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Maneuvering in Silence: Abortion Narratives and Reproductive Life Histories from the Faroe Islands

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ABSTRACT

I explore what silence surrounding abortion means to women in their everyday lives and the composition of their selfhood. My analysis is based on one-year of ethnographic fieldwork consisting of 20 interviews with women from the Faroe Islands and participant observation. Building upon theoretical frameworks of belonging and subjectivity studies, I discuss women's silent maneuverings from an understanding of freedom of choice and power as complex entities and expand on the dimensions of belonging and non-belonging. I find that women's silent maneuverings are a navigational strategy made in a quest for belonging, and propose the concept of *performed belonging*.

KEYWORDS

Abortion stigma; embodiment; performed belonging; reproductive citizenship; split subjectivity; the Faroe islands

In a living room in a town in the Faroe Islands, a North Atlantic archipelago of 50,000 inhabitants, Monika talked me through her experience of abortion at the age of 23, some 12 years ago.[1] It is an experience that she, like many other Faroese women, prefers to keep secret. She had gone to her general practitioner (GP) to request an abortion. Induced abortion[2] in the Faroe Islands is not on demand up until a given gestation week as it is in other Nordic countries. The right to abortion is limited by the criteria that: 1. The pregnant woman's health (physical and mental) or life is at stake or at risk of being at stake; 2. The woman has become pregnant due to rape; 3. The fetus has, or has substantial risk of, severe mental or physical impairment(s); and 4. The woman is deemed mentally or physically incapable of taking care of the child. The law states that an abortion[3] must be granted by two medical practitioners (first a GP, then a gynecological obstetrician). Monika described how she told her GP that she would become depressed if she continued the pregnancy and had a baby at that time of her life. Monika tried to say the "right" thing to be granted access to an abortion. The GP was her family doctor and thus knew the family well. He told her that he knew she came from a "good" family and that her mother would help her raise the child. His response underlines how pronatalism in the society as a whole is furthered in health practices. It is also an example of the institutional silence concerning abortion, in that medical health staff find themselves navigating the restrictive abortion policy via their personal and cultural beliefs. Monika did not wish to share her dilemma with her family because she was afraid of disappointing them, so she left the GP's clinic and went to talk to a friend. Her friend helped her find another GP who was more likely to grant her access to abortion. Although I sensed reluctance in her voice, she went "doctor-shopping." That is she went from doctor to doctor until she found one who would grant her access to an abortion. It was not with pride she said she went "doctor-shopping." instead it was something she felt compelled to do.

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Media teaser: Women navigate in highly subtle and strategic ways to get access to abortion care. What are the consequences for their perceptions of selfhood?

Restrictive legislation, adapted medical practices, and moral regimes constitute the abortion landscape in the Faroe Islands and contribute to abortion stigma. Abortion is a relatively common medical and surgical procedure and a common reproductive decision in women's lives globally (Wulf 1999; Sedgh et al. 2012). Yet abortion is subject to stigma in many parts of the world (Kumar et al. 2009; Norris et al. 2011), even in contexts with relatively liberal abortion laws (Cockrill and Nack 2013; Love 2020; Singer 2018). Kumar et al. (2009) define abortion stigma toward women as based on what is considered socially to be deviant behavior[4] (Goffman 1963).

Abortion stigma is argued to be a significant issue in women's lives (Love 2020). Feminist scholars have addressed the silence manifested in women's lived experiences (but also on a political level and in the community at large) and proposed different strategies to "break the silence" (Bloomer et al. 2017; Chan 2019; Kimport et al. 2012).

With this study, I aim to contribute to the theoretical discussion of abortion silence manifested in women's lived experiences. I examine silence as a constrained choice and a strategic navigation in a local moral world. Second, with original empirical data I aim to contribute to the theoretical understanding of choice as motivated by a quest to belong (Gammeltoft 2014, 2018). Third, I aim to contribute to the theoretical discussion of agency and resistance as subtle and entangled in relations and local moral worlds (Abu-Lughod 1990; Aengst 2014; Mahmood 2005). The Faroe Islands present an interesting case, as women navigate within a modern society with similar lives to the women in neighboring Nordic countries, however they are subject to a moral regime that restricts their rights and bodily autonomy. These contrasts give rise to complex cultural navigation and subjective meaning making.

I begin by describing reproductive policies and the value of motherhood in the Faroese context. Next I discuss the theoretical framework and outline the methodological considerations, before I present the analysis and discussion. The analysis is structured into four analytical themes following a discussion in each subsection. The first two themes involve women's reproductive narratives in Faroese society: these cover institutional practices, the moral regime, and the value of motherhood all of which set the criteria for belonging. The last two analytical themes are concerned with women's subjectivity and constructions as *Other*, and the formation of a split subjectivity as they reconcile their decision to seek an abortion with Faroese values of motherhood, necessitating the construction of a "performed" belonging.

