



Anti-Abortion Clinic Activism, Civil Inattention and the Problem of Gendered Harassment

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Abstract

In the UK, there is evidence of a recent increase in anti-abortion activism outside clinics. In response, abortion service providers have called for the introduction of ‘buffer’ zones to protect women from ‘harassment’ while accessing abortion services. Drawing on two datasets – extensive ethnographic fieldwork, and a content analysis of clinic client comment forms – we deploy Goffman’s concept of ‘civil inattention’ to further our understanding of the material practice of anti-abortion clinic activism. We find that although anti-abortion activists understand their own actions to be supportive, practices of religious observance outside clinics inescapably draw attention to the site and to the act of accessing healthcare, inherently challenging normative expectations of privacy and confidentiality. Our analysis suggests that anti-abortion activism outside clinics consequently violates social rules governing encounters with strangers in specific places and reinforces gendered hierarchies. As such, they are often experienced as acts of gendered harassment.

Keywords

anti-abortion activism, civil inattention, gendered street harassment, public witness

In mainland Britain, abortion clinics have recently become highly visible sites for the making of public claims over the terms of the provision of reproductive rights, as a series of anti-abortion groups have begun to stage actions directly outside clinics. In the North American context, where anti-abortion actions outside clinics have been recurrent since

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the mid-1980s, there is now considerable research on the claims-making tactics of anti-abortion groups. Perhaps most prominently, scholars have focused on the different framings of anti-abortion discourse, including moves in the US from 'foetal personhood' frames (e.g. Petchesky, 1987) towards a 'woman's health' frame (e.g. Saurette and Gordon, 2015). The instrumental use of foetal imagery by anti-abortion groups has often provided a point of departure (Jasper, 1997; Rohlinger and Klein, 2012). Equally, scholars have analysed processes of recruitment and organisational growth in the US anti-abortion movement (Haugeberg, 2017; Munson, 2008), and the development of litigation strategies and free speech advocacy by conservative activists in clinic disputes (Lewis, 2017; Wilson, 2013).

Yet we know relatively little about the material and situational practices of anti-abortion clinic activism, or – from a micro-sociological perspective – how these specific practices shape the experiences of women seeking to terminate a pregnancy. Here, we explore the relationship between the staging of anti-abortion activism outside clinics and the experiences of women accessing abortion services. We do so in mainland UK,¹ where academic discussion of anti-abortion activism is noticeably thin, where there has been an increase in anti-abortion activism and where abortion service providers and rights campaigners have consequently called for the introduction of 'buffer', or exclusion, zones around clinics, in order to combat what they see as the harassment of clinic clients by these groups. Our focus is on 'public witness' forms of anti-abortion activism, acts of presence and of looking. Developing Goffman's (1963) understanding of the social rules of public conduct, we argue that as anti-abortion activism at clinics is structured around the potential production of 'face engagements' in public space, it has significant implications for the definition and reproduction of the social norms which underpin the availability of these engagements, and thus for the delimitation and operation of gendered hierarchies of power.

We propose two key advances in the understanding of anti-abortion activism. First, through our ethnographic observation of anti-abortion activism and analysis of comment forms completed by abortion clinic clients, we bring into tension two original datasets, enabling us to capture the dominant practice of activism outside abortion clinics in Britain. Most significantly, our data enable us to capture the relationship between these practices and the experiences of women forced to negotiate them. Second, in response to our data, we argue that clinic activism is experienced by women as intrusive through the *condition of its presence*, precisely because it subjects them to a critical unwanted scrutiny similar to other unwanted street encounters. Combining a Goffmanian approach with attention to the power relations that structure the use of public spaces thus enables us to draw out the inherently stigmatising structure of anti-abortion activism outside clinics, even where these actions are apparently designed to be non-aggressive.

In what follows, we first set out the British context of abortion, and of anti-abortion activism, before discussing questions of stigmatisation and, drawing on Goffman and Gardner in particular, civil inattention and gender. We then elaborate our research design and methods, before presenting and analysing our data from observational fieldwork and clinic client comment forms. We conclude by situating abortion clinic activism within broader understandings of gendered harassment and civil inattention.

Abortion and Anti-Abortion Activism in England and Wales

In the UK, the 1967 Abortion Act is still the main form of regulation, generally allowing abortion in England, Scotland and Wales up to the 24th week of pregnancy (the Act does not apply to Northern Ireland). In 2016, 98 per cent of abortions in England and Wales were publicly funded through the National Health Service (NHS) (Department of Health, 2017). However, unlike other healthcare areas, the independent sector has long been involved in providing abortion services. As the 1967 Act was being passed, it became clear that the NHS was unlikely to be able to provide sufficient services, due to budgetary shortfalls and the dominance of anti-abortion medical personnel in some areas; charitable bodies filled this gap (McGuinness, 2015). As the contracting out of healthcare services has become more widespread, third sector bodies (notably Marie Stopes UK and the British Pregnancy Advisory Service (bpas)) now provide the majority of abortion services in England and Wales. This model of care has led to the development of free-standing abortion clinics, rather than the integration of abortion services into other healthcare provision. Abortion services are therefore often provided in England and Wales in dedicated, clearly identifiable, public-facing sites;² clinics provide free abortions for NHS patients, as well as a small number of privately funded abortions. Clinics vary as to which stages of pregnancy they can offer services for; consequently, even women who are geographically mobile have few choices of clinic, particularly in the second trimester.

