Encounters with the State:
A Study of Pathways to Pregnancy Prevention and Termination in Phoenix, Arizona

by

Melissa Janel Martinez

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Approved November 2016 by the
Graduate Supervisory Committee:

Madelaine Adelman, Chair
Ann Hibner Koblitz
Doris Marie Provine

ARIZONA STATE UNIVERSITY

December 2016
ABSTRACT

This research project analyzes women’s dynamic pathways to pregnancy prevention and termination in Arizona. Two levels of analysis guide the study: The first is a cultural analysis of the socio-legal conditions that shape the channels to birth control and abortion. During this historical moment, I analyze the fight over increasing (and calls for more) legal constraints against contraception and abortion, coupled with decreasing individual access to reproductive health care information and services. This dissertation includes an examination of the struggle over reproductive health on the ground and in the legal arena, and real pushbacks against these constraints as well. The second is an analysis of how women seek out contraception or abortion within the US socio-legal landscape. The study qualitatively examines narratives from 33 women in the greater Phoenix, Arizona area, a region emblematic of the political contest over the legal regulation of women’s reproductive health currently unfolding nationally. Ultimately, the state is implicated in the various resources and barriers—people, places, processes and policies—that inform women’s pregnancy prevention. These experiences can illuminate the ways that reproductive health care is shaped by intersecting and sometimes competing ideologies, and how women encounter them in their daily lives. The study theorizes the embodiment of women’s local encounters with the state within a cultural context of contested law and policy reform.
In loving memory of my grandmother, Janel Hangartner (1934-2004),
the strongest woman I have ever known.
ACKNOWLEDGMENTS

This dissertation would not have been possible without the many inspirational women in my life. While undertaking a PhD has proven to be a life-changing experience for me, this project was certainly no individual feat which must be acknowledged.

First and foremost, I owe a debt of gratitude to my dissertation committee chair, Dr. Madelaine Adelman. Your constant encouragement, guidance and intellectual insight have been invaluable resources for me throughout the program. I am particularly grateful for time you spent on detailed feedback, which pushed my analytical thinking further. Working with you over the past four years has been an absolute pleasure – so, sincerely, thanks a million, Maddie.

Special mention goes to my remaining committee members, Dr. Ann Hibner Koblitz (ASU Women and Gender Studies) and Dr. Doris Marie Provine (ASU Justice and Social Inquiry). Within the classroom and during dissertation research, you both expanded my intellectual and analytical insight on reproductive politics and socio-legal research, respectively. I am genuinely grateful to you both for the continual support and timely feedback throughout the project.

Next, I am indebted to my academic mentor, Dr. Eve Darian-Smith in Global Studies at the University of California, Santa Barbara. You encouraged me to continue my higher education, first, with my Master’s and, again, with my doctorate. Your confidence in my intellectual capabilities fostered my enthusiasm for socio-legal research early in my undergraduate education. I would not be here today without you, Eve.

I must also recognize that the study would not have been possible without the sample of incredible women who shared their personal stories with me. Thank you for
spending time and allowing me into your lives. You all are the reason I remain impassioned to pursue this kind of research now, and throughout my academic career.

To my Momma – my best friend, my rock, my unwavering ally – I offer a million thanks for always being there. Our weekly chats helped to quell my anxieties and keep me going. Please know that I love you so much – and just as I came from you, so did this academic feat.

To my Daddy and my Brudder (aka Matty) – thank you to both of you for talking sense into me anytime I needed it. More, thank you for showing me what it looks like when thoughtful men align with women rather than undermine them.

Also many thanks to my closest friends, Jessica Burrell and Abby Vercauteren, who offered words of encouragement throughout years of my venting over the program and my dissertation. Our relaxing nights watching Girls and drinking white wine helped me recharge my batteries and maintain my determination.

Thank you to Arizona State University’s School of Social Transformation. Specifically, I am grateful to both Justice and Social Inquiry and Women and Gender Studies for practical help navigating the doctoral program and financial assistance provided throughout my doctoral work. Extended thanks to the ASU Graduate College for funding the final stages and completion of this project.

Finally, I dedicate this doctoral dissertation to my grandmother, Janel Hangartner, whose loving memory continues to inspire me. Your life and spirit taught me what it means to be a strong woman in this world – to embrace the notion that, amidst society’s deep-seated shortcomings, there is still much to be gained from kindness, compassion and solidarity.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>A Note on Terminology</td>
<td>1</td>
</tr>
<tr>
<td>Literature Review</td>
<td>3</td>
</tr>
<tr>
<td>Reproductive Politics in the United States</td>
<td>5</td>
</tr>
<tr>
<td>Law and Society</td>
<td>27</td>
</tr>
<tr>
<td>Encounters with the State and Social Stigma</td>
<td>36</td>
</tr>
<tr>
<td>2 RESEARCH DESIGN AND METHOD</td>
<td>41</td>
</tr>
<tr>
<td>Research Questions</td>
<td>41</td>
</tr>
<tr>
<td>Epistemological and Methodological Approach</td>
<td>42</td>
</tr>
<tr>
<td>Methods</td>
<td>43</td>
</tr>
<tr>
<td>The Study Sample</td>
<td>49</td>
</tr>
<tr>
<td>Research Ethics</td>
<td>52</td>
</tr>
<tr>
<td>Limitations</td>
<td>53</td>
</tr>
<tr>
<td>3 ARIZONA’S SOCIO-LEGAL LANDSCAPE</td>
<td>56</td>
</tr>
<tr>
<td>Arizona’s Historical Timeline</td>
<td>59</td>
</tr>
<tr>
<td>Current Trends in Arizona</td>
<td>69</td>
</tr>
<tr>
<td>Additional Contemporary Legislation in Arizona</td>
<td>79</td>
</tr>
<tr>
<td>4 EXPERIENCES WITH PREGNANCY PREVENTION IN ARIZONA</td>
<td>92</td>
</tr>
<tr>
<td>Encounters with the State</td>
<td>94</td>
</tr>
<tr>
<td>Encounters with Medical Institutions</td>
<td>102</td>
</tr>
<tr>
<td>Encounters with Insurance Institutions</td>
<td>119</td>
</tr>
</tbody>
</table>
1. Introduction