Reproductive policies and values of motherhood in the Faroe Islands

The Faroe Islands is a self-governing country within the Danish Kingdom. The Home Rule Act from 1948 de facto provides the Faroe government, the *Løgting*, with the right to legislate in all affairs within the Kingdom except for matters of defense and foreign policy, the judiciary, and matters of fundamental constitutional supremacy (Nordpolitik 2019). The Home Rule Act divides all political affairs into two classes. Class A affairs can be devolved to the local Faroe government at any time. Class B affairs are those of primary importance to the Kingdom, e.g., foreign policy and defense, which may only be devolved after negotiations between the signatories, the Faroe government, and the Danish government.

Although the right to abortion on-demand before the 12th gestation week was introduced in Denmark in 1973, the Faroe Løgting did not agree to the liberalization of abortion but instead maintained the former Danish Abortion Act of June 23rd 1956. This makes the Faroese abortion legislation among the most restrictive in Europe.[5] Eventually legislation regarding family affairs in general was formally devolved to the Faroe Islands in 2018, including the Abortion Act. However, de facto the legislation was already different in the two parts of the Kingdom.

The devolution turned out to be merely administrative as no amendments were made. Nevertheless, the matter did raise attention in the media and in public debate. In general, abortion is avoided in social and political discourse, and can be considered a taboo (Verstergård 2017). However, in summer 2017, reproductive politics, especially abortion was subject to considerable

political and public debates, and continued to be so during the 2018 elections. Yet most politicians avoided giving their opinion on the matter, highlighting the silence on abortion in the political arena (Pálsdóttir and Persson 2019). The abortion debate mainly took place on social media. During this period, the first pro-choice organization was established, called *Frítt Val – Fyri Fríari Abort* (Free Choice for a Free Abortion).[6] Before Frítt Val, the only organization with an agenda concerning abortion was the pro-life group *Føroya Pro Vita* (For Life).[7]

Some women have told their abortion stories on social media and in magazines but so far always anonymously. International media and supranational organizations like the United Nations Human Rights Office and the Nordic Council have criticized the Faroese abortion law. The United Nations Human Rights Committee on the Elimination of Discrimination Against Women criticized the Faroese abortion legislation as discriminating against Faroese women vis-á-vis Danish women, "causing some Faroese women to travel to Denmark for an abortion or to pretend to be severely mentally ill so as to be unable to care for a child" (CEDAW 2021, 12).

In this small island society citizens are closely related, which can offer both benefits and challenges (Hayfield 2018, 2020). Gossip travels fast and anonymity is not always easy to achieve. Therefore, people's social standing is vulnerable. On the other hand, gossip and close relationships become a means to navigate access to abortion (Verstergård 2017), by for example knowing the "right" doctor. I argue that Faroese women, unlike economically disadvantaged women in larger European countries (Zordo et al. 2017), do not turn to unsafe abortion providers. All abortions performed in the Faroe Islands, reported in this study, were legally performed at the National Hospital. Rather, Faroese women who meet the strict legal requirements for legal abortion, must strategically navigate the abortion law. The navigational methods that women told me about involved either lying or exaggerating their health situation; most commonly by claiming that they were at risk of depression. Other navigational methods involved drawing on gossip to find a pro-choice general physician or to travel to Denmark for an abortion.

Kinship plays an important role in Faroese society with its "traditional" family structure, which anthropologists have described as heteronormative and "child centric" (Gaini 2018; see also Hayfield 2018). Faroese society maintains a procreative norm, and reproduces a social value in motherhood and hence a moral regime of the *good* woman as the reproducing citizen (Roseneil et al. 2013; Timpson 1996). Lowe and Page have shown how anti-abortion activists in England and Wales construct women as ultimately "natural mothers" (Lowe and Jane Page 2019, 166). Although abortion activism does not have deep historical roots as in the US (Ginsburg 1989), the abortion debate in the Faroe Islands is either "harsh" and "extreme" or "utterly silent" (Skaale 2017, 37). The question of abortion challenges deep-rooted values in Faroese society and is highly polarized. On the Center Party's website, the Minister of Foreign Affairs and previous long-time Member of Parliament, Av Rana (2021), writes, "more than 40 million unborn children [worldwide] are sacrificed each year on the abortion altar." The rhetoric of the "unborn child" that is "sacrificed" frames the fetus as a citizen with the same rights as a born child. This is similar to Lowe and Jane Page's (2019) description of anti-abortion rhetoric that personifies the fetus and allocates it human rights, so that the only difference between a born child and a fetus that the fetus is located on the "wet side of the womb" (Lowe and Jane Page 2019, 174).

Analyzing abortion narratives in the Faroe Islands within a framework of belonging

Abortion is one of many reproductive decisions that women (and men) make. Political and structural restrictions to abortion care make the decision-making process more demanding practically, physically, and emotionally (Beynon-Jones 2013; Norris et al. 2011; Zordo et al. 2017).

