Memo for Haifa Workshop, December 6

Thank you in advance for taking the time to think with me about my work on the ways in which abortion law matters. Wednesday’s workshop will be the first chance I’ve had to present my research to an audience of legal scholars, and in particular to those with a law and society perspective, and I’m looking forward to getting your thoughts on this chapter, and on my project in general. The chapter you’ll be reading is from my forthcoming book, which is being published by Beacon Press. It is intended as a trade book, (for a general audience) yet my goal is to deepen discourse around abortion in the university setting, as well.

My forthcoming book examines abortion law “in action” in El Salvador and in the U.S. I’m circulating the second chapter of the book, which contains my findings about what happened on the ground in El Salvador in the years since the country banned abortion, in 1998. The study developed out of my ongoing research into the relationship between law and motherhood -- and in particular to my long-term interest in U.S. cases involving maternal filicide. I hypothesized that access to abortion might affect whether women wound up in these kinds of situations. In 2008, I went to Chile to examine this question. At the time, Chile had the world’s strictest law against abortion—making it a crime in all cases, without exception. I wanted to learn whether banning abortion shaped the circumstances or frequency of cases involving mothers who kill. What I found in Chile baffled me: abortion was tantamount to murder under the law, and yet through use of abortifacients, the country was actually experiencing high rates of illegal abortion and the low rates of law enforcement.

The following year, in 2009, I attended the first bi-national meeting of El Salvadoran and Nicaraguan abortion-rights’ activists. Like Chile, both of these countries ban abortion without exception. The bans were relatively new; when El Salvador banned abortion in 1998, it became the world’s third country, along with Chile and Malta, to do so. Nicaragua joined that number in 2004. In both countries, as in Chile, the bans intensified already restrictive abortion laws, which for decades had outlawed abortion except in cases of threat to maternal life or health, rape or incest, or fetal anomaly.

Lawyers, doctors and activists from the two countries met to share information about the law’s impact—largely on the poorest women in both countries—and to discuss strategies for law reform. At the gathering, it became clear that the situation in El Salvador was different from that of Nicaragua and Chile. In El Salvador, the government actively attempts to enforce the law. I heard stories of women who were shackled to hospital beds, still hemorrhaging, after seeking care in emergency rooms. In the ten years since the ban took effect, scores of women had been imprisoned for crimes related to illegal abortion.

I returned to the U.S. and secured funding for a new research project, looking at the impact of criminalizing abortion in the 21st century. Over the next 5 years, I returned 9 times to El Salvador. There, I conducted roughly 25 interviews (in Spanish) with judges, lawyers, doctors, activists, midwives, religious leaders, government bureaucrats, and women in prison for abortion-related offenses. In addition, I examined texts such as court transcripts, judicial opinions, media coverage, scholarly articles and doctoral dissertations, all of which helped shape my understanding of the purpose and actual impact of the abortion ban.

At some point during the weeks and months I spent in El Salvador, I realized I was not simply researching the impact of El Salvador’s abortion ban. Instead, I was trying to solve the same puzzle in El Salvador that I’d encountered in Chile: there was widespread political support for the ban, yet illegal abortion was commonplace and prosecutions were so sporadic that it was hard to imagine they deterred women from terminating their pregnancies.

Watching the abortion war play out in El Salvador, I slowly realized that, for all the fighting over abortion laws, once you get past the slogans, neither side seems to spend much time considering what they’re fighting for. Even as I was finishing my research in El Salvador, I set about investigating the ways in which we use the law to fight over abortion in the U.S. I started by visiting Oklahoma, one of the most pro-life states in the U.S. There, I came to know lawyers and advocates who have devoted much of their lives to fighting to make abortion once again a crime. Closer to home, I met with Californian abortion-rights scholars and activists. From them, I learned not only what they think is at stake in the fight over abortion laws, but also what issues the abortion war has left behind.

I look forward to hearing your thoughts, and answering any questions you have about the project in general, and the chapter, in particular.
Chapter Two: Assessing the Impact of El Salvador’s Abortion Ban

In 1998, El Salvador passed a law banning abortion under all circumstances. Until that point, abortion was illegal except in cases involving risks to maternal life, severe fetal anomaly, and rape or incest. Since then, El Salvador has worked to enforce its ban, mounting an intensive effort to identify and prosecute those who violate the law. If we’re hoping to understand what happens when abortion is banned, El Salvador is the perfect place to study.

Regardless of whether one favors or opposes the abortion ban, it is vital that we assess the law’s impact. Recall Professor Cass Sunstein’s observation, from the end of the last chapter, that a law cannot be justified merely because one likes its message. Even if we like the message of the law, it is valid only to the extent that it produces results that are consistent with its message.

This chapter explores what happens when abortion is banned.

So what happened when abortion was outlawed in El Salvador? The evidence shows us that three things occurred: (1) abortion remained commonplace—rates did not drop even though it was illegal; (2) doctors became involved in law enforcement; and (3) innocent women were accused and convicted of abortion-related crimes. These three systems—the black market, healthcare, and criminal justice—all yield measurable consequences of the ban on abortion. And, as I explain below, in spite of the vast differences between El Salvador and the U.S., there is good reason to expect that the U.S. would experience each of these three consequences were it to outlaw abortion.

I. Abortions Still Happen

Perhaps the most surprising thing about banning abortion is what does not happen when abortion becomes a crime. Abortion does not go away. Indeed, the rates of abortion are not lower in countries with the most restrictive abortion laws—they are higher.i

Even though abortion is completely outlawed in El Salvador, abortions are commonplace in El Salvador. By the government’s own measure, there are tens of thousands of illegal abortions every year.ii Indeed, the rate of abortion in countries with restrictive abortion laws, including El Salvador, far exceeds that of countries with far more liberal laws, as in the U.S.iv

The correlation of high abortion rates and restrictive abortion laws does not mean that abortion bans cause more women to have abortions. What it does mean is that abortion doesn’t simply go away when it is made illegal.

Because they are illegal, it is hard to get a complete picture of how women obtain abortions in El Salvador. One thing is clear, though: the advent of abortion drugs has completely altered the face of illegal abortion.

Until recently, abortions were exclusively surgical procedures.v Doctors would terminate pregnancies by opening the cervix and suctioning or scraping out the

contents of the uterus. Women unable to find or afford a doctor to perform an illegal abortion might try bringing on a miscarriage themselves, for example, by inserting a sharp object into their uterus. Opening the cervix typically is enough to induce a miscarriage, although it carries with it high risks of bleeding and infection.