Inspired by the escalating debate over reproduction in the United States, this research project analyzes women’s dynamic pathways to pregnancy prevention and termination in Arizona. The fight over increasing legal constraints against contraception and abortion remains pertinent. This project examines the struggle over reproductive health on the ground and in the legal arena, and real pushbacks against these constraints as well. First, the project offers a cultural analysis of the socio-legal conditions that shape the avenues to birth control and abortion in Arizona. Next, I investigate how women seek out contraception or abortion within this US socio-legal landscape, identifying encounters with the state along the way. In the end, different barriers and facilitators (some influenced by the state) inform women’s pregnancy prevention, and have larger implications on social stigma felt by different women.

A Note on Terminology

This project necessitates defining of both *contraception* and *abortion* as used throughout this dissertation. With regard to contraception (commonly referred to as *birth control*), I refer to mechanical hormonal methods or devices used to prevent pregnancy. My project is specifically interested in women’s interactions with the state, so my project limits itself to those forms of contraception that require interactions with a medical institution (state or otherwise) to obtain. This includes multiple forms of hormonal birth control (including the pill, ring, injection, etc.) and intra-uterine devices or the IUD (both copper or hormonal). This project has not included experiences with the hormonal implant for a couple reasons. While use of long-acting reversible contraceptives (LARCsd)
like the implant and IUD\(^1\) continues to increase nationally, the hormonal implant is still only used by approximately 1%\(^2\) of women actively using contraception (Daniels, Daugherty and Jones 2014). Further, in the US in 2012, there were approximately 500,000 women using the hormonal implant compared with the three million women using the IUD and approximately nine million using the pill (Ibid.). Therefore, experiences with the hormonal implant have been excluded from this project due to low rates of usage and the practical limitation of lacking potential participants who used the implant. Additionally, this project excludes those seeking over-the-counter birth control like condoms, sponges, and spermicide, and non-hormonal contraception like diaphragms\(^3\). With regard to abortion, I include experiences of abortions by the RU-486 pill (or chemical abortions) and those by surgical procedure (or instrumental abortions). This study does not include experiences with late-term abortion.\(^4\)

**Literature Review**

\(^1\) Use of LARC$s$ (both the hormonal implant and IUD$s$) exhibits a 12 percent increase in the US since 2002 (Daniels, Daugherty and Jones 2014).

\(^2\) Compared to 0.4 percent in 2002 (Ibid.).

\(^3\) Obtaining diaphragms for birth control involves interactions with the medical arena because they must be individually fit to each patient’s cervical opening. However, none of the women recruited for the project expressed interest in using one nor had medical staff offer it as a viable birth control option. “A decision to try an alternative non-hormonal method is unsupported by ideology” and their use is not “reflected by the culture” (Grigg-Spall 2013: 96). In my own experience, when I asked my doctor about the diaphragm, I received a rather negative response. Generally, even amid my hesitation with hormonal side effects, my doctor stressed its unreliability to prevent pregnancy. It was obvious that she saw the diaphragm as an outdated mode of contraception.

\(^4\) The definition of “late term” remains contested among judges and legislators. Some states delineate it at 16 weeks gestation, others at 20, and some up to 27 weeks gestation (Guttmacher 2016). Current, Arizona policy bans abortions “after viability,” which are only allowed if the life or health of the woman is risk to be determined by physician recommendation and court order (Ibid.). CDC data shows that 91 percent of abortions occur within the first 13 weeks of pregnancy, with only 1.4 percent after 21 weeks gestation (Planned Parenthood 2015).
Two significant, interdisciplinary groups of literature guide my inquiry into women’s encounters with the state as they pursue contraception and abortion. The first is the multidisciplinary research on reproductive politics; the second is law and society scholarship, which introduces the gap problem between law on the books and law in action, and the notion of legal consciousness in everyday life. Research on reproductive politics offers a range of historical and contemporary case studies. Studies examine the regulation of US reproductive health from a dialectical perspective as it shapes women’s lives in terms of knowledge, and generates differential and discriminatory access to reproductive technologies. More, the literature on reproductive politics contextualizes the current debates over abortion and contraception, and analyzes grassroots organizations and social movement strategies to counter controversial changes to women’s reproductive health policies. This area of scholarship is strongest when it comes to being critical of power and politics in debates over reproduction. This previous work is essential in orienting my own project to understand how laws and policies inform experiences on the ground level. Extant research focuses much on the politics of pursuing suggestion pregnancy whereas my proposed project centers its analytical lens on pregnancy prevention. Additionally, this body of research lends itself to a deeper analysis of the link between contraception and abortion in the US and its broader implications. This scholarly work is essential in pushing forward my own thinking on the topic and offers key analytical tools to better understand pregnancy prevention currently.