Anthropological research has over the years identified the obstacles to abortion care, and the maneuvers that women must undertake in order to overcome them. Morgan and Roberts (2012, 241) developed the concept of "reproductive governance," drawing attention to "mechanisms through which different historical configurations of actors [. . .] use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control

reproductive behaviors and population practices." Working within a framework of reproductive governance and reproductive citizenship, Singer (2019) has identified "abortion exile" as a maneuver that is used to achieve abortion care and resist stigma. This scholarship on obstacles to abortion and maneuvers to overcome them has its roots in Western women's liberation movements and feminist theory. Although this approach resulted in important research, it depends on a Western ideal of freedom that defines agency as autonomy and resistance (Mahmood 2005). This obscures the subtleties of power and agency and the meaning-making processes of individuals' reproductive everyday lives (Aengst 2014). Ultimately, this reduces the meaning-making and choices of individuals to mere oppression by a moral regime. Instead Gammeltoft (2018) has proposed an anthropology of belonging to challenge the Western ideal of the agent, so as to understand individuals' choices and ways of life in their local context and as *quests for belonging*.

In her conceptualization of reproductive choices as quests for belonging, from a Vietnamese context, Gammeltoft identifies three key elements of belonging: possession, membership, and moral obligation. The notion of possession is not to be understood in terms of a Western liberal ideal of the autonomous agent. Rather, it speaks of a fundamental connection, "so fundamental, perhaps, that it precedes the experience of being an 'I'" (Gammeltoft 2018, 88). It is the sense of possessing someone and being possessed by others. The second element, membership, is not limited and fixed in social landscapes, as of a gender or class, but of larger social bodies, capturing the "plural and often competing and contradictory memberships that characterize human lives" (Gammeltoft 2018, 89). The final element of belonging, moral obligation, deals with the effect of being possessed by someone or being a member of something; it "allows people to place moral demands and expectations on one another" (Gammeltoft 2018, 89). In this sense, belonging is not subject to a single definition. It is multiple and interrelated. It is temporal. It is neither ultimately good nor bad. It can be both harmful and beneficial at the same time.

In most anthropological research on abortion, terminating a pregnancy is shown as a potentially ethically demanding decision for the individual. According to Gammeltoft (2014, 19), ethically demanding dilemmas "are arenas of the making of subjects," which makes abortion ground for the formation of subjecthood. The ethnographic insight in this article is that the ethical dilemma to terminate a pregnancy is a choice entangled in the social and moral worlds of the women who make these choices. Furthermore, abortion in the Faroese context demonstrates the subtleties and dynamics of agency and power, as women negotiate and re-negotiate their access to abortion, also illustrating their strivings for belonging in their local community.

I thus draw on this framework of an anthropology of belonging in order to explore the silence that characterizes women's decisions and behaviors around abortion. At first glance, the women might appear oppressed and without agency, but through the ethnography I will draw out their subtle agency through their maneuvers to gain access to abortion. Applying Gammeltoft's notion of choice as belonging and adding women's subjective perspectives, I will show how these women must actively *perform* their belonging. I propose that their silence in maneuvering and navigating through the restrictive Faroese abortion landscape can be understood as "performed belonging."

Referring to abortion silence as a navigational strategy and analyzed in a theoretical framework of "choice as belonging" (Gammeltoft 2014), I propose the concept of *performed belonging* on a subjective level. The concept is not to be analytically confused with "performed belonging" described by Yuval-Davis (2006, 2011), Probyn (1999), or Bell (1999), who describe performed belonging as a repetitive act or ritual, *reproducing/constructing* a belonging. Although my analytical focus on performed belonging is partly inspired by their framework, my alternative use of the term is linked to subjectivity studies (Johnson 2008; Root and Browner 2001; Young 1984), that foster a discussion of belonging from a subjective level. Performed belonging as referred to in this article, must be analytically separated from perhaps *ascribed* belonging through repetitive acts, as it projects the social and intersubjective ideas of the social constellation (good woman/citizen) without achieving belonging internally. It is thus a matter of performing a belonging to the ruling moral regime while feeling a nonbelonging. Fulfilling one's obligations as a citizen can secure membership (Harré and Davies 1990; Turner 2001),

which in turn forms a social belonging (Gammeltoft 2014). In this light, keeping silent is a way to maintain one's reproductive citizenship while attending to one's acute reproductive needs.

Methodological approach

I draw on twelve months of fieldwork conducted between 2019 and 2021 in the Faroe Islands and in Denmark. The empirical data consists of 20 individual interviews lasting between one and two hours. The inclusion criterion was Faroese[8] women over 18 years of age with experiences of reproductive dilemmas (unplanned pregnancies, abortion, or the like). Participant-observation informed my understanding of the broader abortion landscape. This consisted of a number of informal conversations with local people, and more general participation in the social life in the Faroes. I participated in a mother's group with my newborn baby, and established together with two other women, a sexual health education programme for all first-year high school students in the Faroes. Finally, I took part in, and followed, informal debates on social media, such as Facebook.