Public opinion data suggest that only approximately 10 per cent of people in Britain completely oppose abortion (Park et al., 2013). Nonetheless, organisations seeking to limit or remove abortion rights have been present in the UK since the 1960s (Read, 1998). Organisations such as the Society for the Protection of the Unborn Child (SPUC) and LIFE have largely focused on political lobbying, offering services to pregnant women, and providing speakers and materials rather than organising actions outside clinics. More recently, newer 'groups' have emerged and consolidated, of which the most active in England and Wales are Abort67,³ 40 Days for Life, Good Counsel Network and Helpers of God's Precious Infants (henceforth: Abort67, 40 Days, GCN, Helpers). While clinic activism is central to each group, the overall picture is quite messy; individuals may be involved in multiple ways (40 Days, for example, is a twice-yearly campaign, rather than a group per se, and involves members of numerous organisations, including Helpers, SPUC and GCN).

Public attention to anti-abortion activism has often centred on the display of large images of dismembered foetuses, a tactic associated with Abort67 (Jackson and Valentine, 2017). This type of activism remains a minority, localised to a few specific areas. Rather, the majority of anti-abortion activism around clinics, and the focus of our discussion, is conducted by local, predominantly Catholic groups who organise prayer vigils, sometimes with 'pavement counsellors' who seek to interact with women to dissuade them from having abortions. This activism includes groups which sign up to the 40 Days for Life campaign. The aim of 40 Days is to stage anti-abortion vigils for continuous 12-hour periods, for 40 consecutive days, twice per year (once at Lent, once in the autumn). While nominally open to all faiths, our observations suggest that in Britain 40 Days

groups are mainly Catholic. Helpers and GCN are also predominately Catholic, though their frequent use of religious iconography (such as images of Our Lady of Guadalupe, a representation of the pregnant Virgin Mary) places them as less ostensibly ecumenical in their orientation than 40 Days. Some clinics have anti-abortion activists present nearly every day, all year round (including paid positions), while at other sites, actions are only held once a week, or during a 40 Days campaign.

For such groups, clinic activism is a form of bearing public witness. Strongly associated with Evangelist traditions of Catholicism, bearing witness, in broad terms, means placing questions of faith at the centre of public policy debates (Gushee, 2008: 50); more directly defined, it calls attention to an unethical or immoral act or event through religious observance and public presence. Bearing witness to abortion involves public prayer and 'pavement counselling' at sites where abortion takes place, as a practical and symbolic act: to provide information to women entering and leaving clinics, and to make abortion visible, bringing it into a space where it can be named and opposed.⁴

Anti-abortion activism outside clinics is not new to Britain; clinics have experienced prayer vigils since the Abortion Act was passed. In the 1990s, activists linked to US anti-abortion movements sought to bring more aggressive forms of activism to the UK, but they were largely unsupported by pre-existing UK anti-abortion organisations and it did not take hold (Read, 1998). Attempts in 2001 to show pictures of aborted fetuses in an election broadcast were blocked by the BBC, with the decision later upheld in a legal case (Hopkins et al., 2005). Recently however, the increasingly international agenda of parts of the US anti-abortion movement has led to a change in activities in Britain; all the anti-abortion groups active at British clinics have links to US organisations. Indeed, Jackson and Valentine (2017) argue that Abort67, who seek to provoke a visceral reaction, are typical of US campaigns in that the group seeks to shift both the language and place of campaigning, focusing on clinic sites.

In response to these recent changes, bpas and other campaigners have turned to lobbying for new legislation to create buffer zones outside clinics.⁵ Such zones have been the subject of conflict, debate, and legislation elsewhere, especially Australia, Canada and the US. In the US, Wilson (2013: 2) notes, activism outside clinics was a hallmark of the development of the anti-abortion movement, enabling it to 'publicize the cause, gain more members, give participants the feeling of empowerment via direct action, impede clinic access, and tax clinic resources'. Political, legal and academic debate over the regulation of expressive behaviour in public spaces consequently centred on the consonance of clinic activism with constitutionally protected freedoms. In the UK, where constitutional amendment rights are not relevant, debate over clinic activism takes the form of dispute over, first, whether or not anti-abortion activism outside clinics constitutes harassment, and second, whether such practices are permissible free speech or should be prohibited under public order legislation.