Law and society research moves the study of reproductive politics beyond a textual or legal analysis of reproductive health policies. This body of research illuminates the mutually constitutive relationship between “law” and “society,” and thus considers
the life of the law, and, vice versa, the legalization of life. Two conceptual socio-legal frameworks ground this study. The first is the gap problem, which probes the divide between law as written and law in action, and the stratified application of law. The second is legal consciousness and the “everydayness” of law, which positions my project to explore how women engage reproductive politics when navigating personal pathways to contraception and abortion. The utility of these socio-legal concepts is demonstrated throughout the law and society literature, and now also positions my analysis of encounters with the state throughout pregnancy prevention and termination in Arizona. They bring a more dynamic and interactive legal dimension to the study of pregnancy prevention and termination. Ultimately, this scholarly work pushes us beyond typically narrow policy analyses to incorporate ground level experiences with reproduction to reveal a complex interplay between law and society.

Below, I review the key contributions of research on reproductive politics and law and society. This chapter will explore the research on the topics to date, and demonstrate the ways previous scholarly work situates my own inquiry into women’s experiences seeking contraception and abortion within a context of mounting legal and political constraints.

Reproductive Politics in the United States

Ideologies of Reproduction
The notion of reproduction is constituted by some of the most controversial ideologies in our society. For centuries, scholars, activists, politicians, corporate leaders and physicians alike have heavily debated the term reproduction. This body of social research on reproduction is mainly comprised of literature from gender studies, history, anthropology, sociology, political science, and others. On its face, reproduction, defined as the process of producing offspring (akin to sex or intercourse), is commonly assigned to the natural or biological side of the nature/culture binary. From this perspective, reproduction is at once a biological imperative and a bodily process, devoid of interpretation. The term implies a range of issues and invokes women of all ages. In other words, most women come to engage reproduction, in one way or another, at some moment in their lives especially with sex education, access to contraception-abortion, fertility assistance, prenatal care, childbirth, childcare and even menopause. The process of pathologizing the female biological condition forms a necessary precursor to legal restriction and regulation of the female reproductive body.

More, in addition to the biology, scholars point to the socially and ideologically constructed nature of reproduction as a cultural object and social experience. Legacies of capitalism, White supremacy, and patriarchal relations have historically transformed the sphere of reproduction (Jagger & McBride 1985). These scholarly works incites deeper understanding of the ways reproduction is entrenched with powerful ideologies of race, class and gender that have both discursive and material consequences for women. Therefore, the area of reproductive health is a complex and vast terrain that touches all stages of the potentially pregnant female body. The ideological underpinnings of the
female reproductive body\(^5\) are key to an analysis of reproductive experiences and the ways they are shaped by powerful forces of state and capital.

First, one’s socio-economic reality shapes interactions with various institutions in the reproductive realm. Hierarchies emerge between the kinds of women deemed ideologically acceptable for reproduction and those relegated to low-wage labor (Nakano Glenn 1994: 19). Particularly, the stratification of women’s reproduction has been shaped by waves of national panic over population growth and fear of disappearing Whiteness in the US. The term *eugenics*, coined by Francis Galton in 1883, embraces a central ideology of reproducing the fittest races in society, and even warns against wasteful medical care for “the weak” (Duster 2003; Ordoover 2003). As such, the reproduction of certain groups of women is deemed dangerous while other are painted as ideal mothers of the nation. In this setting, women of color came to tell a very different story about their reproduction prior to and even after *Roe v. Wade*. Social constructions of reproduction, and their current implications must be analyzed within this historical context.

Cultural constructions of the female body and women’s health have influenced how the state, pharmaceutical interests, and medical institutions compound to shape the topic of reproduction. Karl Marx’s classic work highlights the significance of the distinction between home-based reproduction and market-based production, and the division of productive and reproductive labor (Marx 1976). In the shift to capitalism,

\(^5\) This project excludes the male body because of the corpus of academic research that demonstrates how “control over women’s sexuality continues to be a central issue in our society” (Martin 1992: 301). More specifically, the medical and social construction of the female ability to give birth is central to these ideologies of control and regulation. Therefore, this project focuses on the female body not only due to its natural procreative capabilities but also because of the political and social scrutiny placed on it.
women’s work in the home, including reproductive labor, was deemed to lack real market value, and was often over-controlled and even exploited (Federici 2004). Analyses show that uteri functionality in childbirth was measured against a “progress standard,” where a quickly delivered baby is a product of the healthy uterus “machine” (Martin 1992: 302). Scholars of feminist philosophy have demonstrated that the differentiation between production and reproduction is an “invidious and male-biased distinction” (Jagger & McBride 1985: 185). In this way, reproduction is socially constructed and tied with larger ideologies of gender roles, divisions of labor and the privileging of technology as they shift over time (Nakano Glenn et al. 1994). More, Marxist analyses on the historical duality of production and reproduction help to illuminate modern ideological distinctions between public and private realms and their influence on experiences with reproduction. Marx’s work reveals how women’s domestic subordination is linked with women’s responsibility for reproduction, only reinforcing the fabricated public/private binary.

Moreover, another influential ideology within reproduction is Foucault’s notion of biopower as it draws further attention to the material power of the ways bodies are discursively constructed. Essentially, biopower is the regulation of life processes through methods of administrative calculation, which arrange life into normalizing standards impacting how people view themselves and their social relations (Foucault 1984). As such, technology, science and economy do not exist outside of culture and power (Mamo 2007; Foucault 1984). This approach is central to an analysis of current debates over

---

6 Specifically, these scholars argue that, in a capitalist framework, only productive labor done the public realm, often male-centered, is deemed as having any kind of market value. Conversely, often female-centered reproductive labor in the private home, including procreation, childcare and housework, is seen as not directly contributing to the market economy and therefore lacking any real value. As such, the management of female reproduction becomes central to ideological male dominance (Jagger & McBride 1985).
reproductive health and help trace the multiple ways the state has intervened in women’s reproductive lives. While Foucault’s work does not directly engage reproduction, his notion of biopower speaks to the ways the female reproductive body has been the subject of regulatory control. However, reproductive regulations tend to shift with the national zeitgeist and can include varying forms of exploitation and surveillance for some women, and rewards and support for others. The dynamic relationship between governmentality and reproduction can expose not only the way women’s experiences are shaped by policy, but also the extent to which some women have come to internalize those very the regulations.

