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Legislative Impact of the Construction of an “Abortion Culture”: A Comparative Analysis of the Enaction and Impact of Abortion Restriction Legislation in the Netherlands and the United States

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Legislative Impact of the Construction of an “Abortion Culture”:

A Comparative Analysis of the Enaction and Impact of Abortion Restriction

Legislation in the Netherlands and the United States

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Abstract

This study investigates the different socio-political causes leading to the implementation of similar abortion restrictions (mandatory parental notification for minors, mandatory counseling, and a waiting period) in the Netherlands and the United States. It first investigates the “abortion cultures” of the two countries, using personal interviews with Dutch and American citizens to analyze the social perceptions of abortion and a comparison of sexual health and legislation data to create a wider picture of abortion within both countries. It then investigates the political opportunity structure leading to the implementation of the restrictions of abortion in each country, and then investigates differences in implementation and effect of the restrictions in both countries. Ultimately, the study concludes that a distinction between prevention-based and punishment-based restriction is necessary in the “counseling model” of abortion.

Introduction

When I first introduced my idea for this topic to a group of Dutch host parents, their reaction was incredulous. Several of the host parents informed me that researching laws restricting abortion in the Netherlands would not be possible, because there were no laws restricting abortion in the Netherlands. Abortion, they told me, was simply not an issue in the Netherlands like it is in the United States. I found this reaction a bit concerning (what if they were right?), and also quite interesting (if they were wrong, what factors made them so adamant in their assertion that no restrictions existed?). Further research proved that restrictions to abortion do exist in the Netherlands. In fact, the legal restrictions placed on abortion in the Netherlands align it most closely with the 17 states in the United States with the most restrictive abortion laws in the country. The guiding research question for this project are: how have similar legal barriers to accessing abortion in the Netherlands and the United States occurred within vastly different socio-political environments surrounding abortion? How have the implementation and execution of these similar barriers both reflected and influenced the abortion culture in both countries? I argue that the unique social cultures surrounding abortion and sexual health, and political opportunity structures created by the channels through which the restrictions passed in each country resulted in two different models of abortion care, despite apparently similar restrictions.

I am defining “abortion culture” here as attitudes of Dutch and United States citizens surrounding abortion. I am evaluating attitudes based on three metrics: opinion on whether abortion should be widely available and accessible, knowledge of whether restrictions to

abortion exist within their country (Netherlands) or state (United States), and opinion on whether those restrictions would limit their ability to receive an abortion. I have also evaluated the “abortion cultures” of each country based on a variety of data metrics, described in detail within my analysis section.

I will be using “abortion restrictions”, “legal restrictions to abortion”, and “legal barriers to access abortion” interchangeably throughout this paper. I am defining these terms as legislation that creates barriers to access abortion care--in the form of additional time or money spent, additional people involved, or limitations on where and when abortion care can be accessed--that would not be present for an equivalently risky medical procedure.

Literature review

I will begin with a brief overview of existing literature on the subject of socio-political attitudes surrounding abortion in the Netherlands and the United States. These studies provide a groundwork for how data surrounding abortion in both countries has been collected and analyzed by other academics, and provide a good view into the format of my project. I will be providing an overview of “Legal Abortion Levels and Trends By Woman’s Age at Termination” by Gilda Sedgh, Akinrinola Bankole, Susheela Singh and Michelle Eilers; “Factors Influencing the Percentage of Second Trimester Abortions in the Netherlands” by Olga Loeber and Cecile Wijzen; “Sexual and reproductive health issues of Turkish immigrants to the Netherlands” by Olga Loeber; “Analyzing the Effect of Anti-Abortion State Legislation in the Post-*Casey* Era” by Michael J. New; and “The Relationship Between State Abortion Policies and Abortion Providers” by Marshall H. Medoff. Though by no means a comprehensive review of the subject,

I believe that these articles offer diverse insights into how several key aspects of the socio-political culture surround abortion in the Netherlands and the United States have been previously approached.

“Legal Abortion Levels and Trends By Woman’s Age at Termination” seeks to investigate recent trends in ages at which people have abortions in countries with liberal abortion law. The researchers found their data by compiling available information on abortion incidence and age of abortion, and supplementing that information with standardized questionnaires to state agencies and nationally representative surveys of women in each country analyzed. This data was then collected and cross-referenced with data on the population of women aged 15-44 from the United Nations Statistics Division *Demographic Yearbook*. These rates of abortion incidence by age were then standardized per country using a formula.

Because the researchers used multiple methods to acquire and confirm data (and also acknowledged potential gaps in the data, and excluded countries without sufficient data), I believe the information gathered is strong. The study creates a unique perspective on data that largely previously existed, but had not been comprehensively compiled on a global scale or cross-referenced in order to draw out the data showing age distribution of abortion. This allows for comparisons and trend analysis that would not otherwise be possible. For example, in the case of the Netherlands, the researchers noted that the rate of abortion among adolescents was among the lowest of countries surveyed. But interestingly, the data also shows that between the mid-1990s and late 2000s among those same countries, the Dutch adolescent abortion rate has increased the most steeply. I am following a similar model of data collation and comparison through this study, though focusing more heavily on legislation than demographics.

The second article I will review is “Factors Influencing the Percentage of Second Trimester Abortions in the Netherlands”. The study aims to answer why women delay their abortions until the second trimester, whether there are specific groups of women who are more likely to do so, and whether there are aspects of the abortion system that account for the delay (31). The researchers studied the medical files of people who had received second-trimester abortions from three different clinics and also used data from the Landelijke Abortus Registratie, which compiles data quarterly on all abortions in the Netherlands (31). This seems like a strong basis for analysis, especially given the ability to analyze data from medical records. Receiving data from medical records seems more likely than face-to-face interviews or surveys in preventing underreporting and faulty data. However, there are possible ethical issues inherent in accessing personal medical records, and it is difficult to tell what steps were taken by the researchers to ensure that they obtained consent from the patients whose records were used. The data shows higher incidences of second-trimester abortions in young women, women who travelled from abroad to receive the abortion, and Dutch immigrant populations. This follows the data from the first study discussed, and begins to create a visible trend of high incidences of abortion among young Dutch women. This helps to illustrate who is receiving abortions in the Netherlands, and who the restrictions in place seek to target.

The next study I will review is “Sexual and reproductive health issues of Turkish immigrants to the Netherlands”. Though I would have preferred to find three Dutch studies from three different groups of researchers, I am using two of Olga Loeber’s studies because they most closely related to my chosen topic. The study uses data on family planning from the Dutch Central Bureau of Statistics and the Turkey Demographic and Health Survey. Loeber also writes

in her methods section that “Values and opinions of Turkish immigrant men and women and those of their Dutch peers are reviewed. The differences between both groups and the way they have evolved over the years is analyzed,” (332). I found this second portion of the methods section to be extremely unclear, and I feel the study is weakened as result of a lack of explanation of how these values and opinions were obtained, how large the sample group was, what demographics were represented, and what questions were asked.