The backdrop to these debates is the stigmatisation of abortion. For Kumar et al. (2009), abortion stigma is related to women's discursive positioning in femininity, in which 'real' women are or are destined to become nurturing mothers. They suggest that when women choose to avoid a potential birth their decision is often seen as a threat to the moral order, and argue that stigma is transmitted through the media, political and healthcare structures, as well as through more individualised communications. Abortion

stigma thus stems from the cultural positioning of women, and while widespread, will be shaped differently by local contexts. In the UK, despite the overwhelming public support for abortion rights, the media continue to represent abortion as a controversial issue, suggesting that too many abortions take place, it carries health risks and linking it to other discrediting issues such as promiscuity or excessive alcohol use (Purcell et al., 2014). Abortion is often either positioned as the outcome of women's failure to act responsibly, or as a selfish or immature act (Lowe, 2016).

Sanger (2017) argues that anti-abortion regulation in the US builds on its stigmatised position, and may seek to punish women or persuade them to change their minds. Yet as Foster et al. (2013) note, we know very little about the impact anti-abortion activism has on women's experiences of accessing abortion. Their study in the US found that just over half the women who encountered anti-abortion activists outside clinics were upset by them, with women more likely to report higher levels of distress where making a decision to terminate was difficult. They also found that just seeing the activists was less upsetting than being stopped by them and hearing them. However, anti-abortion activism did not seem to affect how women felt about their abortions at a follow-up one week after the procedure. In other words, while anti-abortion activism can be distressing for women seeking abortion, these feelings of distress are separate from their feelings about the procedure itself. We suggest that encounters outside abortion clinics are a specific form of gendered public encounter, and situating them within a broader understanding of public interactions helps to explain their impact on women.

Encounters in Public Spaces

For Goffman (1963), encounters between social actors take place within a social situation, a sociologically relevant entity defined by the co-presence of two or more social actors, and subject to specific sets of norms and obligations. Public conduct is consequently regulated by social norms, which define the modes of physical, visual and verbal behaviours which are held to be appropriate or improper for each encounter. Goffman differentiates between focused and unfocused interactions; in focused encounters, interactants maintain a mutually negotiated single focus of cognitive and visual attention, initiated and prolonged by eye contact, a 'face engagement'. In contrast, unfocused encounters are characterised by the absence of mutual engagement; communication between interactants is limited to what can be gained from the virtue of co-presence only. Consequently, unfocused interactions are characterised by the absence of verbal communication and substantially less visual engagement than in focused interactions (Cutts and Schneider, 1975).

In unfocused encounters, visual interaction is governed by the rule of civil inattention, or the way that strangers act to register each other's presence, briefly but without recognition. Individuals have the right to be 'civilly disattended in public', such that:

one gives to another enough visual notice to demonstrate that one appreciates that the other is present (and that one admits openly to having seen him), while at the next moment withdrawing one's attention from him so as to express that he does not constitute a target of special curiosity or design. (Goffman, 1963: 88)

Extending civil inattention is regulated by relations of intimacy and proximity: the closer and the less personally familiar the interactants, the greater the obligation to disattend. Expectations of civil inattention are therefore associated with degrees of familiarity, enabling us to negotiate public spaces without having to engage in face-to-face encounters with strangers. Crucially, such expectations are also regulated by status rights, and the maintenance of the norms of situationally appropriate conduct. Those who are not considered to enjoy equal status or who do not act in normatively appropriate ways are not accorded civil inattention, and may be openly stared at or verbally enjoined, becoming the object of unwanted sustained visual scrutiny or speech. Indeed, as Hirschauer (2005) points out, one of Goffman's key contributions was to identify the problem of staying unknown without being positioned as the stranger who is a dangerous, intrusive other. 'Street accosting', as Goffman (1963) calls it – where a stranger generates a face encounter that may be unwelcome, or threatening, creating a situation of conflict – is often a highly problematic breach of civil inattention. Moreover, breaches of civil inattention among social equals are transgressive, with the instigator marking himself or herself as 'profane', and a source of potential danger (Moore and Breeze, 2012).

Goffman's work consequently has obvious possibilities for the study of gendered behavioural norms, although few of these potential applications are present in his own work. Even where Goffman (1977: 309) does explicitly discuss the 'arrangement between the sex-classes', his analysis of the gendered implications of public behavioural norms remains relatively slight. His work has nonetheless been highly influential for scholars discussing the patterning of everyday practices produced by asymmetrical power relationships between the sexes (West, 1996); Gardner (1995), for example, applied Goffman's framework to the unwanted attention received by women from men in public space.

As Gardner (1980) points out, women experience public attention in different ways from men. Defining the linguistic form of civil inattention to be silence, she argues that women are 'liable to receive street remarks at will, in much the same way that lower-status groups frequently are' (1980: 328). Women are assumed to be 'open to the public', to the extent that there is 'no sure way for a woman to pass down the street alone and not be commented upon' (1980: 333, 342), or subject to prolonged staring. Gardner (1995: 4) argues that the failure to extend civil inattention to women in this way is a form of *public harassment*, which she identifies as 'that group of abuses, harrying, and annoyances characteristic of public places and uniquely facilitated by communication in public [...] a sort of civic denial'. The harassment to which women are routinely subjected by men with whom they are unacquainted has three dominant forms: 'access information intrusions' (the pressuring of women to disclose private information); street remarks (whether evaluative or abusive); and exploitations of presence (the abuse of situations of proximity, through verbal and/or non-verbal behaviour, such as touching, following, scrutinising).