All participants were female: 19 were women with personal abortion or reproductive stories and one was a gynecologist. Six of the 19 interviews did not involve personal abortion experiences but addressed abortion as a societal phenomenon, which women experience on different levels. The remaining 13 interviews involved abortion narratives. Two women had undergone two induced abortions. One woman had applied for an induced abortion, which had been granted. However an ultrasound examination found that it was an ectopic pregnancy, which demanded a surgical abortion for health reasons. Three women traveled to Denmark for an induced abortion.

All informants self-identified as Faroese, irrespective of how long they had lived abroad. Interviews were held in Faroese, as Faroese is my own and the informants' first language. The women were between 19 and 67 years of age. To ensure participants' anonymity, all names, dates, and geographical locations mentioned are changed.

All 19 participants received an information letter and a consent form before the interviews, and the gynecologist received oral information on the study and gave oral consent. I conducted all interviews alone and face to face. Nine interviews were transcribed verbatim by a transcriber, while I transcribed the remaining eight. Three participants did not want the interview recorded, and I therefore took notes during those interviews. I was very aware of the sensitivity of the participants' anonymity in relation to the transcriber and writing up of the study, which is why I put great efforts into processes of confidentiality. The Faroes are a small-scale island society where it is easy to identify someone merely by their voice or simple background information. Citizens' interconnectedness meant that often either I or the transcriber had some kind of connection to the participants. The small-scale conditions pose ethical challenges to the researcher and I would argue that my insider status allowed me be alert to these very subtle ethical challenges, and enabled me to continuously navigate the social landscape. My position as a young Faroese woman, may have, from a feminist perspective, constructed me as an ally or a person that the women could confide in. This potential positioning of me as an ally fosters the women's meaning-frame (Hollway and Jefferson 2000) of the study and is part of creating a "relationally safe space" (Hydén 2014, 799), also positioning me as a "sympathetic listener" (Madison 2020, 32). This positioning partly enabled the women to share intimate reproductive stories.

I adopted a narrative interview style centered around one initial preplanned question (Bo et al. 2016). As much as I focused on a narrative analysis, I also paid attention to the non-narrated or embodied side of lived experience. By non-narrated I mean the tacit elements of the narrative: the issues, feelings, or situations that I interpreted to be present.[9] There were also situations where issues were briefly touched upon by the informant but were then wrapped up quickly and left "hanging." In this sense, the silence *in* the narrative also matters. I looked at the women's bodily expressions in order to further interpret the emotions underlying the words that they chose to describe their lived experiences. One must keep in mind that these are mostly *silent* narratives. By silent, I mean that

they were often well held secrets, which some of the informants made a special effort not to tell in their everyday lives.

I interviewed mainly white women with blood related attachment to the Faroes, many of whom had a tertiary education and socio-economic stability. The sample did not include newcomers to the Faroes, or different racial and socio-economic groups. The informants were from both small rural or relatively urbanized communities. I did not interview any men, whether it was those who had been involved in their partner's abortion experience at the time, nor in those cases where a woman did not have a partner at the time of their abortion but had since found one, did I interview their current partners. Anthropological studies show that abortion is often kept secret and that women try to involve as few people as possible, because it is perceived to be a "woman's issue" (Browner and Perdue 1988; see also Gammeltoft 1999; Ginsburg and Rapp 1995; Scheper-Hughes 1992). The drawback of studying only women is that it reproduces abortion as a woman's issue.

The inclusion criteria and sample described above may have caused a selectivity bias in that it is possible that only women who were politically or ideologically motivated by a liberalization of the abortion law showed interest in the study while those with different views may have avoided participation (Madison 2020). Anticipating this potential selection bias I asked for their motivations to participate in the study. Some women wanted to participate because of our interconnectedness. In fact, a majority with this motivation were my primary or secondary acquaintances. Others were politically motivated to contribute to a more nuanced debate about abortion. This means that the study does not necessarily include women with strong religious backgrounds and/or ideologies that are in favor of further restricting access to abortion. Nevertheless, the participating women were not specifically politically engaged in the pro-choice abortion debate, they did not use markedly pro-choice language, and some of the women were not fully aware of what the abortion law entailed.

Authoritative knowledge as multi-sided

As exemplified in the introduction, the informants with abortion experiences found that some of the medical staff tampered with women's access to abortion or postponed their decision, by interfering with the women's personal social circumstances. Such tampering with abortion access has been called "arbitrating abortion" (Kasstan and Unnithan 2020), in which healthcare staff reinterpret the law and adjust practices.