Historically, these so-called “botched” abortions provided the only proof of the crime of illegal abortion. Coat-hanger abortions, for example, were notorious in pre-Roe America in part because they carried a high risk of perforating a woman’s uterus, leaving behind the telltale sign that the woman had deliberately ended her pregnancy.

Beginning in the 1990s, with the advent of abortion drugs, illegal abortion became safer and harder to detect. Taken in the right dose, at the right point in pregnancy, the drug known as *Mifeprex* or *RU-486* (mifepristone is the generic name) will safely end 98% of pregnancies.ii Side effects include excessive bleeding or incomplete abortion, both readily resolved with a visit to a doctor.vi

Although they are not always safe or effective, especially when taken too late in pregnancy or at the wrong dose, compared with the risks of an illegal surgical abortion, abortion drugs have completely altered women’s access to illegal abortion.viii

In El Salvador, and throughout Latin America, women find easy access to illegal abortion drugs via the internet.ix In Brazil, for example, where abortion is illegal except in cases of rape, threat to maternal life, or anencephaly (where the fetus lacks a brain), abortion drugs play a vital role in the thriving black market. An estimated one in five Brazilian women under 40 have had an abortion.x

Even in a poor country like El Salvador, almost everyone has a smart phone and, provided they have money and time, can purchase the drugs that will end an unwanted pregnancy.

To be sure, illegal abortion remains risky.xi Whether they use drugs or other means to terminate their pregnancies, many women experience complications from illegal abortion. In Latin America, complications from illegal abortion constitute the leading cause of mortality of young women.xii

It is the inevitability of such complications that leads to the second concrete change set in motion by banning abortions. Doctors become entangled in the law enforcement process.

**II. Doctors and the Problem of Detecting Abortion**

If the first thing that happened when El Salvador banned abortion was the proliferation of illegal, black market abortions, the second thing that happened was that doctors were enlisted in the law enforcement effort. The overwhelming majority of abortion cases in El Salvador begin in the hospital, with a doctor’s hunch that his or her patient has broken the law.

In 1998, Salvadoran government officials charged with implementing the newly passed abortion ban reached out to doctors. Dr. Alejandro Guidos, former president of the Association of El Salvadoran Obstetricians and Gynecologists, described the state’s approach:

“Officials from the *Fiscalia* (the state prosecutors) went to the hospitals, advising doctors that they had a legal obligation to report women suspected of terminating their pregnancies,” he told me. “And the hospital directors supported the obligation to report. They collaborated.”

The push to enlist doctors in enforcing the abortion law succeeded. A 2006 survey of practicing obstetricians found that more than half (56%) of respondents reported having been involved in notifying legal authorities about a suspected unlawful abortion.

It is inevitable that a country seeking to enforce laws against abortion would seek doctors’ collaboration. It is to doctors that women must turn when an illegal abortion goes wrong. Doctors are therefore in the best position to spot the crime.

But there are serious problems with using doctors to enforce abortion laws. In reporting their patients, doctors break the law and violate the oldest of ethical principles—patient confidentiality. Furthermore, in the vast majority of cases, doctors cannot tell whether a woman has had an abortion or simply a miscarriage. Thus, their reports are based on hunches, rather than on medical evidence.

In the following pages, I describe the what happened in El Salvador when doctors began collaborating with police.

**A. Law, Ethics and Doctors’ Reports to Police**

Doctors routinely treat patients whom they suspect, or even know, to have broken the law. When a doctor reports a patient to police, though, she violates the oldest of ethical principles—patient confidentiality.

The obligation of safeguarding a patient’s secrets is ancient. For over 2400 years, medical doctors have embraced the precepts articulated in the Hippocratic Oath. Recited at medical school graduations around the world, one of the Oath’s central tenets is the following pledge: “Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.”

This principle is based in part on policy considerations. Confidentiality is essential to creating a solid doctor-patient relationship, dedicated to promoting the health and life of the patient.

In El Salvador, as in other countries including the U.S., the ethical obligation of confidentiality has been enacted into law; it is illegal to share patient information. A doctor who reveals her patients’ medical information commits both a civil wrong, for which a patient might sue, and a crime, punishable by imprisonment and the suspension of the doctor’s medical license.

Regardless of these ethical and legal precepts, it’s easy to understand why a doctor might struggle when encountering evidence of an illegal abortion. If you view abortion as the taking of a life, you might be willing to call the police, even if it means violating the norms and laws governing confidentiality.
Salvadoran law would seem to support such reports. It requires doctors to report suspected crimes to the state.\textsuperscript{xx} Because abortion is a “criminal act,” this requirement could be construed to mean that providers must report cases of unlawful abortion to police. Plainly, this was the interpretation the Salvadoran officials meant to convey when they toured hospitals in 1998.

Legally, though, they were wrong. The law explicitly excuses doctors from this duty when the information is acquired in the course of a confidential doctor-patient relationship. The law states that, “[d]octors, pharmacists, nurses and other health professionals must report unlawful criminal acts that they become aware of in the context of their professional relationship, \textit{unless the information they acquire is protected under the terms of professional secrecy}.”

\textsuperscript{xx} There is no conflict under the law, then. Doctors are required to maintain patient confidentiality.

Still, when the state sends prosecutors to inform hospital personnel of the need to report patients they suspect of having abortions, one can understand why doctors might comply.

What happened next was both inevitable and deeply troubling.

**B. The Diagnostic Challenge: Distinguishing Abortion from Miscarriage**

It turns out that it’s almost always impossible, even for doctors, to tell whether a woman has had an abortion or instead, simply suffered a spontaneous miscarriage.

Miscarriage is surprisingly common. Miscarriage is so common an occurrence that, in Spanish, there is no difference between the word for miscarriage and the word for abortion. Any interruption of pregnancy is termed an “aborto.” Although women in El Salvador, like women in the U.S., tend not to speak openly about losing a pregnancy to miscarriage, when they do so, they say they’ve had an “aborto.” There is no other way to describe their loss.

Throughout the world, as many as one in four pregnancies ends in spontaneous miscarriage.\textsuperscript{xxi} Miscarriage most often happens early in pregnancy--within the first 12 weeks. A woman having a miscarriage typically experiences what feels like a heavier period than normal, perhaps passing more blood and some blood clots, along with whatever fetal tissue remained in her uterus after the fetus stopped developing.\textsuperscript{xxii}

A woman might seek medical care following an early miscarriage, in response to heavy bleeding, cramping or the risk that her body hasn’t expelled all of the fetal tissue.