This questionable data collection process extends to the analysis. When analyzing the data from a survey of Dutch and Turkish young people, Loeber also places her own value judgements on the responses received. She writes that “In some respects, Turkish women are even more emancipated than the Dutch in their opinions about combining work and caring for young children,” (335). She offers no definition of “emancipated” within this context, and implies that the Dutch are the natural standard for this form of emancipation through her use of “even more”--as if shocked that non-Western European immigrants could obtain this form of “emancipation”. I believe this study will be useful for me as a compilation of data regarding Turkish sexual and reproductive health, but I will not be using Loeber’s analysis or discussion in my project. Further, following analysis of this study, I sought to thoroughly define all terms used throughout my project, especially those with potentially subjective or varied meanings. I have also outlined my own background and assumptions within the methods section in order to provide insight my own potential biases.

While the studies from the Dutch perspective provide a format for collecting a presenting my own data, they do not specifically focus on the impact of abortion legislation in the Netherlands. I did not find empirical studies on the influence of mandatory counseling, the

waiting period, and mandatory parental notification on abortion rates and access in the Netherlands. I see this as a gap in the literature, and hope that my study will provide some insight into how these barriers influence the culture and experience of abortion in the Netherlands. There is a body of research, however, on the impact of state anti-abortion legislation in the United States, and the two studies I will discuss are representative of this work.

In “Analyzing the Effects of Anti-Abortion Legislation in the Post-*Casey* Era”, Michael New looks at how Medicaid funding, informed consent laws, and parental notification laws have impacted the abortion rate in states in which they have been implemented. The “post-Casey” era refers to the period of time following the Supreme Court ruling in 1992 that abortion laws do not need to follow a previous standard dictated by trimesters, but instead must not place an “undue burden” on the patient (30). This ruling has resulted in the growing prevalence of informed consent laws and parental notification laws in the United States (31). New uses several regression models to map the effect of these pieces of legislation, and concludes that Medicaid funding and informed consent laws result in a statistically significant decline in the total abortion rate, and parental notification laws result in a decline in the abortion rate among minors (42). He concludes that this could be the result of women carrying their pregnancies to term, having abortions out of state, or having illegal or unreported abortions (43). This study provides a strong statistical basis explaining the result of anti-abortion restrictions in the United States, but it lacks the subsequent analysis of why the result (lowered abortion rate) occurs.

While New looked at the impact of anti-abortion legislation on the total abortion rate in those states, in “The Relationship Between State Abortion Policies and Abortion Providers” Marshall Madoff investigates whether restrictive abortion policies affect the total number of

abortion providers in a state. His study concludes that prohibiting Medicaid funding for abortion, requiring parental involvement for minors, and requiring abortion providers to pay an annual licensing fee each have a significant impact on the number of abortion providers in a state (236). Madoff concludes that this shrinking number of abortion providers as a result of these pieces of legislation represents an “undue burden” placed on women, and should therefore be ruled unconstitutional under *Planned Parenthood v. Casey*. This study in combination with New’s provides a more complete picture of the impact of anti-abortion legislation in the United States. New’s study is controlled for race, age, pregnancy rates and stability of the economy, thus hopefully ensuring that the pieces of legislation are the only variables. New and Madoff’s study are based solely in the context of the United States, and so I believe that analyzing why these restrictions have created an undue burden on women in the U.S. but have not been seen to create a similar burden in the Netherlands will create a new lens through which to view the socio-political culture of abortion in both the Netherlands and the United States.

These studies represent a wide spectrum of abortion research in both the United States and the Netherlands. My goal was to use their research in my analysis below as a jumping-off point in looking at how and why similar abortion restrictions have occurred within vastly different socio-political abortion cultures. I used methods similar to Sedgh, Bankole, Singh and Eilers’ study as well as Loeber and Wijzen’s research. I have also aimed to create an intersectional analysis of the varying impact these pieces of legislation have given the different racial and socio-economic compositions of the United States and the Netherlands, as is discussed in Loeber’s research on Turkish immigrants to the Netherlands. My research analyzes the factors studied by New and Madoff within a Dutch-American comparative context.

Theoretical Framework

My theoretical framework has two basic components. First, I discuss feminist analyses of the right to abortion, using Margaret Little's work on bodily autonomy as a guide. Next, I discuss the legal and political frameworks governing the right to abortion in both the Netherlands and the United States, working from Sjef Gevers' analysis of the counseling model in the Netherlands in "Abortion Legislation and the Future of the 'Counseling Model'", and the theory of matrices of domination popularized by Patricia Hill-Collins.

Abortion is loaded with social conceptions of morality and ethics. An understanding of how abortion has been situated within this context of morality is helpful to understanding various state's attempts to codify these morals into law. The laws that I am focusing on throughout this project complicate a woman's ability to make a decision regarding abortion that is completely her own: minors are subject to parental notification, and all women are subject to counseling and an extended period of decision-making time.

In "Abortion, Intimacy, and the Duty to Gestate", Little argues that the abortion debate has been in a way that does not do justice to the intimacy and physical experience of gestation. Little argues that both "pro-choice" and "pro-life" arguments have agreed that if a fetus is a person, then the obvious implication is that its life must be protected (298). But Little writes that even if the fetus is indeed a person, its personhood should not necessarily be seen as mandating protection. After all, non-fetus humans within our society do not have a universal claim to a right to life in all circumstances, and there are circumstances (self defense) in which killing another human is justified within the United States justice system. Little argues that the right to life does

not extend to the right to occupy another person's body. She further argues that engaging in consensual sex does not amount to consenting to gestation, and so abortion must be legal regardless of whether the fetus is recognized as a person (303). This argument hinges on the idea that women have a right to bodily autonomy, and being forced to carry a pregnancy to term, or erecting barriers that impinge on the ability to obtain an abortion, denies that right. The Dutch and American abortion law hinges not on the right to bodily autonomy, but rather on the right to privacy in the United States and a lack of any other options in the Netherlands. I argue that framing the right to abortion under these terms rather than the bodily autonomy argument creates two different models that are both receptive to additional impositions by the state.

Sjef Gevers situates the Netherlands within Albin Eser and Hans-Georg Koch's three abortion models. They are:

1. Indication model on the basis of third party review: The aim is to protect the life of the fetus. This results in a narrow set of acceptable reasons to abortion, primarily medical (protection of the life of the mother) rather than social (rape, incest) (29).
2. Time limitation model: The woman has full rights to decide independently whether to abort, at least within a certain time period of her pregnancy. Third parties are not involved in the decision-making process (30).
3. Counseling model/emergency-oriented discourse model: Abortion is seen as an emergency recourse given no other viable options. It leaves the final decision of whether to abort with the mother, but requires some counseling or consultation with the physician (30).

Gevers writes that the Netherlands falls into the third model, but argues that the continuing

process of individualisation will make this model a relic if it does not adapt to prioritize careful decision making rather than imposing unnecessary requirements (38). I use this concept of models of abortion legislation in my analysis in order to create a new model for the United States' abortion culture.