The extent and gendered implications of street harassment for women and others in a minority position are increasingly being documented (e.g. Logan, 2015; Macmillan et al., 2000). In her review of the literature, Logan (2015) finds that the overwhelming majority of women experience street harassment, leading to increased levels of awareness, fear and environmental monitoring among women, and influencing their decisions

about where, when and how they use public spaces. Many have argued that public spaces have traditionally been designed for, dominated and controlled by white heterosexual men and that women (and other minority groups) have to negotiate their access to public spaces (Pain, 2001; Skeggs, 1999). Established power relationships thus have a significant bearing on the construction and use of public space, while street harassment is a significant factor in the maintenance of these relationships (Logan, 2015).

Studying the effects of offensive speech on individuals, Nielsen (2009) found that street commentary enacted hierarchies of gender, class and ethnicity. As she argues, this is not necessarily surprising given that women are often held to be responsible for inequality, from 'choosing' to be less ambitious when they have children to 'encouraging' rape. As both Nielsen and Gardner point out, because being obliged to receive unwanted speech is reliant on subaltern positioning, such speech is offensive even if the words themselves are ostensibly polite or complimentary. Similarly, Garland-Thomson (2006) and Warren (2011) argue that unwanted eye contact, including staring, are part of processes of objectification and victimisation. The capacity of such processes to be threatening is likely to be structured by the location in which they take place, as in Moore and Breeze's research on public toilets. For Moore and Breeze (2012), paying attention to how people feel about actual or potential surveillance is crucial to understanding their specific concerns about the threat of violence.

Anti-abortion clinic activism does not therefore take place in a neutral context, but in one already governed by relations of power, and where the meaning of abortion is often negatively culturally defined. Women seeking abortion services must negotiate public space, and potential encounters within it, in a context where their individual conducts are subject to stigmatisation. As a form of public witnessing, anti-abortion activism outside clinics can thus be understood as a specific interaction whose purpose is for strangers to look at and/or address women. It also more broadly seeks to make an organised political statement about the 'shamefulness' of abortion, while constituting the 'witnessing' group as a collective public actor. As we will argue, although interactions outside clinics are different from other forms of street harassment, for women they may generate similar feelings of intrusion, anger and fear. It is therefore the broader context of gendered public space that structures the experiences of women when they encounter anti-abortion activists while seeking abortion services.

Research Methods and Design

In order to understand interactions outside clinics, we need to consider site-specific interactions, and the wider social context in which public space is generated and gendered, reinforcing existing relationships of power. To do so, we use a novel mix of approaches, placing in productive tension: (1) ethnographic observations of clinic actions; (2) formal and informal interviews undertaken with anti-abortion activists outside clinics; and (3) accounts of the experience of negotiating clinic actions by women seeking abortion services.

Since spring 2015, we have observed clinic actions at 10 separate sites in England and Wales: Buckhurst Hill; Cardiff; Doncaster; Ealing; Birmingham; Manchester; Leeds; Nottingham; Richmond; and Stratford (London). The clinics were purposively chosen to

include different anti-abortion groups, and to include sites with a daily or weekly presence as well as sites which have only 40 Days campaigns. We included clinics where small numbers of activists are typically present, and those that attract larger groups. In order to focus on less ostensibly 'extreme' but more prevalent forms of action, we excluded sites where activists display large graphic images. Our observations lasted for between one and three hours; visiting some sites on multiple occasions, taking fieldnotes and photographs, noting the local geography and any signs or written materials available and recording interactions between activists, clients and passers-by; and conducting informal interviews whenever permission was given. These fieldnotes are complemented by a small number of formal in-depth interviews with movement leaders and regular participants, and documentary analysis of public statements and other data. The number of active anti-abortion activists is fairly small, so in order to protect the identity of the interviewees we are unable to provide demographic information about them. The interviews were audio-recorded (with permission) and transcribed for analysis.

Fieldwork is complemented by the secondary analysis of anonymous comment forms completed by clients of bpas clinics when they encountered clinic actions while seeking abortion services. Bpas does not specifically ask its service users to supply comments, but where they report being upset, clients are given a form on which they can write anything that 'protestors' said or did that they want bpas to know about. A small number of comments were also made on general service evaluation forms or on other pieces of paper. The forms were collated by bpas, who allowed us to analyse them; in total, our dataset comprises 206 comment forms, completed between August 2011 and April 2015, from 11 different clinics. The comments cover a wide range of issues, including descriptions of encounters, and general reflections and feelings about the clinic actions. Some were very brief, others more extensive. The date and clinic site were usually recorded. The forms do not record who completed them, or why they were attending the clinic; some comments were made by partners, friends or family members. The comments discussed here are representative of the dataset, and are reproduced verbatim.