Herein lies the inevitable challenge for abortion law enforcement: in the absence of physical evidence such as trauma to the uterus, there is no reliable way
to distinguish a woman experiencing complications from an illegal abortion from a woman who has suffered a miscarriage.

Because doctors cannot distinguish a spontaneous miscarriage from an abortion, the government will lack the evidence necessary to support a conviction against women who have early abortions.

Salvadoran lawyer Dennis Munoz, who has defended more women convicted of abortion-related offenses than any other lawyer in the country, explained it this way:

Yes, there are many illegal abortions in El Salvador for sure. But how do you prosecute them without evidence? There’s a rule here called ‘Corpus Delecti,’ which requires the state to prove a crime has taken place.\textsuperscript{xxiii} It’s much easier to prove the crime if you have a body. To catch an early abortion, you need evidence that it’s provoked. Undissolved pills in the vagina or a perforated uterus. There has to be some evidence.\textsuperscript{xxiv}

Dennis’ observation helps explain why, rather than cases against women who took drugs or hired someone to terminate an unwanted pregnancy, the law has generated a line of prosecutions against women who lost their pregnancies at or close to full term. I’ll discuss these cases in the next section of this chapter.

What Dennis’ observation does not explain is why reports to police are generated almost exclusively from public hospitals. And yet, it is true. When El Salvador sought to enlist doctors in enforcing its abortion ban, only those working in public hospitals complied.

\textbf{C. The Cases: Public Hospitals, Poor Women and Police Reports}

My hunch was that a doctor’s willingness to report a woman for suspected abortion would reflect his or her personal beliefs about abortion.

It turns out that I was wrong.

The first comprehensive investigation of abortion prosecutions in El Salvador traced the origins of abortion prosecutions over the 10-year time frame from 2001-2011. By traveling across the country and visiting every criminal court, researchers identified 129 abortion prosecutions.\textsuperscript{xxv} The great majority of these prosecutions were triggered by a doctor’s report. Yet not a single one of these reports was made by a doctor in private practice, seeing a paying patient.\textsuperscript{xxvi}

I wondered about what might make a doctor more willing to act on suspicions in context of a public hospital, and I decided to try talking to a doctor who had made a report. This task was complicated because the doctors’ police reports are anonymous. In the end, I settled for interviews with two doctors; one whom I knew believed doctors should not report their patients, and the other whom I suspected of having denounced a patient.
1. Interview with Dra. Rosario

Dra. Bernadette Rosario\textsuperscript{xxvii} was born into a medical family and raised in San Salvador. In her mid-40s, Dra. Rosario is a powerful woman who has served in the country’s Ministry of Health, as well as on the faculty of the country’s leading medical school. Her office is in Colonia Médica, home to the country’s leading medical practices. The neighborhood is only a mile or two from the public hospital where Beatriz waited out her ordeal. But whereas the entry to the public hospital was crowded with street vendors, ragged children and dilapidated cars, Colonia Medica is tranquil. It consists of several tall buildings arrayed around a circular patch of grass. In the middle of the grass, a bronze statue of an enormous golden hand cradles a tiny baby in its palm.

“Can you tell me about doctor-patient confidentiality rights in El Salvador?” I asked at the start of our conversation.\textsuperscript{xxviii}

I needn’t have worried about putting her on the defensive. Dra. Rosario looked me straight in the eye and answered. “Here, the right to confidentiality comes with a price tag. Patients at the private hospitals buy their privacy—no one ever reveals their secrets. You could lose your medical license and spend 3-6 years in prison for breaching patient confidentiality. And besides, they’re your patients—you know them, or their families, or their friends. Your reputation and your livelihood depend on them.”

“What percentage of Salvadorans go to private doctors and hospitals?”

“Three percent. Maybe five percent.” She smiled and shook her head when she saw the look on my face.

It was hard for me to believe that all the elevator buildings in the Colonia Medica, the medical offices and the small specialty hospitals, served only 300,000 of the country’s 6 million residents.\textsuperscript{xxix}

Dra. Rosario continued, “80% of Salvadorans get their care from public hospitals, located throughout the country. The rest go to social security hospitals and doctors, and they get something in between.”

I’m not naïve about the difference between the quality of health care received by rich and poor Americans. Generally speaking, we, too, live in a tiered health care system.\textsuperscript{xxx} Still, I wondered at how poor women lost their right to confidentiality, simply because they couldn’t afford to see a private doctor.

“Why aren’t doctors in public hospitals worried about breaching patient confidentiality when they report women for abortion?” I asked.

“Well, a lot of doctors think they’re obligated to report women they suspect of having done something to terminate their pregnancies; they do it because they think the law says they must. And then there are those who report because they really believe it’s a terrible crime to terminate a pregnancy and they want to see the law enforced. And of course, doctors in public hospitals typically are young, hoping

to build a reputation and then to start a private practice. They’ll do what they need to do to avoid conflict with their nurses or their superiors.”

“Do women know the public hospital doctors might report them?”

“It depends,” said Dra. Rosario. “Some of them are savvy enough to know exactly what sort of things separate the public from the private hospitals. But my guess is that most women don’t know. No one talks much about abortion or the law, and even if they knew, poor women seek care at public hospitals simply because they’re bleeding to death and they have no other option.”

Dra. Rosario had done little to conceal her opinion that patient confidentiality should preclude abortion reports to police. But then, she was allied with the opponents of the abortion law. I’d gotten her name from the activists working to overturn the ban. I wondered if health care providers who supported the ban, who believed abortion was murder, nonetheless felt bound by patient confidentiality.

### 2. Dr. Diaz’s Interview

I knew it would be difficult to find a doctor willing to speak openly about breaching patient confidentiality. Moreover, because abortion indictments and prosecutions are unpublished, I lacked easy access to the names of doctors who served as witnesses in these cases.xxxi In my case, I caught a break, although I didn’t know why until later.

In 2002, Dr. Marvin Diazxxxii was a young attending physician working in the emergency room of a public hospital while training as an obstetrician. There, he treated a woman named Karina Climaco, whose mother had brought her in, hemorrhaging and passing blood clots.xxxiii Dr. Diaz examine Karina, and found evidence of both uterine enlargement and placental tissue in her vaginal cavity.

According to Karina, after the examination, Dr. Diaz called the police.xxxiv Within hours of her admission to the hospital, police arrived at Karina’s mother’s apartment, searched her home, and found the cold body of a newborn baby.xxxv

Karina was later convicted and imprisoned, before being exonerated when her defense lawyers proved she had a spontaneous miscarriage. The case received considerable publicity, and I was able to review the transcript, where I found Dr. Diaz’s name.