The United States has a long history of regulating and ranking the reproduction of different bodies, which echoes lingering ideologies of patriarchy, White supremacy and eugenics. In other words, there are hierarchies that “regulate sexualities into those which are respectable or disreputable, [and those which are] healthy or unhealthy” (Irvine 2002: 13). These hierarchies inform public and political debates, and, therefore, they hold powerful consequences on experiences of pregnancy prevention and termination as empowered or disempowered. Further, dominant ideologies of reproduction shape experiences of those who do reproduce, and those who do not. Women of color feminists reveal that, “the social value placed on a woman’s reproduction depends on her standing within the hierarchies of race, class and other equitable divisions” (Roberts 2005: 1343). Nevertheless, contraception and abortion shift in and out of the political and economic spotlights depending on the historical context; further establishing the unstable nature of reproduction as a social construct. The research positions my project to approach reproduction as a concept that is never static, but is instead constantly being both
reinforced and renegotiated by state and corporate agendas, and also by scholarship, social activism, and everyday agency in reproductive decision-making.

Changing Landscape of Reproductive Politics

Abortion and contraception offer concrete examples of how notions of reproduction are regulated and (re)defined over time based on the shifting political landscape. The use of both contraception and abortion date back to ancient times. Scholars have even noted that the first prescriptions for birth control date back to ancient Egypt (McFarlane and Meier 2001). Further, birth control and abortion have been historically linked in women’s reproductive lives and decisions (Koblitz 2014). Naturally, the first way the two concepts are connected is that when contraception fails, an abortion is the last option to avoid taking the pregnancy to term. Second, for much of recorded human history, meanings and everyday routines of contraception and abortion were virtually interchangeable (Koblitz 2014: 19). More, it was not until recent medical advances that doctors could determine pregnancy before quickening. Not only was the line between pre- and post-conception birth control blurred, but also notions of contraception and abortion were often indistinguishable. Pregnancy was seen as an ongoing process, not a fixed state of being. In other words,

The borders between contraception and abortion are far from precise, and even something so presumably well-delineated as pregnancy is more intelligible when viewed as a process than as an absolute. The fluidity of terminology has important implications
for discussions of fertility control and goes some way toward explaining why women’s options are in practice almost always more extensive than restrictive law codes and religious pronouncements would lead one to believe. (Koblitz 2014: 107)

The inherent link between abortion and contraception throughout most of history fostered a more complete understanding of pregnancy that shaped reproductive health practices and agency in the face of shifting social and legal regulation.

The regulation of pregnancy prevention and termination is intertwined with prevailing cultural norms and religious ideologies of the time. Much religious doctrine reinforces the conviction that women’s essential role in society was as mother: biological reproducer, nurturer of children, and, hence, domestic guardian of morality. As a result, religious objection and state regulation played out on the bodies of women in particular, and, in many ways, still does. Contraception and abortion remain controversial for believers from many different religious sects (Mastroianni, Donaldson, and Kane 1990). Generally, marriage and specifically sexual intercourse are solely for procreative purposes and thus any attempt to prevent conception is condemned. Religious morality on reproduction also invokes debates over the intrinsic value of human life and begs the determination that human life begins at the moment of conception⁷. In many ways, this assumption offers a fetus more legal protection than the actual woman. Reproductive

⁷ Legal philosopher Ronald Dworkin explains the powerful moral divide; “One side thinks the human fetus is already a moral subject, an unborn child from the moment of conception. The other side thinks that a just conceived fetus is merely a collection of cells, no more a child than a just fertilized chicken egg is a chicken or an acorn is an oak” (Dworkin 1993: 30).
control is really about power; the “control over whether a new person comes into being – the gatekeeping of human existence” (Rapp 2000; Sanger 2012: 861).

Until about the mid-14th century, contraception and abortion methods remained in common use and openly discussed by the general public. However, the Black Plague (approximately 1346-53) devastated populations throughout Europe (McFarlane and Meier 2001). This led to concern over diminishing populations followed by a heightened stigma attached to birth control and pregnancy termination, especially among the more wealthy sects. Correspondingly, between approximately 1350-1700, witch-hunts occurred where many midwives were targeted and persecuted, virtually obliterating generations of knowledge of birth control during that time (Ibid.).

Coincidentally, this period is also marked by a surge in medical and religious curiosity about (and control over) the female reproductive body. The growing male medical profession was coupled with increased fascination with female reproduction. This not only involved the expulsion of women from the medical profession beginning in the 14th and 15th centuries, but also was linked to the gruesome witch-hunts and persecution of midwives (Federici 2004). This zeitgeist reflected loftier moral and religious sentiments seeking to regulate women’s behavior during this time. In fact, in 1588, the Catholic Church took its first regulatory stance on abortion when Pope Sixtus V officially forbid all procured abortions, removing the distinction between animated and unanimated fetuses (Koblitz 2014). However, in 1591, Pope Gregory XIV removed the highest level of sin from abortion, which meant that women could abort absent the stigma of religious guilt (McFarlane and Meier 2001). In contrast to the contemporary Catholic Church’s stance, for most of the history of western Christianity, abortion was verbally
chastised but legally ignored (Luker 1985). Over time, the Catholic position on contraception and abortion shifted with the tides of politics and capitalism, in that restrictions tighten and loosen depending upon fluctuating state concerns over fertility and population.