The use of this secondary dataset rather than undertaking primary research has some limitations. The comment form itself characterises the activity as protest, and a small number of forms were leading, advising clients that they could report harassment to the police. As the forms were not routinely given out, the sample is self-selecting; it is likely that those who felt most strongly completed them. We also do not know how many clients encountered anti-abortion activists. While we are unable to estimate prevalence, the comments nonetheless reveal the immediate emotional responses of clients. Finally, the forms do not record the exact details of each given clinic action, or the name of the group organising it. Nevertheless, some groups are strongly associated with actions at particular clinics; for this reason, in line with our focus on anti-abortion public witnessing, we have removed 59 forms from one clinic associated with the display of large graphic images from our dataset, leaving us with a set of 147 forms, drawn from 10 clinics: Bedford Square (London); Bournemouth; Cardiff; Doncaster; Milton Keynes; Oxford; Peterborough; Richmond; Stratford (London); and Streatham.

The data (fieldwork notes, interview transcripts, client comments) were analysed thematically through a system of close reading, coding and comparison. Both authors shared data gathering and analysis, following in-depth discussions about the coding frameworks

and meaning of the data. NVIVO was used to manage the dataset; each individual comment form in the full dataset is separately numbered. Fieldwork respondents have been anonymised to protect confidentiality. During fieldwork, we were repeatedly asked about our views by anti-abortion activists. These conversations could be difficult to manage as we sought to be open about our support for abortion rights, while being respectful of and without being overtly critical of their position (for discussion, see Gillan and Pickerill, 2012). We seek to ensure that the positions of the activists we observed and spoke with are represented clearly, even though we may disagree with them.

Bearing Public Witness: The Practice of Anti-Abortion Clinic Activism

At all fieldwork sites, religious observance formed a central component of anti-abortion activism. Signs were frequently displayed: these varied, but often featured images of foetuses or babies, or offered information about pregnancy support or post-abortion counselling. The fieldwork revealed the importance of prayer outside clinics to the anti-abortion activists. In interviews, George described their actions as ‘prayer and witnessing’ (March 2015), and Laura ‘prayerful vigil’ (April 2015). At an action outside Nottingham Queen’s Medical Centre, one person wore a sign on his jacket that read ‘just praying’ (fieldnotes, March 2016).

Alongside prayer, anti-abortion activists typically counted off rosary beads, and at some sites displayed religious icons. For Peter, ‘We are there as a prayerful witness. We are not there to chant anything or to harass anybody. [...] We are praying with the intention that people will change their minds’ (interview, March 2015). Many activists were quick to draw a distinction between their actions and what they envisage to be a protest. Ivy, for example stated that:

I think protesters would be people who are there with posters saying ‘this place must close down’ and, you know, maybe more aggressive to the staff or who had those kind of feelings [...]. I wouldn’t say we’ve got aggression. We’re trying very hard to be loving. (Interview, June 2015)⁶

The anti-abortion activists generally believed that their actions are axiomatically acts of love and care, a benign presence, with only a few recognising that their actions could make women feel uncomfortable. George, for example, argued that it was the underlying ‘trauma’ of abortion that caused people to react negatively towards them (interview, March 2015).

Many suggested that they were the only ones to offer women a choice. Simon and Brenda took this position outside a clinic on a cold damp evening in March 2015: ‘People feel they have no choice, but there are other choices. People think it is “informed choice”, but it is not informed. Although something is wrong in their life, this is not the solution’ (Birmingham, fieldnotes, March 2015). Others made similar claims: for example, George stated that abortion was the ‘politically correct’ response, and Arthur felt that women were forced either directly by a partner or their family, or indirectly through wider society, to have terminations. All the activists we spoke to believed that abortion harms

women, and they play an important role in trying to prevent this and/or help women deal with the consequences.

At Birmingham, a glossy 'pavement counselling guide' stresses the importance of prayer and public witness ('Calvary is happening again at each abortion centre', p. 6). It also sets out detailed advice on how to approach women entering and leaving the clinic, understand rather than demonise them ('You are called to convert not condemn', p. 8), conduct conversations, establish trust and manage interactions. The booklet includes six step-by-step pages on how to approach women. Eye contact, gesture, bodily movement and voice are all listed as key to initiating an encounter. It states, for example, 'Have an informal, matter-of-fact approach to help put the woman off guard'; 'Walk slowly and nonchalantly towards the woman as you greet her'; and 'Try and make eye contact with the driver/passenger and attempt to offer a leaflet by holding it out' (pp. 9–11).⁷

Practices at clinics vary depending on the geography of the site, numbers of activists present and interactions with local counter-demonstrations. At sites where activists were present all day, practices changed as anti-abortion activists arrived and left, sometimes with their own signs. Gender did not seem to be a factor in the specific practices adopted: we observed men and women praying, and men and women approaching women seeking abortion services directly. Typically, activists stand either directly outside the entrance or on the pavement opposite the clinic. Sometimes, the numbers (up to 70) may be much larger, especially if linked to specific events. Helpers, for example, organise regular processions beginning at Catholic churches, where larger numbers (often including members of religious orders) walk to and pray outside clinics. Candlelit religious rituals often mark the end of each 40 Days campaign.