After a number of false starts, I found Dr. Diaz’s contact information. At first, he insisted I had the wrong person; his surname is common in El Salvador. I persisted though, and after some back and forth, he agreed to meet with me. I didn’t understand why until I got to his office. There was a Jewish candelabra on his otherwise empty desk.

“What’s this for?” I asked, surprised because there are no more than 100 Jews living in El Salvador.xxxvi Dr. Diaz responded that he was a Converso—descended from a long line of Jews who ostensibly converted to Catholicism during the Spanish inquisition of 1492, and who survived by hiding their religious identity and practices.xxxvii He said he’d guessed I was Jewish from my name. He had guessed
correctly, although I’d never considered my surname, invented at Ellis Island two generations ago, to be particularly Jewish.

“That’s why I agreed to meet you,” he told me. We chatted a little in broken Hebrew, and, oddly moved, I turned to the conversation at hand.

Dr. Diaz remembered the sequence of events around the reporting differently than Karina had recalled it.

“It was her mother who found out about the baby when she noticed blood underneath the bed, and it was the mother who pressed charges. In any case, all we did was come and perform some tests to figure out if the woman had been pregnant. It didn’t mean we were going to call the police, but somehow the police got there at that moment.”

“Would you have reported her, though?”

“Now,” he answered, “we are supposed to protect what our patients tell us and we do.”

“Even though the law says that you have to report it?” I asked.

“Yes,” he answered, “And I have to be sincere with what I am about to say. In El Salvador the law is not applied to everyone, but rather only to certain individuals. For example, in private hospitals things are done where no one really knows what happened except for the doctor and the patient.”

Dr. Diaz is now in private practice; his office is in the same neighborhood as Dra. Rosario’s.

I wanted to probe Dr. Diaz’s comfort level with the outright ban on abortion.

“How does it feel as a doctor to see a 10-year-old girl, pregnant as the result of incest?” I asked.

“The law here is very strict,” he replied. “It says that you can never terminate a pregnancy. There is never an extenuating circumstance…. In my medical view, I’d say it was worth it to allow her to have that baby. I’ve seen people for whom it was hard during the pregnancy because of situations like those, but when the baby is born, the woman’s life is completely transformed. I’ve seen women who come to me, and, well, yes they do need support, and that’s what they don’t have here. You can have a difficult situation, but as long as you’re supported, you will continue to go forward. You’ll be able to overcome any obstacle.”

My conversation with Dr. Diaz shook me at many levels. It was oddly refreshing to meet someone who supported the abortion law. He was not troubled by the law’s failure to make exceptions in “hard” cases like incest, which after all have nothing to do with the fetus’ moral status. Instead, he was bothered by the hypocrisy that permits wealthy women to evade the law.

Dr. Diaz saw abortion as murder.

And yet, even though he supported the abortion ban, Dr. Diaz was unwilling to acknowledge that he’d ever divulged patient confidences, even in the past. He did not want credit for having alerted the police about Karina’s dead baby. Instead he gave me a flimsy story of how it might have been her mother who called the police.
What bears noting is that both Dr. Diaz and Dr. Rosario portrayed medical confidentiality as a commodity. Rich women buy their privacy from private doctors. Poor women arrive at the country’s public hospitals too broke to go anywhere else. They lack the funds to insure their secrets will be kept. The story of how abortion gets prosecuted in El Salvador begins with this reality: doctors at public hospitals call the police.

III. Poor, Innocent Women are Accused of Abortion Crimes

It helps to bear in mind Dr. Diaz’s patient, Karina, as we move from the subject of detecting abortion to considering the third thing that happened when El Salvador banned abortion: innocent women were prosecuted and convicted of abortion-related crimes.

Karina was reported to police on suspicion of illegal abortion after Dr. Diaz treated her in the emergency room of the public hospital. She was hemorrhaging, and the size of her uterus plus the presence of a placenta left no doubt that she had been pregnant. Where was the baby?

It turns out that cases like hers make up over 50% of the cases brought against women for abortion.

A. The Typical Abortion Prosecution in El Salvador

At first, it’s hard to see why the crime of abortion would generate cases like Karina’s, which involve a dead full-term fetus. The answer lies in what we already know. First, it is hard to detect early abortion. Second, when there is physical evidence that a woman has recently delivered a baby, doctors naturally may suspect foul play. Because there is evidence to support their suspicions, they are more willing to notify the police.

The comprehensive study of all abortion-related prosecutions in the decade between 2001-2011 found 129 cases in which women were investigated for abortion-related offenses.xxxix Close to half of these investigations involved fetuses that had reached at least 7-months gestation at the time of their deaths.xlv These are hardly the sort of cases that come to mind when one thinks about making abortion a crime.

Not all abortion investigations turn into cases that get prosecuted. More often than not, the cases are dropped. It is at this point that the emphasis on late-term pregnancy loss, rather than abortion, becomes even more pronounced. Of the 49 women arrested for abortion, only thirteen ultimately were convicted of that crime. Salvadoran law distinguishes between abortion and homicide, treating as homicide any case involving a fetus beyond 7-month’s gestation. Thus, if it turns out the fetus was beyond 7 months’ gestation, the charges against the woman were elevated from abortion, which is punishable by two to eight years imprisonment, to homicide, which carries a maximum sentence of 50 years in prison.

36 of the 49 women originally charged with abortion ultimately were convicted of aggravated homicide.
The typical abortion prosecution in El Salvador doesn’t look at all like what I’d expected. Rather than involving women who obtained early, illegal abortions, the cases involve women accused of deliberately killing their newborns after delivering them at home.

These cases evoke a visceral revulsion with which I am familiar. The facts behind these prosecutions aren’t all that different from some of the cases involving mothers who kill their children. Here, too, the cases involve mothers who denied or concealed their pregnancies, unattended births, babies who die after being delivered in toilets. Here too, the mothers are charged with homicide.

But in these cases, the only crime the mothers seem to have committed is being desperately poor and pregnant, and losing a baby after delivering it at home.

At first, I’ll confess, I did not feel much sympathy for these women. Perhaps their doctors violated confidentiality, but surely, the possibility that a woman has killed her newborn merits a police investigation.

My friend Dennis Munoz, the Salvadoran defense lawyer who is the country’s leading expert in abortion-related prosecutions, persuaded me I was wrong. In case after case, the Salvadoran criminal justice system has wrongly convicted poor women of homicide when the only evidence against them is that they had a late miscarriage.