The population explosions across Europe between the late 15th century and 20th centuries shifted the political landscape of reproduction yet again (McFarlane and Meier 2001). New ideas about suitable population growth emerged as a result of scientific and religious notions of race, sexuality and reproduction. Scholar and reverend Thomas Malthus labeled population growth and its accompanied poverty as a social problem in his publication of *An Essay on the Principle of Population* (Malthus 1798). Rather than the anxiety to keep birth rates steady, general concern was now directed at restricting birth rates especially among poorer populations. This context was met with increased use of birth control like animal skin condoms across Europe among middle and upper classes, and military populations (McFarlane and Meier 2001). The context of population growth transformed both church opinions on abortion and social practices around family planning.

Concurrently, in the US in early colonial times, Black women’s enslaved reproduction was the object of control by slave owners. These policies and regulations were then enforced by the state, which maintained its refusal to criminalize slave abuse and slavery more generally. Beginning with Virginia laws in 1662, colonial and state legislatures used both formal and informal regulations to “treat Black women as breeders” (Solinger 2008: 262). Specifically, these laws dictated “who had the right to have sex with who…to reinforce and police racial boundaries” (Solinger 2008: 263). As a
result, Black reproduction was deemed necessary (and acceptable) when the slave labor force needed to be reproduced. Reproduction and sexuality, especially of women of color, are defined by policy decisions during moments of economic expansion and contraction (Rousseau 2009). In this way, the interests of the state are deeply entangled with ideological rhetoric and the disproportionate regulation of Black women’s reproduction in the US (Ibid.).

Another significant shift emerged during the 1800s when contraception and abortion shifted from socially acceptable to being shrouded in secrecy and religious guilt. For the first two decades of the 19th century, abortion was not illegal in any of the 23 states accepted into the union at that time. Actually, any regulations that did exist at that time were borrowed from English Common law, which allowed any abortion before quickening or fetal movement (Luker 1985). Because wealthy, married, White women sought the most abortions during this period, some of the most restrictive laws in the nation began to emerge in order to save White babies (Ibid.). Additionally, dominant moral and religious sentiments condemned intercourse occurring outside of wedlock, and sex for any reason other than conception. Citing concern with women’s health, the first wave of anti-abortion legislation was promulgated between 1821 and 1841, which deemed abortion illegal in Connecticut and New York (McFarlane and Meier 2001). Puritan disapproval then prompted criminalization, which, in turn, forced public discussion about birth control and pregnancy termination behind closed doors.

In 1860, the American Medical Association (AMA) became a public proponent of the anti-abortion agenda (McFarlane and Meier 2001). During this time, the AMA lauded themselves as the “guardians of public morality” (Ibid.). In doing so, they aimed to
monopolize the practice of medicine and position themselves as the gatekeepers of superior scientific (and moral) knowledge (Luker 1985; Rose 2006). In 1869, the Catholic Church even came to align itself with the AMA’s anti-abortion platform when Pope Pius IX again removed the distinction between the animated and unanimated fetus (Rose 2006). Still, amid AMA influence and growing religious anti-abortion zealots, conflicting definitions of both contraception and abortion proliferated society and politics.

In 1873, we witnessed the first involvement of the federal government in regulating reproduction with passage of the Comstock Act, banning the trade and circulation of all literature on contraception and abortion (Gordon 2002). The Comstock Laws emerged from part of the social purity movement after the US Civil War (1861-1865). Even stricter state laws (known as “little Comstock laws”) began to spring up in states across the union, which increasingly regulated and criminalized family planning practices (McFarlane and Meier 2001). In fact, by 1880, approximately forty anti-abortion laws had been passed across the United States, which severely limited women’s access to safe, legal pregnancy termination (McFarlane and Meier 2001). Beyond government interference, these laws, and future iterations of them, have larger symbolic and material consequences with pregnancy prevention and termination.

Still, ongoing public activism and political discussions on reproduction gradually opened doors to family planning policies. In fact, Margaret Sanger established the first birth control clinic in Brooklyn in 1916 (Chesler 2007). Sanger’s American Birth Control League heavily relied on the role of medical doctors and their regulation of contraceptive technology (Hartmann 1985). This context was also met with national ideals of “true
motherhood” invoked by politicians as the way to combat and check the “rising tide of color” in the United States (Berg 1991: 81). President Theodore Roosevelt, echoing the popular eugenic perspectives of the time, chastised middle-class, White women for hastening the “race death” by not meeting reproductive quotas for the nation (Ibid.). Amid eugenic implications, many African American activists at the time (including Mary McLeod Bethune, Lorraine Hansberry, WEB DuBois, and others from the Harlem Renaissance and the National Council of Negro Women) favored the use of birth control in their communities (Gordon 2002). Many even worked directly with Sanger to publish more information on the use of birth control, and options for family planning services.

Then, in 1939, Sanger launched the Negro Project to increase reproductive health care among communities of color with the assistance of African American doctors and ministers. Some argue that prevailing views of the time mandated Sanger’s engagement with eugenics in order to position herself to simultaneously challenge ideologies on feminism and immorality, and ensure the birth control movement remained mainstream in the US (Chesler 2007). Notably, it was not until the 1960s in the US that sentiments on contraception began to hold more harmful connotations among populations of color.