Bjørg is a 41 year old woman, who now speaks candidly about her abortion choice and experience. It was not so when she had her abortion at the age of 19. At the time Bjørg thought she was the first to ever have an abortion in the Faroes, saying that she felt like a "spot of shame on the Faroese society," and afraid of disappointing her parents she wanted it kept a secret from them too. Most of her friends were "conservative," as Bjørg puts it, which made her feel alone. Later, when she learned, through gossip, that there were many young women like her, having abortions and hiding it, she began being open about it. Bjørg remembers having to "beg" for the abortion at the doctor's surgery. She said:

> And then I was at the doctors, the first time was just about trying to convince me not to get an abortion. And she's the family doctor. So she kept saying "It's a good support base" [the family], you know. To me that was so personal. To talk about my family. It had nothing to do with it. I mean, I'd got pregnant and that had to change. I remember it crossed my personal boundaries that she kept saying that they [the family] were going to help me and stuff like that. (. . .) She wanted me to think about it for a week. So I had to wait until the ninth week and when I came back, she was still reluctant. And then she suddenly says, "You'll have to excuse me, a little baby is coming in and it's really ill." And I was like "of course," you know? And then I just sat there, for a long while, I remember, and waited and I felt like I was wasting a doctor's time who had sick people to care for. I felt *bad*. And then she came back, and she still thought I should think more about it and come back a couple of days later. And I remember I was like, I almost bowed down on the floor and like *begged*. I was so desperate. (. . .) But then I left again and then came back. When I returned, she had gone on her second honeymoon. So I don't know if she just thought I was going to have it [the baby]. Like "She has a good mother so it'll be all right." [Emphasis added]

The above passage elucidates the many navigations and maneuverings between women/patients and medical staff, and highlights an institutional silence. Like Monika, Bjørg reveals ambivalent emotions in her narrative. She feels "bad" for taking up other people's time. Bjørg's "begging" indicates her performance as an inferior citizen (Bacchi and Beasley 2002; Ho 2009), while also being affirmative about her needs and her decision, exemplified in her returning several times to the doctor and resisting the doctor's attempts to make Bjørg change her mind. Bjørg managed to convince the doctor's secretary, who was a friend of the family, to arrange an appointment for an abortion without the doctor's approval. Bjørg's GP was reluctant to grant her access to abortion as she knew her family, while the secretary went the extra mile *because* she knew Bjørg's family.

The Faroese government places access to reproductive healthcare under the power of medical experts and institutions, positioning medical facilities and staff as "rational" and abortion-seeking women as "irrational" and incapable of making an autonomous and informed reproductive choice (Beynon-Jones 2013). Amuchástegui and Flores (2013) found that in the context of a newly legalized abortion law, the liberalization had symbolic effects, positioning women as "legitimate users" (ibid:922) and as such serving as an ally in the abortion-seeking women's moral justification of abortion. Restrictive abortion legislation formally positions the state as a non-ally to abortion-seeking women, placing authoritative knowledge and the power in medical institutions, and positioning women as "lesser" citizens (Bacchi and Beasley 2002), which reinforces their feeling of stigma. Individual medical staff can appear to apply the law according to their own personal beliefs. We see that Bjørg and Monika both experienced themselves as lesser citizens (as medical staff interfered with their access to abortion) while other medical staff served as allies who facilitated access to abortion. Thus I argue, that we need to expand our understanding of who holds authoritative knowledge beyond "institutions" and "doctors," to secretaries and other individual medical staff who can serve as allies, as the abortion-seekers work with them to go "doctor-shopping," or convince a secretary to help them.

I want to stress that the arbitration that the two different medical staff carried out for Monika and Bjørg depended on their preexisting relationships. Close relations in a small island community can aid potential navigation while also restricting abortion access.

While it may be true that abortion care practitioners engage in "dominant discourses of abortion and motherhood" that stratify abortion care (Beynon-Jones 2013, 12), the analysis above enriches the theoretical understanding of medical authoritative knowledge in the medical anthropological literature.

The ruling moral regime and definitions of a good woman

Several participants in the study recognized the restricted access to health care as treating citizens differently based on their gender. For example Barbara, a 34-year-old mother of two, had wanted to terminate her first pregnancy but changed her mind at the last moment:

> It's like, you won't get this or that medication because you don't fulfil such and such criteria. But that's what I mean, it just becomes like, oh, we'll just say this, we know it's not true, but we'll just say this. And you have to say, okay let's pretend that so I can get this [abortion]. So, you kind of pay with your own self-esteem. And in one way or another you lose it (. . .) your own self-esteem. (. . .) And that's basically the same standard that keeps [going], because it sure isn't the father [of the fetus] who's forced to declare he's mentally unstable, is it? What if that was the reason, and that was why you wanted an abortion? I mean, you could say that the circumstances aren't good because the father is mentally instable, you see? No, no. It's *you* (laughs). Only you. Because you can have the baby. You can just choose to have it adopted. It's stuff like that. No. It's so far out. That those need to be the reasons, instead of just nothing. And that's exactly the point, that you must defend yourself in some way. Which I would have done if I said it in public. Because that's like the standards, so that's what I must relate to.