To help me understand the connection between abortion laws and the criminalization of miscarriage, in March, 2012, Dennis took me to meet Christina, his former client.

B. From the Hospital to the Prison: Christina’s Story

We visited Christina at her grandmother’s home in El Transito, a village two hours outside of San Salvador. She began her story at the point where she was 17 and expecting her second child. Several months into her pregnancy, she and her three-year-old son left El Transito and moved to San Salvador, living in the second bedroom of her mother and stepfather’s apartment so that Christina would be close to the public hospital when her baby came.

It was Saturday, October 23, 2004. Earlier that week, Christina and her mother had shopped for new linens and baby clothes, having decided to spend money on the baby rather than on a baby shower. As her mother prepared to leave for work, Christina mentioned that she’d had diarrhea earlier that morning. Neither she nor her mother was alarmed, though. Christina had had stomach problems regularly since her appendix burst, about a year before, and her baby wasn’t due for another month or so.

After dinner, when her mother returned from her shift at the tortilla factory, Christina mentioned that her stomach was upset. She lay down on the bed she shared with her three-year old son. She felt sick, but it didn’t feel like she was having contractions; she knew because she remembered how they’d felt.
Several hours later, she got out of bed and told her mother she couldn’t sleep. Her mother made her some tea with sugar.

In the middle of the night Christina awakened with an urge to go to the bathroom. She sat up in bed and felt a sudden, tremendous pain. The apartment was small so she managed to get to the bathroom by dragging herself, one hand on each wall. The pain was so intense she felt she was suffocating. The last thing she remembers is struggling to push open the metal bathroom door.

She woke up in a hospital bed where a woman stood over her demanding, “Y el bebé?” (“And the baby?”). As she emerged from the fog of anesthesia, three guards stood at her bedside, asking, “What’s your name? Where do you live? How many months pregnant were you?” She kept falling asleep, and they kept shaking her awake, saying, “You have to answer us.”

Over the course of long hours of interrogation, she learned that her baby had died. After getting a call from the doctors, police had searched Christina’s mother’s apartment and found the body in the mess of blood and towels left behind when her mother dragged Christina to the neighbor’s waiting truck, so they could drive her to the hospital.

Christina had experienced what doctors call “precipitous labor and delivery,” in which there is a sudden onset and rapid progression of the birth process.\textsuperscript{xlii} Doctors don’t always know why this happens, but one expert on the subject, Dr. Anne Lyerly Drapkin, a professor and obstetrician at the University of North Carolina, offered several explanations for what might have caused Christina’s miscarriage.

“My first guess,” she said, “involves infection. The fact that she had ongoing gastro-intestinal problems is a common sign of infection. In pregnant women, such infections can spread to the amniotic sac, leading to precipitous delivery and/or miscarriage.”\textsuperscript{xliii}

Dr. Lyerly Drapkin noted that a quick pathology investigation of the placenta would have revealed the presence or absence of infection. In Christina’s case, no such examination was performed.

Instead, after two or three days at the hospital, Christina was arrested on suspicion of abortion and was transferred, handcuffed and still bleeding, to the police station just outside of the women’s prison in the city of Iligan. After a week of interrogations, and after the coroner determined that the fetus was beyond seven months’ gestation, Christina was charged with homicide.

At her preliminary hearing, the prosecutor argued that Christina must have known she was in labor because she had already had a child. Once a woman experiences labor pains, he claimed, she cannot mistake them for any other sort of pain. Christina killed her child, the state alleged, by not telling someone she was in labor.
The presiding judge told the prosecutor to respect Christina’s loss. He dismissed the case for lack of proof.

Fifteen days later, the prosecution claimed it had new evidence and Christina’s case was re-opened. She was assigned a new public defender, whom she didn’t meet until the day of her preliminary hearing. Once again, the state had charged her with *homicidio culposo*—our version of manslaughter. The crime carried a potential sentence of 2 – 8 years. This time, the judge let the case go to trial.

At trial, her new lawyer failed to object when the judges decided to convict Christina of a far more serious crime than the one with which she had been charged: *homicidio agravado*, or aggravated homicide. The judges justified this heightened penalty by referencing the innocence of the victim, and by once more invoking the notion that, as an experienced mother, Christina must have known she was in labor.

Christina was convicted on the theory that, by failing to get medical help, she caused her baby’s death. Aggravated homicide carries a much higher penalty than *homicidio culposo*, and Christina was sentenced to 30 years.

I asked Dr. Lyerly Drapkin what she thought of the state’s claim that Christina must have known she was in labor.

“There’s no logic to the court’s position,” she said.

There no reason why she should have known it was labor, and a lot of reasons why she shouldn’t have—her history of gastro-intestinal trouble actually means she was unlikely to know it was different; women deliver precipitously all the time, vaginal birth changes the musculature such that later deliveries tend to be much faster than first-time births. And given that she was a month away from her due date, she was more likely to think she was not in labor.

Inside Ilopango, the women’s prison, Christina met eight or nine women convicted of abortion-related crimes. Amidst the hundreds of women imprisoned in the crowded women’s cells of Ilopango, they stuck together.

Like all prisons, Ilopango had a social hierarchy. According to Christina, the drug traffickers and mass-murderers were treated the best. The other inmates applauded them. The worst treatment, by contrast, was reserved for those who had killed their children. “*Te comiste a tus hijos,*” (“You ate your children”), they called out in passing to her and to the others incarcerated for abortion-related offenses.

After almost two years in prison, one of the other “abortion” inmates introduced Christina to Dennis Munoz, who was her lawyer. Dennis quickly spotted the judicial error in Christina’s case. The judges had convicted her of a more serious crime than that with which she had been charged. In El Salvador, as in the U.S.,
judges are not permitted to revise the charges against a criminal defendant. Only the prosecutor can determine what crimes to charge.

Dennis submitted a motion seeking a new trial, arguing the court had overstepped its bounds by convicting her of a crime with which she had not been charged. The state quickly responded, offering to release Christina for time served. Christina was happy to go home to her son and her family, and opted not to seek a new trial and the chance to clear her name.

For Dennis, Christina’s case was just one among a score of similar cases; one in which justice came relatively easily.

C. Late Miscarriages, Wrongful Convictions and Implications for the Abortion Ban

In El Salvador, the battle over the abortion ban increasingly focuses on cases like Christina’s.

The problem of wrongful convictions in cases like Christina’s emerged as a surprise finding of the 2009 conference between Nicaragua and El Salvador, convened by opponents of the abortion bans in both countries. Few in attendance anticipated that they would come to be working on cases of women who never wanted to terminate their pregnancies in the first place.