National fear continued to rise from the 1930s to approximately the 1970s, when President Nixon proclaimed that “color [was] overrunning the Western world” (Silliman

---

8 The proposal for the Negro Project (1939-1942) even included a quote by WEB DuBois, stating that “the mass of ignorant Negroes still breed carelessly and disastrously, so that the increase among Negroes, even more than the increase among Whites, is from that part of the population least intelligent and fit, and least able to rear their children properly” (DuBois 1932: 166).

9 Religious participation was considered extremely important to the project because of the assumption of White sponsors that “the most successful educational approach to the Negro is through a religious appeal” (Gordon 1990: 328). This further exhibits how religious, morality and reproduction are intimately intertwined across racial communities.
et al. 2004: 8). In doing so, Nixon reinforced the notion that White reproduction was the savior not only of White supremacy but also of US society more largely (Silliman et al. 2004). In decades prior to Nixon’s presidency, we witnessed the forced sterilization of tens of thousands of politically powerless people, mostly poor women of color (Rousseau 2009). While there are exceptions, the main targets were notably low-income Black, Latina and Native American women (Duster 2003). Low-income men of color were also sterilized during the era\(^\text{10}\) but at much lower rates (Kluchin 2009). Also at this time, White, middle-class women reported very different experiences of reproductive control, predominantly characterized by limited access to voluntary sterilization and long-acting reversible contraception like the IUD (Kluchin 2009: 52-53). Divergent reproductive needs among women meant that, for the most part, White, middle class women were fighting for abortion and contraception, while women of color and low-income women sought to validate their procreation within a context of eugenic political pronouncements and involuntary sterilization.

Motherhood, and thus reproduction itself, became a “primary site of racial competition” in the early decades of the 20\(^\text{th}\) century (Berg 1991: 8). By 1932, amid White anxiety over rising immigration, The Eugenics Society was credited with the passing of eugenic laws in 26 states (Davis 2008). These laws justified the sterilization of thousands of “unfit” mothers who were mostly low-income women of color (Davis 2008; Nelson 2003). In this way, stratified reproduction and eugenic control was in direct service of White supremacy. Reproduction was then invoked as a racial duty not only

\(^{10}\) Although induced for different reasons (e.g. aggression, criminal behavior, excessive sexuality, etc.), male sterilization had a similar effect of curbing reproduction among people of color (Kluchin 2009).
among White women, but among women of color as well. Procreation was viewed as a way to maintain populations of color and confront a political legacy of White control over Black and brown bodies (Roberts 1999). This reality demands a deeper understanding of the co-constitutive relationship between White and non-White reproduction. In other words, larger meanings of reproduction by White women are partly constructed by meanings assigned to reproduction by people of color, and vice versa. Feminists, anthropologists, and historians alike note the mutual dependency of Black and White constructions of maternity (Roberts 1999; Nakano Glenn 1994; Berg 1991). For one to exist in all its idealism and privilege so must the other in all its deviancy.

In the 20th century, reproductive health issues continued to shift in and out of the political and economic spotlight. Coupled with modern rhetoric of freedom and choice, conversations surrounding reproduction persisted as public centerpieces. General awareness of the positive effect of contraceptive access on reduced birth rates grew, while advancing medical technology increased both the safety and success of abortion procedures (Stormer 2016). Further, amid the rise of urbanization, industrialization and lowering birthrates, US politicians, and legislators also began to change their stance on birth control and abortion. In fact, in 1942, the Surgeon General permitted states to use federal funds for contraception (Luker 1985). Then, in 1967, the American Medical Association issued a statement advocating the liberalizing of abortion laws because of increased safety of the procedure (Ibid.). This time, restrictions grew more lax, which shifted national attitudes towards opening access to pregnancy prevention methods (Petchesky 1990; Luker 1985).
Court cases also began to chip away at the Comstock Laws that had restricted access to contraception during this period. By the 1970s, thanks to the Supreme Court decisions *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972), women gained more open access to barrier and hormonal forms of contraception. The former recognized birth control decisions as protected by rights to marital privacy, while the latter extended those rights to non-married people (Luker 1985). These shifts demonstrate how institutional stances on reproduction are less the result of medical and scientific advances, and more the dictates of political and economic interests.

More, both state officials and medical professionals started to question the unintended effects of the national criminalization of abortion. Dr. Alan Guttmacher revealed that the illegality of abortion was coupled with surges in out-of-wedlock births, illegal abortions and maternal mortality (Stormer 2016). While abortion was still very controversial, many states reformed policies to include therapeutic exceptions for abortion when there are present health risks to the woman or the fetus exhibits significant birth defects (Luker 1985). These legal reforms were symbolic but also “aggravated inequities in access” (Stormer 2016: 167). The state continued to regulate abortion but now did so by employing a rhetoric of aggregated harm versus the “moral physiology of natural law” (Stormer 2016: 170). In a time still marked by neo-Malthusian ideas of progress and civilization, changes in US policy reflected less an endorsement for reproductive freedom, and more a political move to maintain a civilized status on the Malthusian scale (Stormer 2016).