According to Barbara's narrative, women's reproductive rights and autonomy are not considered from a woman's standpoint. She felt that women are forced to "pay" with their self-esteem when they had to beg for an abortion, implying that this payment reflects a nation/society that has an oppressive view of women. Barbara's statement elucidates her perception that Faroese society only sees value in women

who fulfill the social expectations of motherhood. She is talking about a moral regime, a "standard," concerning reproductive duties. While she expresses her disagreement and dissatisfaction with the felt moral regime, she still feels it is something she must "relate to." In citizenship studies, feminist scholars have shown that control over women's bodies and reproductive rights, such as that enacted by restrictive abortion legislation, requires that first a distinction is drawn between "full citizens" and "lesser citizens." Lesser citizens are assumed to be unable to rationally fulfil the expectations of full citizenship (Amery 2013; Bacchi and Beasley 2002; Mishtal 2012; Outshoorn et al. 2012; Turner 2001).

In light of this moral regime, I argue that, in the Faroes, choosing an abortion can be understood to be the same as renouncing motherhood. Not only can choosing abortion be seen as equivalent to renouncing motherhood, but as Mariann said:

> The whole thing about creating a family and having a family is so *Faroese*. I mean if you said, I don't want a family [having children, reproducing]. It's just like "*What are you saying?*" (eyes wide open and laughs) I mean, it's as if there's some value in having children. And I have a friend who hasn't been able to get pregnant and went to Iceland to get help [infertility treatment]. And that's something you just don't tell *anyone*. I mean, just as an example, how much weight goes off your shoulders. It's like 30 kilograms off your shoulders to just say, you know what, it's not really working for us, so we must go to Iceland to get help. And hopefully that will help. Because now she spent ten years trying to get pregnant. I mean, you know. It's stuff like that. It's so depressing.

In the above passage, Mariann is talking about a moral regime concerning other reproductive issues, in this case infertility. Mariann then moves on to abortion:

> And it's the same with abortion. The fact that you cannot talk about it. Like my friend – I don't think she has any psychological problems due to it [abortion] – but just the fact that she can't say "Yes, oh my God, it was good that I had that abortion." Or just that she can't talk about it, something that's normal and something that is okay. Without feeling that she's done something horribly wrong and that she is selfish.

Not only becoming a mother but also *how* and *when* a woman becomes a mother seems to be important, as exemplified in Mariann's statement. Women find themselves in a dilemma, as their expectations of the ideal female citizen is a woman who has children, but not in any way or at any time. The valued female citizen has children at the *right* time and in the *right* way.

Silence about abortion decisions and experiences can be understood from a Foucauldian framework of power, as if the ruling moral regime silences women's abortion experiences because they do not fulfill the obligations and expectations of a reproductive citizen in society (Foucault 1982, 1984). While this may be true, I argue that remaining silent can also be understood as a navigational method to resist abortion stigma (Cockrill and Nack 2013; Hoggart 2017) and indicative of relationships with the dominant moral regime in society. As Barbara said, "that's like the standards, so that's what I must relate to." Women who obtain an abortion in a moral regime that condemns and structurally restricts abortion, "pay with [their] self-esteem," but they choose to remain silent, as a navigational strategy to maintain their value as moral citizens/good women. The women's choice is "culturally constrained" (Aengst 2014, 422; see also Mahmood 2005), as their choice to remain silent arises in a cultural context. Thus, it is important not to reduce agency to free will or publicly expressed subversion, as this would ignore the woman's cultural context, i.e., the moral regimes, ideals of motherhood, and abortion stigma.

An "othering"

It was especially the women with older abortion experiences (see Table 1), like, Bjørg, Sóley, and Greta, who spoke of emotions of loneliness and othering. Bjørg said:

> I didn't really talk to anyone about it, and I was just so, I literally thought I was going to be the first Faroese to have an abortion, because I'd never heard of anyone else.

Sóley, who was not used to speaking openly of her abortion experiences in public (although she was less reluctant to do so in a safe setting or when abroad), said:

> I've been so afraid of it [speaking about abortion and supporting pro-choice activism]. Because what if I supported it, then people would probably think I'd had an abortion, and what if they *knew* I'd had an abortion, what would they think? (. . .) There are many enemies out there that you must be ready for.

Sóley had her first abortion at the age of 16. Since she was still a minor, her mother accompanied her to the GP to request an abortion. Sóley remembers that her mother did the talking. After the abortion they never spoke about it again. I asked Sóley if she felt that her abortion experience said something about her as a person, to which she replied:

> Yes, definitely. Someone who doesn't take care of herself (. . .) One thing is to have one [abortion] and it is quite another thing to have one more.