I am using Patricia Hill-Collins' theory of matrices of domination to analyze the systems that create and sustain these models of abortion and legal restrictions. The idea of matrices of domination is closely linked to the theory of intersectional forms of oppression. Because oppression can be experienced in multiple forms from various systems, so, too, can power be applied from multiple levels along different systems. Collins writes that power can be applied and experienced on a personal, cultural, and social level, and that all three of these forms are ways in which oppression is made concrete (Collins 6). Matrices of domination operate on a personal level through individual cases of domestic abuse or sexual assault, as well as the individual internalization of misogyny, racism, homophobia, or any other oppressive force. On a cultural level, Collins explains that "dominant groups aim to replace subjugated knowledge with their own specialized thought because they realize that gaining control over this dimension of subordinate groups' lives simplifies control" (8). Finally, the social level of domination is exemplified by social institutions such as schools, universities, the media, and other sites of control headed by the state or the dominant cultural force. Collins argues that these places have historically advanced hegemonic narratives as a mode of subjugation and control. Government and the health care industry are two forms of social domination. In the case of abortion, they work together to exert control over female bodies. Because social structures cannot be extricated from their societies, they can be expected to reproduce patriarchal modes

of thought. I argue in the analysis that this is one explanation for the similarity of the laws restricting abortion in the Netherlands and the United States.

These theories intersect to form a useful, practical lens through which to investigate how and why identical laws restricting abortion have occurred in different social and political contexts.

Overview of abortion legislation

There are a variety of lens with which one could investigate the culture of abortion in any nation. For the purpose of the comparative nature of this project, and due to its specific focus on the intersection between the health insurance system and the legislative framework, I will be investigating three aspects of the abortion system of the Netherlands and the United States in depth. Those three aspects are parental notification laws for young people, mandatory wait periods, and mandatory counseling requirements. I will be using a theoretical framework detailed in the following section to evaluate how these three elements have helped both countries to create distinct socio-political cultures surrounding abortion. Here, I will briefly explain the current and historical statuses of all three legal elements in the Netherlands and in the United States, beginning with the Netherlands.

The Netherlands

Abortion was legalized in the Netherlands in 1981, following several unsuccessful attempts at legalization in the 1970s (United Nations 2). However, even prior to 1981, abortion was widely available through non-profit clinics and several hospitals (2). The law formally went into effect in 1984, making the provision of abortion legal within licensed hospitals and clinics.

The law outlines several provisions and restrictions regarding abortion care, as well as granting abortions their own specific medical status. The Dutch Ministry of Health, Welfare, and Sport writes in its abortion Q&A that “Abortion is not seen as a routine medical procedure but as a procedure to which a woman is entitled if her circumstances leave her no other alternative,” (Ministry 3). Abortion is not afforded the same legal status as any other routine surgical practice, and as such, the process surrounding the procedure is more complex. Dutch abortion law dictates that a person seeking abortion care must undergo mandatory counseling with the physician who will perform the abortion (United Nations 2). Following the counseling, the patient must wait six days before the abortion can be performed. Parental notification is mandatory for anyone under 16 years old or younger seeking an abortion. Additionally, the site providing the abortion must be licensed to perform abortions (2).

Abortion care is completely covered for Dutch citizens under the national health insurance system. The Dutch system mandates that all citizens must be insured, and all citizens over age 18 must pay a flat rate for a standardized package of treatment provided through private insurers (“Health” 1). The private insurers cannot refuse to insure anyone based on age or history of illness. Abortion is not covered under the standard package of treatments, but is instead fully covered under the Exceptional Medical Expenses act, which covers treatment of non-standard medical issues, such as nursing, personal care, or residence in an institution (“Exceptional” 1). Abortion care must be paid for out-of-pocket for undocumented immigrants or people living abroad (1).

The United States

In the United States, the laws governing abortion become more varied. The population

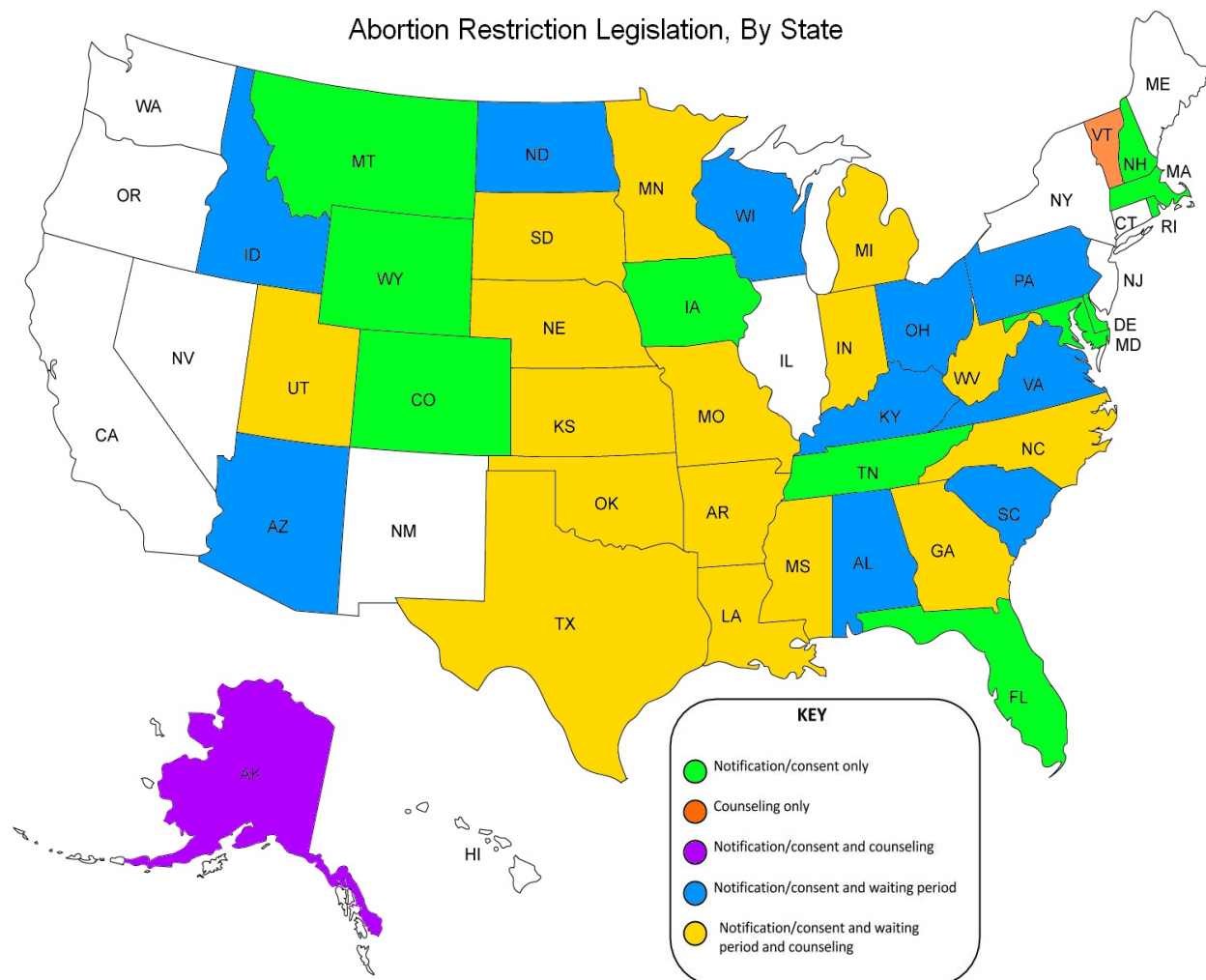
Netherlands of the Netherlands is slightly over 16.5 million people, according to World Bank. To put that in perspective, the population of the state of California is over two times that number. Due to the unique regulations from state to state, there are few laws that hold true for the entire country. However, the legal status of abortion, as dictated by the Supreme Court, covers the entirety of the United States. Beyond that, laws governing parental notification, mandated wait periods, and licensing requirements vary from state to state. I chose to focus on these three barriers to access because they are relatively common legal restrictions.