Nevertheless, between 1967 and 1972, most states in the US relaxed abortion restrictions. Then, on January 22nd, 1973 in a 7-2 decision, the US Supreme Court struck
down every abortion ban in the country with *Roe v. Wade* (1973) (Gordon 2002; Petchesky 1990; Luker 1985). This case decided that a woman’s decision to procure an abortion is protected under the right to privacy granted by the Equal Protections Clause of the 14th Amendment. However, the justices argued that this right must be balanced with the state’s interests in promoting the health of prenatal life and women’s health. *Roe* was eventually reformed legislatively, which added restrictions on abortions in terms of gestational age and viability of the fetus.\(^\text{11}\) More, a direct response to *Roe*, the Hyde Amendment is a legislative provision that continues to bar the use of federal Medicaid funds for abortion (Gordon 2002). Originally passed in 1976, this legal provision is still viewed as a major success for conservative politicians and pro-life activists in the US. However, in 1993, President Clinton included an important exception to the Hyde Amendment for abortion in cases of rape or incest (Ibid.).

Reaffirming *Roe*, *Planned Parenthood v. Casey* (1992) gave states the ability to enact certain restrictions as long as they did not place an *undue burden* on the women. Since the decision, legislatures and judiciaries throughout the country have tested the meaning of the “undue burden” (Gold and Nash 2012). Ultimately, appeals courts and the Supreme Court overturned some restrictions (e.g. Arizona’s 20-week ban on abortion) while others stand because judges determined they do not present an undue burden for women (e.g. Targeted Regulation of Abortion Providers in Arizona)\(^\text{12}\). Although many pro-choice women applauded increased access to family planning services from *Roe* and

\(^{11}\) Essentially, the right does not apply if the fetus is viable outside the womb, which usually occurs between 24-28 weeks (about 7 months). This rule can only be violated if the mother’s health is at risk by continuing the pregnancy (Luker 1985).

\(^{12}\) By 2014, more than half of US states have some kind of imposed restriction for obtaining abortions (Gold and Nash 2012).
Casey, poor women and women of color again faced a familiar state-generated paradox: limited governmental support and social stigma of reproduction, met with decreased state support for family planning and pregnancy prevention.

Consequently, throughout the 1980s and 1990s, control of reproductive decision-making remained central to welfare programs. In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), known as the Welfare Reform Act, into law. The Welfare Reform Act did away with previously earmarked funds for family planning services and instead included sanctions that denied public benefits to unwed parents under 18 years of age (McFarlane and Meier 2001). The effect of this policy on poor women and women of color was similar to restrictions enacted in the early 20th century designed to limit “undesirable” reproduction. Further, these policies did little to address the issue of unwanted pregnancy prevention while withdrawing state financial support to young mothers of color. This marks a political paradigm shift as policies reflect less eugenic ideologies and more state paternalism and institutionalized racism. While these policies purported to be in the best interests for low-income communities, they still failed to offer any substantive relief from structural poverty (Silliman et al. 2004).

During the late 20th and early 21st, state involvement in contraceptive technologies changed the national landscape of contraception, abortion and reproduction yet again. Public debate now centered more on emergency contraception (Plan B, or generic Next Choice) and the abortion pill (RU-486). In fact, the latter is heralded as one of the most important achievements for women’s reproductive autonomy (after the hormonal birth control pill and emergency contraception) (Foster & Wynn 2012). However, politicians
and pharmaceutical companies were less than enthusiastic about RU-486 and Plan B (Haussman 2013). When up for approval, the FDA maintained its prescription-only status of emergency contraception despite overwhelming support from medical professionals for expanding availability. Scholarly opinion contends that the “FDA decision [at that time] was influenced by the particular conservative evangelical orientation of the Bush administration” (Foster & Wynn 2012: 53). State power and religious influence can marginalize even the role of medical professionals in debates on reproduction (Rose 2006). Further, emerging reproductive technologies publically blurred the line between contraception and abortion and, in doing so, invoked larger discussions on how abortion is defined by different groups. While current tracking of abortion rates is limited to the surgical procedure and abortion by RU-486, emergency contraception and even hormonal birth control complicate discussions on chemical abortion. Working in a range of ways, increasing hormonal technologies make it difficult to draw firm boundaries between birth control and abortifacients; between pregnancy prevention and termination.

Abortion and contraception remain controversial reproductive health topics because they involve the politics of artificially terminating pregnancy, or the natural reproductive process by which human life is created. The messy terrain reveals that the issues of pregnancy prevention and termination are inherently political and intimately intertwined. Research shows that pregnancy prevention is directly related to a decrease in

---

13 Specifically, in the case of RU-486, the pharmaceutical company Searle did not make enough profit from this drug to risk profits from other drugs by being tied to the abortion controversy. George Bush Sr. was heavily involved in keeping RU-486 out of the US market (coincidentally, while Bush was Reagan’s VP, Donald Rumsfeld headed Searle from 1977-1985) (Haussman 2013).
surgical abortions (McFarlane and Meier 2001: 46). However, oftentimes we not only hear isolated debates on abortion and contraception, but those who label themselves anti-abortion are often anti-contraception as well. The fundamental point here is that, as political interest in reproductive health shifts and transforms, so do the material consequences like access to abortion and contraception. The literature on the timeline of reproductive politics reveals the waxing and waning of its visibility and regulation.

Experiences of Stratified Reproduction

The literature on experiences of stratified reproductive politics reveals an embedded ideological hierarchy in reproduction. This hierarchy constrains women at the margins from accessing health needs like prenatal care. This is due not only to logistical or economic barriers, but also to the proliferation of stereotypes that pathologize women at the bottom of the reproductive ranks. Scholars have revealed the extent and effect of these stereotypes on women’s experiences with reproduction. Furthermore, this body of literature frames this project to delve more deeply into the everyday politics of pregnancy prevention and termination. Experiences with reproduction are demarcated by powerful stigmas and complicated access to health care needs.

