our analysis of documents from illegal abortion court cases reveals layers of reproductive injustice for the women in these cases that is broader than restricted abortion access, although this is clearly an important issue. The women in these cases had limited autonomy over their sexual and reproductive health and futures, and faced the further threat of criminal prosecution.[57] Rates of conviction and prison sentences were similar for women, and trained and untrained providers (see Appendix 1). However, it would appear charges for illegal abortion are uncommon in the Pacific Islands given that we found only 18 cases over a 57-year period and there are an estimated 34 abortions per 1,000 women aged 15 to 49 in Oceania (excluding Australia and New Zealand).[58] This may suggest that abortion remains largely carried out in secret by women and any complications are managed discreetly in hospitals or health centres,[59] and that

[52]Millar, op.cit. note 45.
[53]Ibid.; Gurevich, op. cit. note 35, pp. 515–539; Tsing, op. cit. note 35, pp. 282–299.
[54]Burry, K., Beek, K., Haire, B., & Worth, H. (2022). Infanticide and Reproductive (In)Justice in the South Pacific: The Construction of Pacific Women in Criminal Trials. In T. Morison & J.J.M.J. Mavuso (Eds.), Sexual and Reproductive Justice: From the Margins to the Center. Washington, DC: Lexington Books.
[55]Gurevich, op. cit. note 35, pp. 515–539; Tsing, op. cit. note 35, pp. 282–299.
[56]Norris, et al., op. cit. note 47, pp. S49–S54.
[57]Bhakuni, op. cit. note 9, pp. 1–6.
[58]Guttmacher Institute, op. cit. note 22.
[59]Vallely, et al., op. cit. note 24, p. 22.

suspected or known abortion cases are dealt with outside the criminal justice system. Pacific women may also be increasingly accessing medical abortion, such as the drug misoprostol,[60] which is generally safer and more discreet compared to physical means.[61] Furthermore, wealthier women may be able to access abortion through private providers,[62] or by travelling to jurisdictions where legal abortion is more accessible.[63] Our analysis of these cases demonstrates the methods of abortion used, including surgical, medical, physical force or exertion, and various substances ingested orally or inserted vaginally and anally. For some women, the abortion was successful though often painful and perilous. For others, their pregnancies ended in stillbirth or early neonatal death. Some women also required hospital attention for pain, blood loss and infection, and two women died as a result of the procedures.

As well as demonstrating the lengths women must go to access (usually unsafe) abortion procedures in legally restrictive settings, there was also some evidence from these court cases of women having limited understanding of the medical procedures that were performed on their bodies. This was especially apparent in Case 14 (Country D, 2006) where the confusion and distress of the young girl during her doctor and hospital visits was raised in the testimonies of her teacher and welfare officer. The lack of communication from medical staff during childbirth and clinic visits for reproductive health issues has been described in other studies in the Pacific region.[64]

Details of the circumstances surrounding women's pregnancies and abortions were also included in some court documents, and they describe themes of fear of the reactions of others including family and partners, socioeconomic hardship, as well as sexual and reproductive abuse and coercion.[65] In cases 3 and 7, the key matter of debate was whether the doctors had determined that the woman's physical or mental distress was sufficient to warrant a legal abortion. However, women's own assessments of their need to end their pregnancies was not given the same legal weight, and usually fell outside the grounds for legally and socially permissible terminations.

Narratives on gender, maternity and abortion in some cases spoke to broad moral and religious opposition to abortion. These arguments appear to conceptualise pregnancy as occurring separately to the context of the women's bodies and lives, maintaining 'an overwhelming tendency to assimilate the interests of Pacific women and their children.'[66] This tendency perhaps explains some courts' considerations of women's desires to preserve their personal reputation and opportunities for education, work, and economic security as invalid. Furthermore, this construction of women and pregnancy precludes analysis of pregnancy as a social act where women are deeply imbedded and vulnerable to their family, social, and political environments. Women's positions within these environments can enable or inhibit their reproductive autonomy and ability to parent safely and sustainably.[67]

However, evidence from Case 8 (Country B, 2004) involving a nurse who was charged with procuring 16 abortions suggests women's agency in their use of their networks to access abortion services, where they have the resources and contacts to do so. Additionally, in contrast to the broad moral and religious disapproval of abortion raised in some cases, this nurse framed her decision to provide abortions as life saving for the women in her community who approached her, and she used appropriate medical instruments. Furthermore, in some cases involving sexual and reproductive coercion, the women were the complainants, such as Case 5 (Country A, 2016) involving a woman whose partner coordinated with his family to deliver her to a community abortion provider. These cases may be understood as examples of women utilising the legal system to obtain justice in relation to their experiences of reproductive oppression. A similar pattern was noted by Christine Salomon in Kanak women in New Caledonia who have utilised the introduced legal system and divorce and child custody laws to improve their position and control over their domestic lives.[68]