In Birmingham, activists typically stand by the driveway entrance to the Edgbaston clinic, their backs to the clinic wall. Most often, they are in pairs, though sometimes in groups of three or four; at this site, activists typically position professionally produced posters in A frames on the pavement, either side of the driveway. During one observation at this site, Theresa and Bernadette told us about their motivations and experience. Theresa told us about how moved she was to 'see tears in the eyes of the young women who use the clinic', underlining that:

we respect people's personal space, we never ever harass anyone [...] we're not here to harass people, we're not better than them, we're not telling people they will go to hell if they do this – we're here to say there are other choices, that's all.

In Birmingham, clients typically enter the driveway by car, creating fewer direct interactions than at other sites. At Richmond, in contrast, all clients have to arrive on foot. Here, we observed pavement counsellors frequently seeking to interact with clinic users while the latter tried to avoid them. On one occasion, a man accompanying a woman initially took a leaflet, before glancing down and throwing it back at the pavement counsellor (fieldnotes, September 2016). On another occasion, as a female pavement counsellor sought to engage two women, the older of the two women put her arm protectively around the younger one to guide her away from the anti-abortion activist (fieldnotes, October 2016). Such incidents illustrate how interactions with anti-abortion activists are often unwelcome.

We saw similar incidents at another site, in Manchester in late October 2016. Here, activists positioned themselves in groups of three and four directly opposite the clinic, either in a small parking bay about five metres from the clinic or, later in the day, on a narrow stretch of pavement level with the clinic entrance. The clinic is in a narrow, leafy cul-de-sac, in Fallowfield. A blue Peugeot was parked directly outside the pedestrian entrance, blocking the pavement, with a 40 Days for Life poster propped against the front bumper, so that anyone approaching the clinic would see it. Anyone leaving the clinic was obliged either to squeeze past the car, or to walk in the street, next to the activists. It later became clear that the car belonged to one of the activists. The activists declined to talk to us, but one of them, Rosemary, said, 'We are just here to meditate and pray, and we don't approach mums,'⁸ we are just here to talk to them if they want to.'

Yet this was not empirically the case: for example, between 11.10 and 11.30 a.m. we observed five encounters between anti-abortion activists and lone women or couples entering or leaving the clinic, in which the activists deliberately drew the attention of and then approached the clinic clients. First, a young woman left the clinic. Rosemary waved to her, and the woman smiled back. Nadine, another activist, then crossed to her, before the woman took a leaflet and got into her car. Five minutes later, a man and woman left the clinic; this time, Rosemary crossed the road to offer them a leaflet as they came towards the activists; the couple's car was parked in the bay behind the activists. The couple declined the leaflet, amiably enough, but the man became increasingly agitated as he tried to manoeuvre his car out of the bay and between the parked cars on either side of the narrow street. Visibly angry, he reversed directly towards the activists, who quickly moved their artefacts – candles, chairs, signs – out of the way, before the car drove off. Following this episode, separately, at short intervals, two young women approached the clinic, and a lone young woman left it. On both occasions, Rosemary crossed the road to offer them literature, which they refused. A few minutes later, at 11.30 a.m., a woman exited the clinic; Rosemary hailed her, crossed the street to stand next to her on the pavement outside the clinic, and offered her some literature, which the woman took before walking away.

In each case, the encounter was initiated by one of the two female activists present, most often Rosemary. The initiation was through gesture, voice and movement; on three occasions, the activist made a little wave with her hand before crossing. The clinic is set back from the road, and there is a flight of eight steps up to the door, enabling the activists to clearly see people leaving; because the street is a narrow cul-de-sac, and the activists had parked their car directly outside the clinic, the women/couple were obliged to move towards them before they had a chance to get to their cars, waiting taxis or walk up the street to the main road. Despite claims to the contrary, therefore, the activists approached women without having been invited to do so, breaching norms of civil inattention. By observing, approaching and addressing clinic clients, the activists actively position them as 'available', imposing (in Gardner's terms) a 'civic denial'.

Women's Experiences: Harassment at the Clinic Gates

Our comment forms dataset shows that many women experience such encounters as upsetting and intrusive. While some respondents reported being angry, many underlined the emotional

distress they felt; indeed, the descriptors *upset*, *intimidated*, *uncomfortable*, *distressed* and *stressed* (or derivatives, such as *upsetting* or *stressful*) were used a total of 65 times in the 147 forms in our dataset, across seven clinics, demonstrating the emotionally destabilising effects on clinic clients of being observed or approached by anti-abortion activists outside clinics.