Yet the stories told by defense lawyers like Dennis Munoz made it clear that, in El Salvador, cases like Christina’s had become commonplace. To be sure, before the 1998 ban, women were convicted of homicide in cases involving dead newborns. But those cases did not originate in calls to police from public hospitals involving women who had had late-term miscarriages. Instead, they involved babies whose bodies, when found, showed signs of having been born alive.

At first, abortion-rights activists struggled over whether to work on these sorts of cases, rather than strategizing ways to overturn the ban. They had joined together in an effort to persuade the government to make exceptions to the ban, The Agrupacion Ciudana, as they are known, supports the “Decriminalization of Ethical, Therapeutic and Eugenic Abortions”. The group consists of lawyers, academics, students and activists. They write grants to fund their work, which originally consisted of social media publicity and street-level activism, such as parades and protests.xlvi

As I learned from one of the group’s founders, Morena Herrera, many felt disturbed by cases like Christina’s, and worried they were a distraction from the battle over the abortion law.xlvi

Eventually, though, the Agrupacion Ciudana dedicated itself to defending these women and to protesting the pattern of wrongful convictions.xlvii Their lawyers undertook to investigate the cases of all of the women incarcerated on abortion-related offenses.

On April 1, 2014, the Agrupacion Ciudana submitted 17 petitions to the Legislative Assembly, each of which demanded a legal pardon for a woman serving a sentence for an abortion-related homicide.
The 17 cases included every Salvadoran woman then incarcerated for abortion-related homicide.\textsuperscript{xlviii} According to Dennis Munoz and his colleagues, there was \textit{not a single guilty woman} among those who had been imprisoned for these crimes since 1998. It is a stunning claim. Yet the facts behind their cases are so similar as to be interchangeable. If it could happen to one woman, why not 17? Each of the 17 women was serving a sentence of between 30 – 40 years. The majority were poor, uneducated and young—over a quarter were illiterate and over half had not made it past third grade.\textsuperscript{xlix} All had experienced obstetrical complications at some point during their pregnancies, resulting in late miscarriages. They gave birth unattended. Their newborns were stillborn or died shortly after birth. The women bled so heavily that they sought care at a hospital, where they were arrested.

The \textit{Campaign for the 17}, or \textit{Las 17}, as it is known in El Salvador, has had surprising success. January 22, 2015, the Legislative Assembly announced its decision to pardon Guadalupe, one of the 17 women.\textsuperscript{1} It was one of the only pardons issued by the government in years, owing in part to the fact that in order to pardon a crime, the state must acknowledge its own error.

Scarcely a month later, the \textit{Agrupacion Ciudana} secured another victory—this time for a woman who had been incarcerated after her doctor reported her to police for a suspected abortion. She was sentenced to 30 years in prison for having brought about the death of her 5-month-old fetus. In April, 2015, after serving 15 months in prison, the judge found that her doctor had violated the obligation to maintain patient confidentiality, and in addition, that the prosecution had failed to prove that the baby had been born alive.\textsuperscript{ii} In May, 2016, a third woman—Maria Teresa Rivera—was released after serving four years of a 40-year sentence, when the state acknowledged lack of evidence of live birth or criminal intent.\textsuperscript{iii}

But these victories remain exceptions. The 2014 Legislative Assembly rejected the pardons of the remaining 15 women, in some cases without comment, in other cases given explanations such as “risk of recidivism due to poor social status and lack of education.”\textsuperscript{ili}

The \textit{Agrupacion Ciudana} continues to fight, but it seems that for every woman whose freedom they’ve secured, there are several more women newly convicted. By 2015, \textit{Las 17} had become 23, which was the grand total of the original 17, minus 3, for the women exonerated, and plus 8 for the newcomers. Dennis Munoz and the other \textit{Agrupacion} lawyers know all of the newly-convicted women. The facts of their cases are familiar by now. But the work of overturning their convictions proceeds slowly, case by case.

\textbf{IV. Assessing the Consequences of Banning Abortion}

What are we to make of the what has happened in El Salvador under the abortion ban? The effort to assess the law’s consequences feels like a charged, partisan endeavor. At the end of the day, it seems that abortion exists in a world in which, as Friedrich Nietzsche observed, “There are no facts, only interpretations.”

I can’t tell you how to interpret the story I’ve told you. But I can assure you that it would be largely the same story, anyplace around the globe.

A. Abortion will still happen

No one ever claimed that banning abortion would eliminate it. What’s surprising is that there is no evidence that banning abortion reduces the abortion rate.

It is possible, of course, that the ban makes a difference at the individual level, leading some women to keep their unwanted pregnancies, rather than having abortions.

But we know that there can’t be millions or even thousands such women, because if there were, then we would see higher birth rates in countries with abortion bans than we do in similar countries with more permissive laws. We don’t. El Salvador’s birth rates are no higher now than they were before the ban, in 1998. Nor are they significantly different from those of their neighbors with more permissive abortion laws: Honduras, Costa Rica and Panama.

B. Banning abortion has an impact on women and girls

When abortion is illegal, it is unsafe. In El Salvador, scores of women die every year from illegal abortions. They aren’t the daughters of the elite, whose money helps them find safe, private ways to end their unwanted pregnancies. They are the women who live far from cities, in cinderblock homes with dirt floors and no running water. They are the women who continue to use coat-hangers in the age of the Internet.

In addition, banning abortion changes the lives of girls who, because they cannot get an abortion, become mothers as teenagers. El Salvador has one of the highest rates of unwed teen mothers in the world—a Pan American Health Organization report noted one in four births in El Salvador are to women ages 15-19.

In El Salvador, having a child at age fourteen isn’t simply a cause for shame in the eyes of a religious community. It also increases the odds of a life lived in crushing poverty, of marginal education and employment, of vulnerability to the violence and chaos that scores the lives of the poorest Salvadorans.

Some girls, faced with that prospect, opt to kill themselves. Government statistics reveal that three out of eight maternal deaths in El Salvador are the result of suicide among pregnant girls under nineteen. Many of these girls have suffered rape and sexual abuse, and are silenced by the shame of these humiliations, in addition to the stigma of pregnancy.
Across the globe, one finds similar trends. Where abortion is illegal, there are high rates of medical complications and deaths due to illegal abortion. There are high rates of teen pregnancies. There are pregnant teens who commit suicide.

For opponents of the abortion ban, each of these trends is a clear indictment of the law.