10 | CONCLUSION

Motherhood has a complex history as an essentialised component of female identity in the Pacific, which can complicate explicit attempts to control reproduction.[69] Maternity can be understood as a source of power and influence, and as a source of oppression; it is both a core place of value that can be claimed by Pacific women, and an area where women's control may be limited, for example, through sexual and family violence, legal and practical barriers to contraception and abortion, and limited freedom over reproductive decision making.[70] There is evidence, discussed in this article, of Pacific women's reproductive health, decisions and practices as encompassed within broader social, moral, and demographic goals, placed under greater

[60]Drysdale, op. cit. note 24; Vallely, et al., op. cit. note 24, p. 22.
[61]Palma Manríquez, I., et al. (2018). Experience of clandestine use of medical abortion among university students in Chile: A qualitative study. *Contraception*. *97*(2), 100–107; Pourette, D., et al. (2018). Complications with use of misoprostol for abortion in Madagascar: Between ease of access and lack of information. *Contraception*. *97*(2), 116–121.
[62]Whittaker, A. (2002). 'The Truth of Our Day by Day Lives': Abortion Decision Making in Rural Thailand. *Culture, Health & Sexuality*. *4*(1), 1–20; Lane, S.D., Madut Jok, J., & El-Mouelhy, M.T. (1998). Buying safety: The economics of reproductive risk and abortion in Egypt. *Social Science & Medicine*. *47*(8), 1089–1099.
[63]White, Mann & Larkan, op. cit. note 24, pp. 731–745; Grossman, D., et al. (2012). Mexican Women Seeking Safe Abortion Services in San Diego, California. *Health Care for Women International*. *33*(11), 1060–1069; Palmer, B. (2011). 'Lonely, tragic, but legally necessary pilgrimages': Transnational Abortion Travel in the 1970s. *The Canadian Historical Review*. *92*(4), 637–664.
[64]Lukere, V., & Jolly, M. (Eds.). (2002). Birthing in the Pacific: Beyond tradition and modernity? Honolulu: University of Hawai'i Press.
[65]Bankole, Singh & Haas, op. cit. note 41, pp. 117–152.
[66]Jolly, op. cit. note 13, p. 24.
[67]Ross, op. cit. note 10, pp. 286–314; Browner, C.H. (2000). Situating Women's Reproductive Activities. *American Anthropologist*. *102*(4), 773–788.
[68]Christine, op. cit. note 19, p. 90.
[69]George, op. cit. note 19, pp. 77–96; Lukere & Jolly, op. cit. note 62.
[70]Dawson, et al., op. cit. note 2, p. 68; Family Planning New Zealand, op. cit. note 43; UNFPA, UNESCO, WHO, op. cit. note 5; Republic of the Marshall Islands, op. cit. note 5; Fiji Women's Crisis Centre, op. cit. note 5; Kennedy, et al., op. cit. note 5(i), p. 30; Kennedy, et al., op. cit. note 5(ii), p. 11; Vanuatu Women's Centre, op. cit. note 5; Secretariat of the Pacific Community, op. cit. note 5.

public scrutiny by missionary and colonial efforts,[71] and for monitoring within patriarchal and legal structures.[72] Despite these multiple challenges, some women also utilise their own networks and use available systems to regain some sense of ownership over their reproductive lives and experiences. Yet violence, coercion, and socio-economic hardship were all constants in these women's lives, factors that were intertwined with their often unsafe abortions and subsequent involvement in the criminal justice system. Overall, our analysis of these cases from a reproductive justice lens highlights the interconnection between women's socioeconomic disadvantage, gendered violence, limited reproductive control, and the punitive consequences related to not performing gender appropriately by having goals that diverge from mothering.[73]

CONFLICT OF INTEREST

We declare no conflict of interest.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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[71]Lukere, op. cit. note 15, pp. 100–124; Mallett, op. cit. note 17, pp. 125–147; Jolly, op. cit. note 14(i), pp. 177–212; Jolly, op. cit. note 14(ii), pp. 27–48.
[72]Christine, op. cit. note 19, pp. 79–99; Jolly, op. cit. note 17, pp. 148–177.
[73]Ross, op. cit. note 10, pp. 286–314; George, op. cit. note 19, pp. 77–96; Jolly, op. cit. note 13, pp. 1–30; Lukere, op. cit. note 15, pp. 178–202.