The United States legalized abortion in 1973, with the *Roe v. Wade* ruling dictating that the right to abortion was constitutionally protected under the right to privacy. Following *Roe v. Wade*, the ruling was modified through the 1992 case of *Planned Parenthood v. Casey*. The court ruled that abortion restrictions from state to state must hold up to an evaluation of whether they impose an “undue burden” on the woman seeking the abortion. Prior to that ruling, abortion restrictions were governed by rules for each trimester.

In the U.S., 38 states require some form of parental involvement if a minor decides to have an abortion (Guttmacher 1). Twenty-two states require one or both parents’ consent, 12 states require one or both parents to be notified, and four states require both notification and consent (1). For a graphic breakdown of each state, see figure 1. Mandatory waiting periods are enforced in 26 states. All but nine of those states have 24-hour wait periods. Seventeen states require the woman to receive counseling before an abortion. In five states, the counseling must include information on the purported link between abortion and breast cancer; in 12 states there must be information on the fetus’s ability to feel pain; in eight states the counseling is required to include information on long-term mental health consequences of abortion (1). All of the 17 states

in which counseling is mandatory also require a mandatory wait period and parental notification or consent. These 17 states (Arkansas, Georgia, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Dakota, Texas, Utah) form the group with abortion restrictions equivalent to those present in the entirety of the Netherlands, and thus will be the focus of this comparison.

Figure 1



Methodology and Assumptions

I used three types of sources to form my overview and analysis for this project. The first was gathering data from statistical surveys and primary sources, as well as reading through academic analyses of the abortion culture in the United States and the Netherlands. The second source was conducting interviews with Dutch residents and residents of two of the 17 states about their perceptions of the abortion culture within their communities. The third source was interviews with an abortion expert in the United States and in the Netherlands.

Because I am interested in the root causes of legislation passed in the Netherlands and the United States, the bulk of my research consisted of analysis of primary sources. I used resources created by the Dutch and U.S. governments, as well as research by the United Nations, World Fact Book, and the Guttmacher Institute. I also used data collected from prior studies on abortion laws in the Netherlands and the United States. I am synthesizing and comparing that data here in a way that, to my knowledge, has not previously been done. This synthesis creates a new lens to analyze both Dutch and U.S. abortion legislation. Comparing the two nations allows their similarities to reveal how the differences in their culture and framing have shaped the perceived and actual effect of the legislation in both countries.

I interviewed two Dutch and two American citizens in order to gain a greater understanding of the knowledge and perception of laws surrounding abortion, as well as their perceptions of the social culture surrounding abortion in their communities. The Dutch citizens interviewed were two men and one woman. All three currently live in Amsterdam. The American citizens were both women, one of whom lives in North Carolina, and the other lives in Texas.

The questions I asked during these interviews are included in the appendix. I asked the same set of questions to the non-expert Dutch and American citizens who I interviewed. I found these interviewees through personal contacts.

I used interviews with experts in abortion law in the Netherlands and the United States to fill in the gaps of my understanding from my research, and especially to help formulate an understanding of the Dutch abortion culture. I interviewed Professor Joyce Outshoorn, a professor of Women's Studies at the University of Leiden, whose thesis focused on the abortion debate in the Netherlands. I also interviewed Alison Griffin, who is the Public Affairs Manager at Planned Parenthood Minnesota. I tailored the questions for the expert interviews to the specialities of the interview subject. I know Ms. Griffin through my own work at Planned Parenthood, and met Professor Outshoorn through her lecture to the SIT program.

This combination of primary documents, data analysis, and interviews creates a picture of the United States' and the Netherlands' political, actual, and perceived relationship to abortion legislation. I believe it creates a sufficient depiction of the abortion culture and messaging in both countries, and I feel comfortable drawing conclusions from that information set. However, there are clear limitations to the extent to how complete this picture can be. A more thorough and complete analysis could be achieved through a much larger and more diverse sample of Dutch and American citizens in order to gain a more complete understanding of their knowledge of abortion laws and perceptions of the culture surrounding abortion in their communities. The time commitment necessary to conduct such a survey was outside the scope of this study.

I did to limit my prior assumptions and to create unbiased, nonleading survey questions. However, I personally identify as pro-choice, and have worked for Planned Parenthood for the

past four years. That is reflected in my interview subjects, and may be reflected in my analysis to a lesser extent. Additionally, I do not speak Dutch, so I was limited to English language sources. This was not an issue for my analysis of the United States, but it limited my available pool of resources when looking for analyses of the Dutch abortion system.

Comparison and Analysis

The central questions that I will answer through this analysis are the following: What socio-political cultural distinctions in each country have shaped the political opportunity structure for these pieces of legislation? How did identical legislation to restrict abortion in the Netherlands and the United States emerge from such different socio-political cultures surrounding abortion? What differences have emerged in the enactment of the legislation, and why? I will argue that almost identical restrictions—but within extremely different socio-political cultures, and with different results—occurred for two reasons: (1) because of the different political channels through which abortion was legalized in each country, and (2) because the social and political motivations for the restrictions in each country have led to distinct methods of implementation. Finally, I will argue that, based on this evidence, Eser and Koch's counseling model must make a distinction between prevention-based and punishment-based models.

1. Socio-political culture analysis

First, I will examine my root assertion that the socio-political cultures in the Netherlands and the United States are distinct by analyzing the interviews I conducted with Dutch and

American citizens. I will then supplement the information from those interviews with an analysis of the socio-political abortion culture in both countries. The analysis of the “abortion culture” looks at accessibility of birth control, rate of unintended pregnancy, accessibility and affordability of abortion care, social acceptance of abortion, and significant legislation introduced to limit abortion accessibility since 2008 as indicators of the social and political pressures influencing attitudes and legislation around abortion in the past five years.

1. (a) Interviews

I conducted interviews with four people, two Dutch and two American. All are current college students. Of the Dutch students, one, Joerie, is male, and the other, Marie, is female. Joerie lives in a small town in North Holland, and Marie lives in a large city. Both American students are female. Amelia lives in Texas, and Brittany lives in North Carolina. These four students’ views should not be seen as representative of their countries, but rather as a sample of attitudes and opinions surrounding abortion in their communities.