For the ban’s supporters, though, I imagine these indirect consequences on the lives of women and girls are viewed as part of a picture that includes other lives—those which begin at conception and which the law must acknowledge and the state must endeavor to protect.

C. The law won’t catch the “right” women

The most intense condemnation of abortion typically is reserved for women whose motives seem entirely selfish. The wealthy, married woman for whom a baby is inconvenient, or the woman who has an abortion because she wants to be able to wear her bikini. The women who Dr. Mayora, an outspoken supporter of El Salvador’s ban, decried as “wanting an abortion for any reason, or for no reason at all.”

What we learn from El Salvador is that the law can’t catch such women. Illegal abortion no longer need involve “abortion doctors.” Ready access to abortion drugs, and the fact that abortion is almost always indistinguishable from miscarriage means most women who have early abortions will escape detection, even when things go wrong and they wind up in the hospital.

What is true for El Salvador will be doubly true in wealthier countries, where women will have many more options for ending an unwanted pregnancy in a relatively safe, discrete way.

D. The law will catch innocent women

The law will catch women who arouse their doctor’s suspicion. In El Salvador, the women accused of abortion are among the poorest women in the country.

Their doctors don’t know them. And in most cases, they don’t know anyone who lives as they do. These women are so poor and marginal that their doctors find it hard to understand their responses to crisis. Their world is so unfamiliar that it becomes possible for doctors, and later prosecutors and judges, to project their own fears onto it, inventing motives for crimes in the process.

To the woman in labor who fell down the steep path to the latrine, they impute the intention to conceal her delivery and kill her child. She must have wanted the child to suffocate in the muck so that she could avoid the burden of raising it on her own, with no husband and no money.

The lucky ones have lawyers who spend years undoing the errors that led to their convictions.

But there is no way to undo the harm brought on by a state that took a woman in crisis, having arrived at a hospital hemorrhaging and in pain, having given birth alone, having lost a child, and treated her like a criminal.
It is tempting to say these cases will not arise in the U.S. Surely, our defense lawyers would protect the rights of wrongly accused, insisting that the state prove the woman’s guilt rather than being able to presume it.

But here, too, doctors can be suspicious of women who live on the margins of society, of those they meet only in the emergency rooms of public hospitals. The consequences of making abortion a crime includes a pattern we’ve already seen, in the context of prosecutions brought against pregnant women who use illegal drugs. Doctors in these cases have disproportionately singled out poor women, reporting them to police for behaviors that go almost completely unpunished in their wealthier counterparts.

Ban abortion, and, as we’ll see in Chapter 5, that pattern will intensify. The hospital will increasingly become a crime scene investigation, and poor women will be the suspects.

V. Conclusion

We saw, in the first chapter, how abortion opponents look to the law to reinforce their moral vision. In this chapter, we see the pragmatic limitations of the law.

The conceit of the law is that the moral stance and the practical consequences will move in one direction. Can we honestly say this is true about the abortion ban? At best, the results are ambiguous. It is a law whose only tangible benefit beyond its moral message is hypothetical: there must be some women whom the law deters, even if there aren’t enough to cause a rise in birth rates.

Are these hypothetical lives saved enough to offset the consequences we’ve seen in El Salvador?

I can’t make that calculus for you, but make no mistake: these consequences will follow us as we turn to the question of restricting abortions in the U.S.

We’ll be tempted to ignore them, because they play no part in our pitched battle over abortion law. But if we keep them in mind, they’ll permit us to see the shallow and misleading nature of our abortion war.

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ii Abortion being illegal, it is hard to get accurate information about the rates of abortion. The WHO bases its estimations on numbers of women hospitalized for abortion complications (where available) and information on the safety of abortion, as well as findings from surveys of women and studies using an indirect abortion estimation methodology from country where those were available. E-mail from Dr. Gilda Sedgh, Guttmacher Institute, to author (July 7, 2012) (on file with author). See article by Gilda Sedgh. [https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Sedgh-Lancet-2012-01.pdf](https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Sedgh-Lancet-2012-01.pdf)

iii It is difficult to calculate the precise number of clandestine abortions. A recent survey by the Ministry of Health reported 19,290 between 2005 and 2008; the Guttmacher Institute, a U.S.-based organization working on reproductive health issues around the world, estimates 35,000 a year in El Salvador. Cite to this article instead: [http://foreignpolicy.com/2017/01/03/on-the-front-lines-of-el-salvadors-underground-abortion-economy/?utm_source=Sailthru&utm_medium=email&utm_campaign=New+Campaign&utm_term=%2AEEditors+Picks](http://foreignpolicy.com/2017/01/03/on-the-front-lines-of-el-salvadors-underground-abortion-economy/?utm_source=Sailthru&utm_medium=email&utm_campaign=New+Campaign&utm_term=%2AEEditors+Picks).


For an equally rich history of abortion doctors in pre-Roe America, see: Carole E. Joffe, *Doctors of conscience: the struggle to provide abortion before and after Roe v. Wade*, (Boston: Beacon Press, 1995).

vi Tekoa King and Mary Brucker, “Pharmacology for Women’s Health,” *The Journal of Midwifery & Women’s Health*, 55: 394. doi:10.1016/j.jmwh.2010.05.005. Mifepristone blocks the hormone progesterone needed to maintain the pregnancy. Because this hormone is blocked, the uterine lining begins to shed, the cervix begins to soften, and bleeding may occur. With the later addition of the second medication, misoprostol, the uterus contracts and the pregnancy is usually expelled within six to eight hours.


The most widely available illegal abortion drug in Latin America is misoprostol (brand name is Cytotec), which is less effective than mifepristone (brand name is Mifepr). Ngoc, Nguyen Thi Nhu


[www.ilibrarian.net/navon/paper/Translated_from_Spanish.pdf?paperid=11414235](http://apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf)


See [http://www.who.int/bulletin/volumes/92/3/14](http://www.who.int/bulletin/volumes/92/3/14) (discussing the definition of “unsafe abortion,” in view of factors ranging from legal context to relative risks depending on access to trained health care providers and medical abortions).

According to the World Health Organization (WHO), Latin America and the Caribbean have the highest regional rate of unsafe abortions per capita in the world (31 per 1,000 women, aged 15 to 44) and see an estimated 4.2 million unsafe abortions every year.  
[http://apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf](http://apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf)

Alejandro Guidos, M.D. (President of El Salvador’s Association of Obstetricians and Gynecologists), in discussion with the author, June 2014.