Sóley refers to repeat abortions as being less justifiable than having one. She had internalized the idea that an unplanned pregnancy is a mistake one should learn from. Sóley, like several other women in my study, imagined people would turn their back on her if they knew about her abortion decision. Greta, a woman in her late 50s, was afraid of people knowing about her abortions: she had a high profile job and a good career, which did not fit well with the image of "an irresponsible and promiscuous woman," as she described it. The women's fear of people knowing about their abortions and their negative descriptions of women having abortions, illustrate felt and internalized abortion stigma.

I will base the following analysis of abortion stigma on Herek's (2009) framework of sexual stigma, which has also been applied in other studies on abortion stigma (Cockrill and Nack 2013; Hoggart 2017). Herek's stigma framework is used to understand stigma on an individual level, and includes three kinds of stigma: internalized stigma, when an individual takes on stigma from their community; felt stigma, when someone perceives the negative thoughts of others; and enacted stigma which describes actual stigmatizing experiences. The following analysis will concentrate on felt and internalized abortion stigma. Sóley's and Greta's examples also emphasize how felt and internalized stigma reached beyond age, profession/social standing, and even motherhood. They both had their abortions when they were young with neither a profession, high social standing, nor motherhood. One could assume that after achieving an education, profession, and even becoming a mother, they would reject shame and resist internalized abortion stigma (Hoggart 2017). However, despite their positions as mothers today (see Table 1), their narratives also revealed feelings of shame and internalized abortion stigma, indicating the significance of abortion stigma and value of motherhood in the local moral world.

Felt and internalized abortion stigma prevents more open talk about personal reproductive decisions and experiences that go against the ruling moral regime. As the ethnographical insights show, women fear the potential consequences for their social life and career of speaking in public about personal abortion decisions and experiences. The feeling of othering and loneliness inhabit their imaginations, such as Bjørg's and Sóley's notion that they are the "first Faroese to have an abortion."

Maintaining silent abortion navigation has a dual temporality (Vigh 2010:151) as it performs in the socially immediate and the socially imagined. By obtaining the abortion in silence and keeping it a secret, the abortion-seeking woman enables herself to "survive" as a moral citizen in both the immediate moment and the imagined future. Surviving in the immediate implies that the woman can terminate her unwanted pregnancy and thus continue the life she wishes/plans. Surviving in the imagined means that by remaining silent the woman resists becoming labeled as an inferior reproductive citizen/woman. The silent maneuverings are examples of how the women get what they need – to act as autonomous citizens in relation to their reproductive decisions – despite the moral and structural barriers, to survive the immediate, but keep aspects of their lived experience hidden to survive the imagined. Thus, the silence about their decision helps to make their moral non-belonging hidden.

Table 1. Informants included in this paper, except the gynecological obstetrician.

Pseudonym	Age at time of interview	Abortion*	Age at time of abortion	Children at time of abortion*	Children at time of interview
Bjørg	41	1	19	0	3
Monika	33	1.	23	0	1
Sóley	32	2	16, 18	0, 0	2
Helena	25	1	22	0	1
Greta	54	2	16, not known	0	4
Malan	67	1	18	0	4
Edith	20	0	n/a		1
Mariann	30	0	n/a		2
Annika	27	0	n/a		0
Barbara	34	0 (Wanted one but changed her mind)	n/a	0	2
Gunnhild	30	0	n/a		2 (and pregnant with the third)
Kristianna	49	1 miscarriage and 1 induced abortion	42, 45	0	0
Rósa	19	1		0	0
Halla	34	1 (in DK)	32	3	3
Drós	43	1 (due to health reasons – but wanted one)	40	2	2
Beinta	36	1 (in DK)	33	0	1
Sára	31	1	30	0	0
Alda	35	0 (wanted one due to health condition but was rejected one)	33 but was rejected access to abortion	3	3
Vár	34	1 (in DK)	20	0	0

*In the cases where I did not confirm my interpretation with the interviewees, it was because I interpreted their self-censorship and swallowing of words as we had entered a vulnerable space (Liamputtong 2007) and I deemed it ethically right to not delve more into it. Interviewing is a constant ethical sensing of what the space has room for and how we can navigate the interview (Hydén 2014; Øye et al. 2016).

Notes.

Belonging as performed

Faroese women navigate a reproductive landscape, where their agency is both authoritative (the fact that they seek an abortion and continue negotiating until successful; "doctor-shopping" as Monika described it) and subjugated (where they feel they are in the position of "begging" as Bjørg described her experience). The abortion narratives portray an embodied autonomy, a feeling of right choice and agency, while at the same time being infiltrated by a felt and internalized stigma which left their subjectivity in a conflicted and *split position*.