I asked all participants to describe the culture surrounding abortion in their communities. Marie explained that “abortion is not something to look down upon and--while preferably avoided--is a good solution to having an unwanted child.” Joerie responded that “in my social bubble, mostly right-wing political people, abortion is not frowned upon at all. We are actually quite proud of the decision of almost all of our political parties, which is the allowance of abortion of course.” When compared to responses from the American students, a sharp contrast is drawn. Amelia responded “Generally, I’ve been surprised to find another person born and raised in Texas who is pro-choice, and I’ve never met someone open about the fact that they had an abortion, because it would be asking for trouble,” and Brittany answered “...there definitely is the

social stigma of questioning the motives behind getting an abortion.”

With regards to the political culture around abortion, responses fell along similar lines. The American students described an ongoing debate around abortion, whereas for the Dutch students, the debate was regarded as closed. Marie responded “As far as I know, political debates in the Netherlands about abortion are almost non-existent.” Brittany detailed current abortion restriction legislation that has already passed in North Carolina, as well as a bill currently in debate that would expand the grounds for which abortion providers could be sued. When asked what she saw as the purpose behind that legislation, she answered bluntly: “To stop women from having abortions.” Marie’s answer to the same question was markedly different: “I think their intended purpose is to make sure the woman is safe and sane, and supports her decision.”

When asked to rate how friendly their country is towards abortion on a scale of one to ten (with a one defined as abortion is illegal, highly inaccessible, and heavily socially stigmatized, and a ten defined as abortion is legal, easily accessible, there is little to no social stigma) both American interviewees rated the United States as a two or a three. Marie gave the Netherlands a nine, and Joerie gave it a ten. Though the number of people interviewed was limited, these interviews showed a clear distinction in popular perception of the abortion culture in the Netherlands and the United States.

1. (b) Data analysis

This anecdotal evidence matches the data available for both countries. My overview of a Dutch “abortion culture” will look at political and social factors surrounding abortion and sexual health care in the Netherlands. These factors are: accessibility of birth control, rate of unintended pregnancy, accessibility and affordability of abortion care, social acceptance of abortion, and

significant legislation introduced to limit abortion accessibility since 2008. I am choosing to look at birth control accessibility in addition to abortion related laws because accessibility of birth control affects the rate of unintended pregnancy, which in turn affects the abortion rate (“Fact on Unintended” 2). This can be seen in both the case of the United States, using women who qualify for Title X funding as the sample, and in the Netherlands, where birth control has previously been fully funded by using undocumented women (for whom birth control is not covered) as the sample (Schoevers 259). Accessibility of pre or post natal care has not been proven to influence abortion rates, so I am not analyzing it as a factor here (Bitler 1).

As of 2010, birth control for women over age 21 is no longer covered under the mandatory health insurance package for all Dutch citizens (“Birth Control” 1). This means that Dutch people seeking contraception must either pay out of pocket, or pay an additional amount to a private insurer in order to have it provided. The cost for a month of the popular oral contraception Yasmin is €9.31 in the Netherlands (Medicijnkosten 1). This change in coverage is due not to a lack of political support for funding birth control (as it remains funded for teens), but instead due to the Dutch health care system running €1.4 billion over budget (1). The same round of equal-opportunity cuts also affected dental care for young people and walking aids for the elderly. But despite the rationale for the cuts, the effect remains that women over 21 must pay for birth control out of pocket, which creates an additional barrier to access of birth control, especially for low-income women. Birth control is available over-the-counter at pharmacies with a prescription from a general practitioner (“Contraception” 1).

The Netherlands has a total birth rate of 10.85 births per 1,000 people, ranking them 176th in the world (“Birth Rate” 1). The Dutch abortion rate is 9 per 1,000 people as of 2009

(“Annual number” 1). Specific statistics on the rate of unintended pregnancies do not appear to be available. Statistics are not yet available from more recent years, so it remains unclear how out-of-pocket payment for birth control may affect the birth or abortion rate.

As I wrote above, abortion is fully covered under General Exceptional Medical Expenses Act (AWBZ). The AWBZ is paid automatically through the tax system, and is thus compulsory for all citizens. However, though the payment system is different from the standard insurance package, the treatment is provided by the insurance company chosen by the Dutch citizen (“AWBZ” 1). Abortion is covered by the publicly funded AWBZ, but those funds are funneled through the private insurance companies in order to provide the funding to the hospital or clinic for the necessary care. Almost all Dutch citizens have health insurance--as of 2009, less than two percent of the total population was uninsured (“Number” 1). Dutch citizens who are unable to pay the flat fee for insurance can be granted an insurance allowance, dependant on their income, which makes the mandatory insurance policy accessible for almost all Dutch citizens (“Health Insurance” 48). Abortion care is provided at licensed hospitals or clinics in the Netherlands. There are 14 clinics and 94 hospitals licensed to perform abortions available to service a female-bodied population of roughly 8.4 million (“Population” 1).

The most recent comprehensive study of public opinion regarding abortion comes from 2005. The study polled a representative sample of 1,000 residents each of ten different European nations on a variety of social issues, including abortion (Finchelstein 1). Respondents were asked to answer whether a statement was very much, a little, not really, or not at all in line with their beliefs. The statement regarding abortion was “If a woman doesn’t want children, she should be able to have an abortion,” (13). Fifty-nine percent of those polled responded positively, and 37

percent responded negatively. Among countries polled overall, more positive responses correlated with high levels of income and education, an age younger than 65, and left-of-center political identification (14). A 1995 study by Bernadette Hayes further indicates that abortion attitudes correlate with religious identification in the Netherlands. Forty percent of Catholics and 54 percent of Protestants polled identified as anti-abortion, as compared to 25 percent of those polled who did not identify with any religion (Hayes 186). Taken together, these studies indicate that the most receptive audience towards abortion in the Netherlands is younger, more highly educated, more wealthy, more liberal, and less religious. But even when looking at the total population, close to two-thirds of the Dutch support legal access to abortion.

Politically, attempts to further limit access to abortion in recent years have been met with mixed success. Changes to the Pregnancy Termination Act in 2009 did increase limits on abortion access, but changes were made directly to the act by the then-Secretary of Health Jet Bussemaker and the cabinet, rather than by Parliament (“Abortion boat” 1). The changes limited the distribution of the abortion pill solely to specially approved clinics, whereas previously the government did not regulate pregnancies under six weeks (Haenen 1). Bussemaker argued that, in practice, this change had little practical effect on Dutch women’s ability to access the abortion pill. Instead, coverage and response to the change focused primarily on its effect on Women on Waves, a Dutch non-profit that had previously provided the abortion pill on international waters by sailing a boat to countries where abortion was not legal (Ellis-Kahana 2). This, in tandem with the 2010 moratorium on public funding for contraception, can be seen as limits to access to sexual health care by the federal government. However, both cases were defended by the government as practical, rather than moral decisions, and the current coalition government

supports access to abortion up to 24 weeks, as is currently permissible by law (“VVD: Abortus”). Internationally, the Dutch government has been a strong advocate for liberal sexual and reproductive laws globally, as can be seen by the Dutch delegation’s hand in writing the Call to Action for Access for All at the Access for All: Supplying a New Decade for Reproductive Health conference in 2011 (“Netherlands lobbies”).