Outside clinic woman asking a lot of questions about why I'm coming into the clinic made me feel very uncomfortable and upset. (#137, Streatham, 2012)

I felt intimidated and scared to go into the clinic. I felt judged and uncomfortable. Not a nice feeling at all. (#80, Doncaster, 2013)

The moment I saw them outside I was panic and shy, they are intruding my personal decision one way or the other, I have to cover my face when next am coming here cos I don't feel safe or secure. (#203, Stratford, 2015)

These comments detail immediate emotional responses of anxiety and distress, conditioned by a sense of the women's own vulnerability in this situation. In part, the distress can be explained by the unpredictability of the encounter: while it was clearly understood that the activists were campaigning against abortion, they did not necessarily know what actions, if any, the anti-abortion activists would take. This created a climate of uncertainty and, in some cases, fear. This included being left 'physically shaking' (#90, Milton Keynes, 2012) or worried about being 'injured by an over-zealous extremist' (#175, Richmond, 2014). Rather than a routine entry into a healthcare setting, clients are suddenly placed in a situation they feel is unpredictable and potentially unsafe.

The forms equally suggest that such encounters are *inherently intrusive*. Just under a quarter of the comments in the complete dataset suggest that while people are entitled to their own views on abortion, outside a clinic is the wrong place to express those views, and to do so is to intrude into private decision making. Anti-abortion activists are widely seen as questioning the personal decisions taken by clients, rather than providing support. For one woman,

Making the choice to have an abortion is a very personal decision [...]. Why is bullying in schools, work or general society not accepted and in some cases reason for jail time but in the case of my personal medical treatment allowed? Causing undue stress on ANY human being for any reason especially one who is about to undergo surgery surely must be seen as a crime. (#173, Richmond, 2014)

Many comments described the unease felt by clinic clients at being watched, approached or 'judged by a stranger' (#160, Stratford, 2014), even where the activists were obviously engaged in acts of religious observance:

Though they did not approach me I felt harassed as I walked through the gate knowing that they watch me and they know the reason I am here. (#149, Doncaster, 2014)

Having leaflets shoved in my face disregarding a much thought about decision, and being told I'd be 'prayed' for is an invasion of privacy in my view tantamount to harassment. (#177, Richmond, 2014)

The repeated positioning of the activists as ‘strangers pushing their opinions on you’ (#195, Stratford, 2015) is significant, given the gendering of public space in which ‘strangers’ are usually associated with a risk to women’s public safety (Pain, 2001). Being watched by someone unknown is repeatedly seen in the comment forms as an unpleasant and invasive act, and this is so even where the anti-abortion activists were themselves ostensibly silent or pleasant.

Observation by anti-abortion activists creates a sense of the public exposure, and of the assumed public availability, of women accessing the clinic. Discussion about private abortion decisions on the street was profoundly embarrassing for some of the women, especially if the conversations were overheard by passers-by. One comment reported that this led to people ‘looking at me weirdly’ (#204, Stratford, 2015). But these feelings go further than the social destabilisation of the encounter itself, with many concerned it encouraged a more general public scrutiny:

In a situation where a woman has been raped, or giving birth may cause the death of the mother or child, abortion, unfortunately, is sometimes necessary. A female has the right to choose the path of her life, a protester does not make what is already a difficult decision, any easier. It made me feel uncomfortable going into the clinic while a man was staring at me. (#198, Richmond, 2015)

Here, being observed or approached while entering or leaving a clinic is upsetting because it draws the wider public into acknowledging the services provided in the building; it makes public knowledge of an intimate, stigmatised medical matter (Kumar et al., 2009), one the women did not want to broadcast, contravening what they consider their own embodied rights. Perhaps even more significantly, it destabilises the women’s sense of autonomy, of their capacity (and their right) to take their own decisions – not simply about healthcare, but about their lives generally. As one form put it, ‘These people need to respect that everyone is free to make their own choice!’ (#154, Oxford, 2014).

Specifically, therefore, where women experience anti-abortion activism negatively, they do so as a result of perceptions of being addressed by strangers in an inappropriate place, which can be linked to wider understanding of gendered fear in public spaces. Frequently, the distress experienced is intimately linked to the visual mode of that address: the failure of anti-abortion activists to disattend them. By making clinic clients the visible and public subject of observation, anti-abortion activists create and reinforce a *moral hierarchy of judgement*. Though it is underpinned by specific religious practices of observance (themselves seen by many women as inherently judgemental), this hierarchy depends on a normative and pervasive positioning of women as *always available to be addressed* by strangers; the very structure of the encounter, the unspoken understanding on which it is implicitly based, denies the public autonomy of women.

Discussion

As our data demonstrate, the anti-abortion activists we encountered stated that they were not harassing women, but were present outside clinics to offer a ‘choice’. Their forms of action are rooted in faith-based understandings of public witnessing. Many told us they

were there simply to pray; but it was clear that vigils are also designed to produce transformative encounters with clinic clients by questioning their decisions. While activists regularly approach, seek to make eye contact with, hand literature to and engage in encounters with clinic clients, they do not see this conduct as harassment. They believe that their leaflets, signs, hymns and prayers guarantee not only their faith, but the sincerity and respectfulness of their action. Claiming their actions to be compassionate and supportive, activists distanced themselves from being dangerous strangers; by offering assistance to those in need, they attempt to place themselves beyond the norm of civil inattention. Their erroneous belief that abortion is intrinsically harmful also allows them to construct adverse reactions to their presence as arising from the procedure, rather than from the encounter itself. While their stated objective might be praying to end abortion, the 'focused interactions' or 'face engagements' (in Goffman's terms) they stage outside clinics are a deliberate attempt to deter women from exercising their reproductive rights, further contributing to the stigmatisation of abortion.