The concept of "split subjectivity" is widely discussed in the field of motherhood and pregnancy (Chodorow 1999; Johnson 2008; Root and Browner 2001; Young 1984), where the feeling of being oneself is accompanied by the feeling of becoming someone else. There is an internal/bodily experience and an external/performance of oneself. Young (1984) described how her bodily feelings and performance of her external self were constantly floating between one and the other while also being one and the same. This is how I interpret the generally conflictual interplay between the two subjectivities in the women's abortion narratives in this study. They see themselves as having made the right reproductive choice for themselves, ensuring a feeling of agency in their lives, yet also feeling themselves to be inferior citizens, or "denizens" (Yuval-Davis 2011, 158). Living under a moral regime which condemns their reproductive choices and which contains a cultural understanding of what identity the subject occupies when choosing an abortion affects women's subjective understandings of selfhood.

Staying silent on reproductive decisions or challenges, the women negotiate and maintain their (performed) belonging in the society/community/intimate relations. This is what Gammeltoft (2014, 2018) means by claiming that (reproductive) choices are made in "quests for belonging." Gammeltoft (2014) argues that choices are made in quests for belonging because they are interrelational. That is, choices are made in the context of a collective. In her fieldwork and analytical focus, women's

reproductive decisions and agency are intertwined with and obliged by a collective, or shared "knowledge," whether medical authoritative knowledge (Jordan 1993), religious governmentality (Morgan and Roberts 2012), or family morals (Gammeltoft 2014). It is thus a "constrained" agency, that strives for belonging, doing the right thing, and being a good citizen/woman. These Faroese women often felt that their abortion decision was made in silence and it was often a lonely matter. Simultaneously, they navigated through the close relations in the Faroes. I have wondered how this can be seen in the light of belonging, since I have argued that abortion can be understood as a rejection of motherhood, *risking* one's belonging as a reproductive citizen. As I have identified in the previous analytical sections, the women maneuver in silence as a quest for belonging. However, I find that they feel "othering" and possess a split subjecthood, which requires them to consciously perform their belonging. With the empirically developed concept of performed belonging I seek to expand on Gammeltoft's (2014) notion of choice as a quest for belonging. This is productive in cases when the reproductive choice counters a moral or social belonging but where re-negotiations will grant a *performed* belonging. By performed belonging I mean that the belonging is not achieved internally but nonetheless an individual externally acts in order to conform to expectations of belonging in the social and moral landscape.

Concluding remarks

I find that women maneuver in the restrictive abortion landscape in silence, navigating relationships and moral codes to achieve access to abortion care. They did so by following gossip about which GP would most likely grant access to abortion and/or by turning to other medical staff, who act as either allies or gatekeepers to abortion care. In the context of the Faroe Islands, I contribute to understanding authoritative medical knowledge as multi-sided and relational. I find the silent maneuvering to be a constrained choice of women relating to the ruling moral regime, where the embodiment of femininity and a "good woman" is to a certain extent identified with motherhood. I highlight that it is important for anthropological research on reproduction not to reduce agency to full autonomy and public subversion. While I find that the silent maneuvering is made in a quest for belonging, I also find that the women feel "othering" as their reproductive decision is irreconcilable with the ruling moral regime of ideal womanhood. The silence has a dual temporality, aiding women to survive socially and as a moral citizen in the immediate moment (having the abortion) and the imagined future (by not revealing the abortion, and thus resisting stigma). The silence can in this sense be understood as concealing their non-belonging. However, I find that the silence in the women's lived experiences constructs a split subjectivity. This conflictual aspect in their subjectivity has led me to formulate the concept of performed belonging as a contribution to the understanding of choice as belonging.

Notes

1. Monika is a pseudonym as all names in the article are, to protect participants' anonymity.
2. Henceforth abortion, unless specified otherwise.
3. This is the only place a woman can legally seek abortion in the Faroe Islands, as there are no private abortion clinics.
4. In this sense as deviating from the ideals of womanhood.
5. The ERC project "Europe Abortion Access"(https://europeabortionaccessproject.org) sets out to identify abortion landscapes in Europe. Further, they map abortion travel within Europe. The Faroe Islands are not included in the project. This is most likely because from a European perspective, the Faroes are perceived as politically part of Denmark with common legislation. The Faroes are, however, not members of the European Union.
6. A grassroots organization initiated by a group of women who wrote an open letter on their liberal abortion standpoint. More than 200 people signed the letter when it was released in late 2017 and in 2022 more than 1000 have signed it. In 2022 the organization constituted a board of 11 women and about 130 signed members.
7. This Faroese organization cooperates with other pro-life organizations in the "International Right to Life Movement."

8. As there is no universal classification of what a "Faroese" person is, I refer to the women as Faroese when they self-identified as such. It was thus a matter of feeling national identity.
9. In the cases where I did not confirm my interpretation with the interviewees, it was because I interpreted their self-censorship and swallowing of words as we had entered a vulnerable space (Liamputtong 2007) and I deemed it ethically right to not delve more into it. Interviewing is a constant ethical sensing of what the space has room for and how we can navigate the interview (Hydén 2014; Øye et al. 2016).

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