The Christian Union (ChristenUnie) and the Political Reformed Party (SGP) are the only Dutch parties currently actively attempting to advance legislation to limit abortion due to a moral stance on abortion. Both parties are founded on a platform of Christian morals, though the SGP takes a more conservative stance than the ChristenUnie. ChristenUnie currently holds five out of 150 total seats in the House of Representatives, and two out of 75 seats in the Senate. SGP holds three seats in the House, and one in the Senate. In April of 2011, both parties introduced an unsuccessful piece of legislation to lower the 24 week limit on abortion in the Netherlands (“No change”). Though both groups would support criminalization of abortion in the Netherlands, their current minority roles prevent them from affecting significant change.

I will be using the same factors to assess the abortion culture in the United States as I used for the Netherlands. Again, these factors are: accessibility of birth control, rate of unintended pregnancy, accessibility and affordability of abortion care, social acceptance of abortion, and significant legislation introduced to limit abortion accessibility since 2008. Because the law regarding abortion varies from state to state, I will be focusing on the 17 states discussed above, while also providing a image of the United States’ abortion culture as a whole.

Birth control played a major role in debate of the health care reform ushered in by the passage of the Affordable Care Act in 2010. The sweeping reform act included a mandate that

insurers cover contraception (Pear 1). Because insurance is commonly provided through employers in the United States, the Catholic church and religiously affiliated schools and hospitals protested the requirement that they provide contraception to their employees (1). This protest led to a series of compromises and accommodations. As of February 2013, the Obama administration issued a compromise allowing religiously affiliated employers to opt out of providing contraception coverage. Instead, the private insurance companies providing the coverage would be required to provide a separate plan for the female employees affected. The plan would cover contraception for free, with the insurance company bearing the cost (1).

That is the current status of birth control coverage in the United States--free contraception for insured women, whether paid for by private insurers or employers. However, as of 2011, 15.7 percent of Americans do not have health insurance (Todd 2). A key component of the Affordable Care Act is the mandate that all Americans must have health insurance, but the mandate does not go into effect until 2014 (Sahadi 1). Even when it does go into effect, the penalty for not having insurance will never rise above 2.5 percent of a family's annual income, likely ensuring that some people will choose to continue to be uninsured (1). Undocumented immigrants can buy private insurance, but buying personal private insurance is currently the most expensive way to purchase health insurance. Most undocumented immigrants are not eligible for state-funded health care plans such as Medicaid or CHIP, though the state does reimburse hospitals for emergency care for undocumented immigrants (Galewitz 1). However, birth control would not fall under the umbrella of emergency care, leaving undocumented immigrants and uninsured citizens out of the free contraception mandate. For those women, purchasing birth control costs between \$15-50 per month, depending on the brand ("Birth Control" 1).

As of 2006, 49 percent of the 6.9 million pregnancies in the United States were unintentional (“Facts on Unintended” 1). Rates of unintended pregnancy were highest among poor and low-income women, women ages 18-24, and minority women (1). The abortion rate in the U.S. as of 2008 was 20 per 1,000 people (1). The estimated total birth rate as of 2013 is 13.66 per 1,000 people (“United States” 1).

Due to the Hyde Amendment, abortion care is not publicly funded by the U.S. federal government, except in the case of rape, incest, or life endangerment (“State Funding” 1). This manifests primarily through a lack of federal funding for abortions through Medicaid. Thirty-two states follow the federal government’s standard and fund abortion only in those exceptional cases (1). Seventeen states provide funding for all or most medically necessary abortions, either voluntarily or due to a court order (1). With regard to private insurance coverage, eight states have laws in effect banning or restricting private insurance companies from covering abortion except in the case of life endangerment (as well as cases of rape, incest, fetal impairment, or substantial body impairment for one state) (1). Seven of these states require women to purchase an additional abortion rider and pay an additional premium for abortion coverage. Eighteen states restrict abortion coverage for public employees to life endangerment (seven states), or life endangerment plus threat to women’s health, rape, incest, or fetal abnormalities (9 states). Two states prohibit any abortion coverage (1).

An additional upcoming effect of the Affordable Care Act will be the creation of a mandatory state exchange system offering comparative information on private health insurance policies (“Health Reform” 1). This will go into effect in 2014. States are permitted to ban abortion coverage in plans offered through the exchange. If abortion is covered, the policyholder

must pay a separate premium for the coverage (1). Seventeen states have already enacted legislation to restrict abortion coverage in the exchange (1).

Abortion can be covered under private insurance for women who do not live in any of the states, or work in any of the sectors where abortion funding is restricted in these ways. Private insurance including abortion coverage can be either purchased independently, or covered through the employer of the policyholder. For women who need to purchase a separate abortion rider, costs can average around \$80 per year just for abortion coverage (Hegeman 1). But for women forced to pay for abortion care out of pocket, the cost is significantly higher. Abortion care can cost between \$300 and \$950 in the first trimester at Planned Parenthood, the largest provider of abortions in the country (“In-clinic” 1). Although abortion is technically legal in the United States, significant legal and financial barriers prevent ease of access to abortion care for many women. For a visual representation of these abortion restrictions on the 17 states I will be focusing on, see table 4.

According to a 2012 Gallup poll, 52 percent of Americans believe abortion should be legal only under certain circumstances, 28 percent believe it should be legal under all circumstances, and eighteen percent believe it should be illegal in all circumstances (“Abortion” 1). Mormons and white evangelical Protestants are the religious groups with the strongest sentiments against abortion, with 64 and 63 percent responding that abortion should be illegal in all or most cases (“Public Opinion” 2). Jewish and non-religious respondents voiced the strongest support for the abortion remaining legal in all or most cases (2). Most Democrats (66%) and most independents (55%) polled believe abortion should be legal in all or most cases, and most Republicans (58%) believe abortion should be illegal in all or most cases (4). Less than

half of Americans polled who were 65 years old or older believed abortion should be legal in all or most cases, a statistic which reverses for polled Americans under 65 (5). Over half of those polled who had completed or attended college believed abortion should be legal in all or most cases (6). To summarize, the factors found most likely to indicate support of abortion's legal status in all or most cases are: Jewish or non-religious identification, liberal political beliefs, being under age 65, and college education.

The Republican Party, one of two major U.S. political parties, has included the desire to institute a constitutional ban on abortion with no exceptions in its party platform in 2004, 2008, and 2012 (Allen 1). The year 2011 saw a dramatic uptick in the proposal and passage of anti-abortion legislation as compared to 2010 and 2009 (Benson 1). In 2011 alone, legislators in all 50 states introduced 1,000 provisions related to reproductive rights, 135 of which became law (1). Ninety-two of those 135 provisions restrict abortion. This wave of both attempted and successful abortion restrictions coincided with two massive national battles regarding abortion in 2010 and 2011. Abortion coverage played a key role in the passage of health care reform in 2010, as key swing Democrats--Representative Bart Stupak and Senator Ben Nelson--used the necessity of their votes to attempt to limit abortion coverage in the health insurance exchanges. After a series of prolonged negotiations stalling the passage of the bill, the end result was a system in which women seeking health insurance in the exchange including abortion coverage beyond cases of rape, incest, or life endangerment must purchase separate abortion riders with separate premiums (Cohen 1). In 2011, the federal government neared shutdown due to an inability to come to a timely agreement on the federal budget. Federal funding for Planned Parenthood played a significant role in Republicans' refusal to pass the budget deal.