The comments collected from clinic clients reject claims that these actions are benign or supportive; instead they are often seen as deliberate rule infractions. Anti-abortion activists are often seen as potentially dangerous strangers; being watched or approached by them induces a range of negative emotions, from discomfort to fear. In our fieldwork, we observed similar reactions outside clinics, regardless of whether the anti-abortion activists were male or female. Abortion is considered a healthcare decision, and thus a matter for women and healthcare professionals; the involvement of anti-abortion activists in that process is unwelcome and unwarranted. Entering an abortion clinic suggests a specific purpose, in a way that an appointment at a hospital or GP surgery may not. While it is the case that anyone could see people entering and exiting a building, anti-abortion activists who stand outside clinics are expressly there to draw attention to the building as part of their mission to bear witness. The harassment that women feel, we argue, stems from the presence of activists at clinic sites, rather than from their precise conduct.

Our study identifies two reasons why this might be the case. First, by drawing attention to a healthcare appointment, anti-abortion activists violate socially constructed expectations of entitlement to confidentiality; clinic actions are in the wrong *place*, are *situationally inappropriate*. Anti-abortion activists outside clinics are directly engaged in the generation of a space of religious observance; this spatial generation is dependent upon its definition as a public space, both in the narrow legal form of entitlement to occupy space, and in the more general sense that public space is the space of collective self-constitution and social realisation. Central to claiming space in this way is the process of making the invisible visible. For clinic activists, this applies at once to their own presence as a social actor, to the site of abortion services and to the act of accessing abortion services. It thus involves a process of 'witnessing', constituted by the twin practices of *attending* and of *looking*.

For women accessing abortion services, however, our data show that the spaces outside clinics are understood as public in the narrow legal sense only. In the broader sense, they are not public spaces governed by expectations of focused, mutual interaction, but spaces governed by normative expectations of unfocused interaction, and a visual grammar of civil inattention. Focused interactions in these spaces are, in Gardner's (1995)

terms, an ‘information intrusion’. Through seeking information and questioning women’s private decision making over abortion, anti-abortion activists pressurise women to make their purpose public. The failure by anti-abortion activists to civilly disattend directly challenges women’s expectations of privacy and confidentiality, and makes their access of a specific reproductive healthcare service material and public. Moreover, the context of abortion stigma heightens the discrediting that some women feel when seeking services. That women may be equally upset by male and female anti-abortion activists would seem to suggest that the gendering of public space in this context is not dependent on the identity of the stranger alone.

Second, given that it is axiomatically women who are the subject of these breaches of civil inattention, the initiation of a visual or verbal encounter by activists is likely to position these women as inherently open to public attention, placing their social status into doubt. The breach of civil inattention thus depends upon and reinforces the perception of women entering and leaving abortion clinics as observable and approachable, and as such, unequal. Situating this experience in a broader understanding of gendered harassment in public spaces may help us explain the reactions of clinic clients. Street harassment reasserts gendered power relationships by subjecting women to unwelcome attention. Women often take steps to minimise what they see as the risks; but when accessing abortion, women’s ability to exercise any control over who is watching, or to avoid encounters, is removed; they can do little but walk through or past activists, who (through positioning and address) are able to control the space of the encounter. The lack of available avoidance actions may explain the anger some clients feel about these encounters. The relationship between surveillance, privacy and fear explains why women experience encounters with anti-abortion activists as harassment, even when they are not being approached aggressively. In policy terms, this suggests that the call for buffer zones around clinics is justified, as only the complete removal of anti-abortion activists from outside clinics will suffice in removing the source of distress.

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Notes

1. Northern Ireland also experiences anti-abortion activism outside clinics, but the different legal position inevitably shapes such activity.
2. In Scotland, hospitals often provide abortions and, as anti-abortion activists are not allowed on hospital grounds, their capacity for interaction is diminished.
3. Abort67 is an ‘education’ project of the Centre for Bioethical Reform.
4. Fieldnotes from background discussion with ‘Ivy’, Birmingham, February 2015.
5. An Early Day Motion introduced to Parliament by Labour MP Diane Abbott in June 2015 supported the call for buffer zones.

6. Nonetheless, many activists and organisations do celebrate clinic closures; see, for example, <http://www.marchforlife.co.uk/blog/22/4/2016/byhdtjhl1r0elowytpdv8mjm4vs9bq>
7. *40 Days for Life: A Practical Guide to Pavement Counselling* (32 pages; no publication date or details, though we assume 2016). This appears to be locally produced as it specifically advises participants to contact one of the regional organisers. We have not seen it replicated elsewhere.
8. The positioning of women entering the clinic as *mothers* was common; we discuss this elsewhere.

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