[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751804/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751804/)


[https://www.einstein.yu.edu/uploadedFiles/EJBM/page41_page44.pdf](https://www.einstein.yu.edu/uploadedFiles/EJBM/page41_page44.pdf)

El Salvador’s Health Code 287 states that breaching [patient] confidentiality may result in oral reprimand, written reprimand, a fine, a five-year suspension or the loss of one’s medical license.

For U.S. law requiring doctors to maintain confidentiality, see *Health Insurance Portability and Accountability Act*, Pub. L. No. 104-191 (1996) (requiring health care providers and health plan to have policies and procedures concerning use and disclosure of protected health information).

Breach of Professional Confidentiality Sect. 187. - Revealing private information that has been obtained because of profession or trade, shall be punished with imprisonment for six months to two years and the disqualification of profession or occupation for one to two years.

See Republic of El Salvador. Criminal and procedural codes: prison law and its regulations. Editorial Jurídica Salvadoreña; 2001. Penal Code, Art 312: A functionary or public employee, agent of public authority who becomes aware of an unlawful act during the exercise of his or her responsibilities and does not report it within 24 hours will be levied a fine of between 50 and 100 days’ pay. The same punishment will be applied to the supervisor or manager of a hospital, health center or other public or private establishment that does not report admitting a patient who was injured in what could reasonably be considered a criminal act within 8 hours of seeking care.

they become aware of in the context of their professional relationship, unless the information they acquire is protected under the terms of professional secrecy. (translation; italics added).


xxiii As applied in homicide cases, the term “corpus delecti” has at least two component elements: the fact of death, and the criminal act or agency of another person as the cause thereof. 40 AM. JUR. 2D HOMICIDE § 4.

xxiv Dennis Munoz, in discussion with the author, March 2014.


xxvi Another study confirmed the disproportionate reporting patterns by doctors treating patients at public hospitals, and suggested three possible explanations: First, public health institutions are more likely to treat indigent women and adolescents who often resort to unsafe, low-cost, and readily detectable abortion methods (e.g., insertion of foreign objects). Second, private sector providers have an explicit profit motive to protect their individual patients’ privacy and avoid legal inconveniences. Finally, because public health care workers are subject to governmental oversight and are susceptible to shifting ministerial politics, they may be more fearful of reprisal if they do not comply with prevailing governmental ideology or policies susceptible to shifting ministerial politics, they may be more fearful of reprisal if they do not comply with prevailing governmental ideology or policies. McNaughton, “Patient Privacy and Conflicting Legal and Ethical Obligations in El Salvador: Reporting of Unlawful Abortions.”

xxvii Because of the sensitive nature of the subject, I’ve used pseudonyms rather than the actual names of both doctors I interviewed.

xxviii Dra. Rosario (pseudonym), in discussion with the author, March 2014. Transcription and notes on file with author.

xxix Id.


xxxii See supra note 25 and accompanying text for a description of the labor-intensive empirical work undertaken by Angelica Rivas and Sarah Gross, who sought simply to identify cases in which abortion was prosecuted. Identifying medical witnesses would be more challenging still, as it would require the production of transcripts—a cost-prohibitive and tediously time-consuming endeavor.

xxxiii At his request, I have used a pseudonym rather than his real name.

xxxiv In order to protect his identity, I have not used the names of those involved in this prosecution.

xxxv This chronology of events is according to the defendant (interview with author on June 2, 2011). The trial record is less clear about the sequence of events, noting only that a police officer responded to a 911 call and found a dead baby under her bed. It is clear that Karina’s mother permitted the officer to enter her home; what’s unclear is whether she summoned the officer, or whether Dr. Diaz notified the police.

xxxv Id.

xxxvi http://www.jewishvirtuallibrary.org/el-salvador-virtual-jewish-history-tour#life


xxxvii Dr. Marvin Diaz, in El Salvador, May 23, 2012, in discussion with the author. In asserting that the defendant’s mother pressed charges against her daughter, Dr. Diaz made the common mistake of confusing civil and criminal charges. Even if her mother had found the baby and called the police, as opposed to simply permitting them to enter and search her apartment, in criminal actions it is the state that presses criminal charges.


46.5% of women arrested in abortion-related cases involved cases of advanced pregnancy, and resulted in charges of simple or aggravated homicide.


xlii See Rebecca G. Stephenson, Linda J. O’Connor, *Obstetric and Gynecologic Care in Physical Therapy*, (Slack Incorporated; 2 edition, January 1, 2000). “Precipitous labor occurs in 10% of all deliveries. This indicates completion of the first and second stages of labor in less than 1 hour. It occurs more in multiparas than in primigravidas. The infant is sometimes injured during this rapid, uncontrolled labor because of the force on the presenting part.... There is no known etiology for precipitous labor.” (at 248).

xliii Dr. Anne Lyerly Drapkin (Associate Professor of Social Medicine and Obstetrics and Gynecology, University of North Carolina) in telephonic discussion with the author on August 2, 2012.

xliv Dr. Anne Lyerly Drapkin (Associate Professor of Social Medicine and Obstetrics and Gynecology, University of North Carolina) in telephonic discussion with the author on August 2, 2012.

xlv See http://agrupacionciudana.org/en/resources/7-el-salvador-feminists-fight-for-justice

xlii Morena Herrera, in discussion with the author, June 2014.


xlviii The only women excluded were those whose cases were still on appeal, so their sentences were not yet final. Dennis Munoz, in discussion with the author, March 2014.


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livi Twenty–four percent of pregnancies occurred in women from 15 to 19 years old. The specific fertility rate of women from 15 to 19 years old was 89 per 1,000. Seven of 10 adolescents with sexual experience had a pregnancy, and 8.9% of this group had had a previous pregnancy. http://www.paho.org/salud-en-las-americanas.2012/index.php?option=com_content&view=article&id=36%3Ael-salvador&catid=21%3Acountry-chapters&Itemid=145&lang=en
liviii Dr. Carlos Mayora, in discussion with the author.
lix This is taken from the facts of Manuela’s case, which resulted in an appeal to the InterAmerican Court of Human Rights in Peru. She died in prison of cancer, which the prison doctors misdiagnosed and failed to treat. http://www.telegraph.co.uk/news/worldnews/centralamericaandthecaribbean/elsalvador/11412550/Ar-e-El-Salvadors-extreme-anti-abortion-laws-justified.html
lix See *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (holding that a urine test conducted by the hospital in conjunction with law enforcement absent the patient’s consent was a violation of the Fourth Amendment right to be free from unreasonable searches). The use of criminal sanctions in the public hospital setting disproportionately affects poor, minority women.