Conservative lawmakers claimed that federal funding for Planned Parenthood through Title X (a fund providing, among other services, state money for family planning) and Medicaid was indirect support for abortion services, despite the fact that the Hyde Amendment prevents federal money from supporting abortion (Dwyer 1). Federal shutdown was avoided less than an hour before it was set to begin when Republicans agreed to drop their demand to defund Planned Parenthood in exchange for Democrats agreeing to greater cuts to other federal services (Kane 1).

For comparative purposes, I have synthesized this information into the chart below.

	Netherlands	United States
<i>Accessibility of birth control</i>	Not covered under health insurance. One month of pills costs approximately €9.31 (\$12.09)	Covered under health insurance. One month of pills costs \$15-50 (€11.50-38.51)
<i>Total abortion rate</i>	9 per 1,000	20 per 1,000
<i>Accessibility/affordability of abortion care</i>	Fully covered under mandatory health insurance. Less than 2% of the total population is uninsured.	Not universally covered, even through private insurance. Many plans require buying a separate "abortion rider" with a premium around \$80/year. Costs \$300-950 out of pocket.
<i>Social acceptance of abortion</i>	59% polled agree "If a woman doesn't want children, she should be able to have an abortion", 37% disagree	28% polled believe abortion should be legal under all circumstances, 52% agree only under certain circumstances, 18% believe abortion should be illegal.
<i>Significant legislation to limit abortion</i>	Limited to fringe parties, largely unsuccessful.	Two major federal debates. 92 provisions restricting abortion on a state level passed in 2011 alone.

Overall, the US abortion rate is over double that of the Netherlands, despite lower levels of social acceptance, higher likelihood of significant expense, and a vastly greater level of political debate. The higher rate of abortion in the US despite lower levels of accessibility imply that other factors (possibilities include comprehensive sex education, family attitudes regarding

contraception, contraceptive use rate) are more likely to reduce the abortion rate than imposing greater barriers to access. Further, it indicates that these restrictions are more indicative of the creation of hostile socio-political culture surrounding abortion in the United States than of a desire to address the causes of abortion.

2. Cause and implementation analysis

I will begin by discussing the political causes leading to the implementation of the restrictions in the Dutch and American case, and follow with an analysis of the implementation and practical effect of the restrictions.

2. (a) Political causes of implementation

As discussed above, abortion was legalized in the United States through the Supreme Court's *Roe v. Wade* decision, whereas it was legalized through a piece of federal legislation in the Netherlands. These different channels of implementation have created different possibilities for ongoing attempts to limit access to abortions through increasing restrictions. However, the creation of the restrictions in both countries was possible due both to a framing of abortion as a right to privacy or emergency recourse rather than a right to bodily autonomy.

Roe v. Wade, and especially the subsequent *Planned Parenthood v. Casey* decision, allowed states to create their own laws governing to what extent abortion would be restricted. *Roe v. Wade* legalized abortion as a right to privacy issue rather than a right to bodily autonomy. This framework for legalizing abortion has created an effective channel for increasingly limiting access to abortion: passing legislation to limit access in states where that is politically viable.

Belief that abortion should be restricted or illegal correlates strongly with religious belief,

and the 17 states in which abortion is restricted along along all three measures studied have populations in which over 80 percent of residents identify as Christian (“Tracking Religious” 1). This creates less political risk for politicians advancing legislation that as commonly seen as aiming to restrict abortion. This is especially true in states with historically strong Republican majorities, which represent 15 of the 17 states (as determined by their votes in the 2000, 2004, 2008 and 2012 presidential elections).

These pieces of legislation are frequently backed by lobbying efforts from non-profits dedicated to “restor[ing] protections for unborn children and their mothers” (“Minnesota Citizens Concerned for Life”), “fight[ing] for the rights of the unborn” (“Texas Right to Life”) and “working for alternatives to abortion and humane solutions to the problems of women who seek abortion” (“South Dakota Right to Life”). On the websites for these groups, restrictions to abortion such as the wait period, mandatory counseling and parental notification are listed as “Legislative Victories” (“Minnesota Citizens”)—an indication that they help to accomplish the groups’ stated goal of advancing a pro-life agenda. The *Planned Parenthood v. Casey* decision stipulates only that states must not place an “undue burden” on the woman seeking an abortion and it has proven difficult to determine legally at what point these restrictions represent an undue burden. Legislation limiting various channels of abortion access (timely access, access without third-party involvement, access without additional disclosures) has proven to be an effective method of increasing barriers to access abortion such that abortion rates and number of abortion providers decline in states where restrictive legislation has passed (New 30).

This framework of limiting abortion access through state legislation is not possible in the Dutch context. Abortion was legalized in the Netherlands through the Termination of Pregnancy

Act, and the waiting period, counseling, and parental notification were instituted as part of the act. The framing of the Termination of Pregnancy Act posits abortion as an emergency recourse rather than a standard medical procedure. This framing is accomplished by funding it through the Exceptional Medical Expenses Act rather than through the standard health insurance package. It is also affirmed by the Ministry of Health in its Q&A on abortion, which defines abortion as “a procedure to which a woman is entitled if her circumstances leave her no other alternative” (Q&A 4). This structure means that restrictions that would not be put in place for a standard medical procedure can be justified, because abortion is specifically defined as a non-standard emergency option.

An important distinction between the Dutch and American restrictions, however, is that the Dutch restrictions are an element of the original framework through which abortion was legalized, rather than representative of an ongoing attempt to progressively limit abortion. It is not possible to legislate abortion on a more local level in the Netherlands, and there is no system of constitutional review by the judiciary (Adams 399). According to Dr. Joyce Outshoorn, this means that Parliament is the sole channel through which abortion could be further legislated, and a lack of interest by major coalition members has led to limited discussion of abortion following its legalization (Outshoorn).

Further, the initial goal of the restrictions was not to restrict abortion access among Dutch women, but instead to limit the number of women traveling from countries where abortion was not legal to obtain abortions in the Netherlands (Outshoorn). But the legislation proved unhelpful even for this reason, as the restrictions could be interpreted in ways that lowered the barriers to access for these women. For example, the five day waiting period could start when the woman

consulted a physician in her home country, and then have finished by the time the woman arrives in the Netherlands for her abortion (Outshoorn).

The different channels through which abortion was legalized have created a space for an active pro-life political culture in the United States—which already is a more friendly environment for pro-life sentiments than the Netherlands through its higher levels of religious affiliation and lower percentage of abortion acceptance. In the Netherlands, the restrictions are static, and it is politically difficult to push through legislation that would create a less friendly environment for abortion politically or socially.

2. (b) Implementation and practical effect

There are several key distinctions in the two nation's implementation of these restrictions. The difference in how each of the restrictions is implemented is both a result of and a contributor to the socio-political climate surrounding abortion in both countries. The implementation difference creates highly distinct effects for provision of abortion in each country. The Netherlands' implementation creates relatively insignificant barriers and contributes to a socio-political culture of pragmatism--and, to a lesser extent, paternalism. The United States' implementation of the same restrictions creates much higher barriers to access abortion, and contributes to a socio-political culture that punishes women seeking abortion through an intersectional matrix of domination.

The practical effect of the waiting period is significantly different in the Netherlands than in the 17 U.S. states. The health insurance system also requires consulting a general physician before undergoing medical treatment or surgery. The effect of this is that the waiting period typically begins with that first consultation, and the five days have generally passed by the time the

abortion is set to occur (Outshoorn). Further, the Netherlands has over 100 licensed abortion providers, and so even if two trips to the provider are necessary, the time and cost of travel are likely to be low. In contrast, Mississippi has two licensed abortion providers for a state that is triple the area of the Netherlands (“State Facts” 1). This means that though on paper the Netherlands’ five-day waiting period appears to create a larger barrier than Mississippi’s 24-hour waiting period, in practice the barrier is likely to be much higher for a woman traveling twice to one of two abortion providers in her state.

Similarly, mandatory parental notification is a less significant barrier in the Netherlands. Dr. Outshoorn informed me that, in practice, Dutch abortion providers are likely to provide abortion care without parental notification for patients ages 12 to 16 if it appears that notifying the parents would create a significant risk for the patient (Outshoorn). Outshoorn suggested that this is the result of the Netherlands’ general respect for the autonomy of teens (Outshoorn). Comparatively, Minnesota’s mandatory parental notification law requires a judicial bypass in order to circumvent parental notification (“Parental Involvement” 1). Again, laws with similar construction are implemented in accordance with the prevailing social norms to produce different outcomes. Mandatory counseling illustrates the largest difference between the two country’s implementation of restrictions. Counseling in the Netherlands centers around ensuring that the woman has not been forced or pressured into having the abortion and providing information about family planning and contraception (“Q&A” 4). Counseling varies from state to state in the 17 US states, but typically involves disclosure of at least one of three factors: the possible tie between abortion and breast cancer, the ability of the fetus to feel pain, and negative psychological effects (“An Overview” 3). The Dutch counseling model focuses on prevention of

future abortions, whereas the US model focuses on prevention of the current abortion.

If both are to be evaluated on the basis of Little's framework for support of abortion under a right to bodily autonomy, it seems clear that their framework would lead to further restrictions. Neither country legalized abortion because women have the right to decide what happens to and within their own bodies. Instead, in the United States it was passed under a right to privacy, and in the Netherlands it was passed as an emergency recourse. Both of these frameworks for legalization are open to the possibility of further restricting that right, because neither leave the decision solely in the hand of the woman (thus their equal classification under Esser and Koch's counseling model). However, it is clear that the socio-political climate in both countries has had a significant impact on the implementation and effect of these restrictions.

3. Counseling model distinctions

Due to this clear difference in intention, implementation, and effect between the United States' and the Netherlands' abortion legislation, it seems misleading to categorize their models of abortion legislation identically. But using Esser and Koch's framework for understanding abortion models globally, and Gevers' analysis of how the Netherlands fits into those models, there is no other existent academic category. To account for this issue, I propose a distinction between prevention-based and punishment-based counseling within Esser and Koch's model.

The prevention-based counseling model aims to provide counseling in order to best protect the interest of the patient. This is a paternalistic model of medical care, in which women are not seen as responsible enough to make their own medical decisions, but it does not actively prevent access to abortions or limit the number of abortion providers. This can be seen in the

Netherlands' counseling services focusing on family planning and preventing coercion, situational leniency on parental notification, and an effectively non-obtrusive waiting period.

The punishment-based counseling model aims to create barriers to prevent women from accessing abortion at all, or to punish them if they choose to pursue the abortion. This model of care uses the state and the health care system to create a matrix of domination in which women are effectively prevented from accessing legal health services. This can be seen in the United States' counseling focusing on fetal pain, negative psychological effects, and breast cancer risk; the need for judicial involvement to bypass parental notification; and a waiting period that creates a time and finance barrier by creating the need to travel twice to a limited number of abortion providers. Ironically, this model does little to prevent abortions--it focuses instead on punishing women once they have decided to obtain one.

Creating this distinction in the counseling model allows for a further academic discussion regarding the impact of restrictions in countries where abortion has been legalized. The Netherlands provides an imperfect but effective model for non-obtrusive restrictions that serve to effectively end the political debate around abortion, whereas the United States shows that similar restrictions can be used to progressively limit abortion access.

Conclusions

The creation of a new distinction in the counseling model allows for an easy summary of how the socio-political cultures surrounding abortion in the Netherlands and the United States led to the implementation of similar legislation restricting abortion, but with different intent, resulting in different implementation and results. The Dutch prevention model of counseling has

reinforced a culture of openness and ease of access regarding abortion and sexual and reproductive health, whereas the American punishment model has restricted access to abortion services and providers while creating a political maelstrom of a debate around sexual health. But when it comes to actually lowering abortion rates, the Dutch model proves to be more successful, with the Netherlands boasting an abortion less than half that of the United States’.

A successful model for limiting abortions cannot be created in a vacuum. The United States’ population is significantly more racially and economically diverse than that of the Netherlands. The Netherlands’ population is less religious, and the channels through which abortion regulations can be passed in the U.S. are greater in number. There are significant barriers to moving towards from a model of punishment to one of prevention, but the Netherlands provides an indication that it is possible.

Suggestions for further research

My ability to conduct extensive interviews for this project was limited by time. It would be interesting to conduct a survey of Dutch and American views on the morality of abortion and abortion politics. I would especially be interested in a cross-generation sample, in which changing views could be tracked, and perhaps provide an indication for the future of abortion legislation in both countries. In the Dutch context, abortion rates are significantly higher among migrant women. I would be interested also in a study tracking abortion rates, contraception use, and sexual health views along several generations of Dutch migrant women.

From a more political perspective, a comparison of language used in political debates about sexual health issues in the Netherlands and the United States could provide useful insight into the

difference in political framing of the issue. This could be accomplished by either tracking the language used by legislators on the floor, or by tracking the language used by the media to describe political debates about sexual health issues.

Both of these suggestions would provide a deeper look than I was able to provide of the nuanced cultural distinctions between the two countries. The cultural norms around abortion provide the backbone of the political opportunity structure for abortion restriction, and would make for a fascinating study.

Appendix

Interview questions for non-expert Dutch/American citizen interviewees

1. What do you know about laws or regulations around abortion in the Netherlands?
2. If you do know of any, what are they? What do you think their intended purpose is?
3. Are you aware of any political debates surrounding abortion? If so, what are they, and what is your opinion about them?
4. How would you describe the culture surrounding abortion in your community (family, friend group)? What is the common attitude around abortion?
5. If someone you know were to need an abortion, how easy to access and affordable do you think it would be?
6. If you had to rate the culture around abortion in the Netherlands from 1-10, with 1 being the least friendly to abortion (i.e., abortion is illegal, highly inaccessible, and heavily socially stigmatized) and 10 being the most friendly (abortion is legal, easily accessible, there is little to no social stigma), what number would you give it?

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