More specifically, the hierarchy of reproduction is reflected in the gap between rights and the ability to access them. Despite federal guarantees to certain reproductive rights (e.g. use of contraception with *Eisenstadt v. Baird* (1972) and access to legal abortion with *Roe v. Wade* (1973)), many women still encounter barriers to obtaining an abortion and contraception. Several burdens stand out as particularly cumbersome including finances and geographic location. Simply put, the location of providers remains
an issue especially for rural states like Arizona. Nationally, in 2011, 89 percent of counties were without an abortion provider with 34 percent of women living in those counties (Jones and Jerman 2014). That same year in Arizona, 67 percent of counties were without a single provider of abortions with 14 percent of women living in those counties (Ibid.). Additionally, financial burdens result from competition and profit margins of the limited abortion providers in the state. In 2012, the median cost for both the surgical abortion at 10 weeks and abortion by pill was approximately $500, with 53 percent of abortions paid for out-of-pocket regardless of insurance coverage (Jones, Jerman and Onda 2016). Many minority women report having to delay paying rent and utilities, forgo groceries, and borrow from friends and relatives (Jones, Upadhyay, and Weitz 2013). Moreover, Medicaid was used by 24 percent of patients and represents the second most common method of payment for abortion (Jones, Jerman and Onda 2016).

Failing to anticipate differential needs, the gap between law and implementation is not only a common pattern in US political history, but has come to define everyday experiences with contraception and abortion.

Legislation, buoyed by scientific racism in the early 20th century and by neoliberalism in the early 21st century, has created and perpetuated a hierarchy of reproduction among women. Within this ranking system, reproduction by women of color, and low-income women, was framed as pathological and dangerous to national interests. In fact, American anthropologist Leo Chavez suggests that reproduction has become a “ground-zero in a political war—not just of words, but of public laws and policies” (Chavez 2004: 173). Thus, we see how the regulation of Black and brown procreative bodies has been framed disparagingly by stereotypes of the Black “welfare
“queen,” popping out babies to mooch off government funds. Individual choices (and not structural inequalities) are then blamed for their social problems and “deviant lifestyles” (Bridges 2011: 10; and see Roberts 1999). Although these stereotypes helped to advance policy reforms that withdrew state resources from low income White women and women of color, their reproductive reality is vastly more complex than these stereotypes. The realm of reproduction not only holds larger implications for differences between male and female, but also for differences in female bodies by race, class, nationality and sexuality (Bridges 2011; Roberts 2005).

Women of color in the US have been labeled as enacting “‘dangerous,’ ‘pathological,’ and ‘abnormal’ reproductive behaviors” (Roberts 2005; Chavez 2004: 173). These labels arise in public discourse and are concretized within US law and policy, especially with regard to health care and welfare reforms (Chavez 2004). Similar to stereotypes of Black “welfare queens,” Latina reproduction is defined by assumptions of high fertility coupled with an overuse of social and medical services (Gutiérrez 2008). Yet studies have shown that these stereotypes often discourage Mexican immigrant women from pursuing health care services (Gutiérrez 2008: 121). These works reveal the ways public fear frames Latina reproduction as a (re)conquest of the US. Latina women are “living under a particular set of circumstances shaped by the intersection of race/ethnicity, gender, sexuality class and generational status” which inform the ways they negotiate their own reproductive health within the confines of reproductive hierarchy (Garcia 2012: 16-17).

Even when women of color have access to proper reproductive health care (e.g. birth control, abortion and obstetrical care), their engagement in this realm is often met
with increased methods of social surveillance and regulation like PRWORA discussed previously. In fact, poor and marginalized minorities have 25% fewer positive encounters with the health care system than more advantaged groups of women (Levins 2000: 19). When Mexican immigrant women access public prenatal care, they enter a system in which their prior knowledge about self-care in pregnancy and childbirth is often displaced (Gálvez 2011). More, they are framed as needy patients (Ibid.). Additionally, adolescents from minority or low-income groups have a particularly difficult time accessing contraception, and are more likely to be framed as “difficult” patients when they do inquire into contraceptive alternatives (Ford & Forthofer 2010; Ehrenreich 2008). In essence, these women receive care that has “both reflected and reinforced society’s definitions of and attitudes toward women, their bodies and reproduction” (Todd 2008: 32). Even when seeking out contraception, experiences of women of color are shaped by the asymmetrical power dynamic between patient and doctor, strict legal regulation, and powerful social and cultural stereotypes.

The experiences of reproduction depend on a “woman’s standing within the hierarchies of race, class and other equitable divisions” (Roberts 2005: 1343). The reproductive hierarchy is exemplified by the disparity of decreased public benefits for low-income women who want another child, and public celebration of high-tech birth of septuplets by White, wealthy women (Roberts 2005). However, experiences of pregnancy prevention and termination by women of color and low-income women can reveal both reproductive oppressions, and reproductive agency. Situated among critical past research, my project adds to the conversation by tracking the material and symbolic consequences
of such powerful reproductive stereotypes on the ground level, and reexamining the role of the state.

Ultimately, connecting research on reproductive politics to work emerging from the field of law and society offers unique analytical insight to this project. Combining these two bodies of research fosters a more complete understanding of the complex and shifting ways women navigate their options for contraception and abortion. One of the main advantages of integrating and applying law and society concepts to research on reproductive politics is the capacity to acknowledge and understand law’s interaction with our everyday lives and with something as intimate as reproduction. Further, studies of everyday legal consciousness and the gap problem allow deeper exploration into interactions between law and reproductive health decisions. These analytical concepts offer a broadened understanding of law, as it emerges from both state and non-state entities, and complex engagements with varied regulatory mechanisms. While legal restrictions have vested interests in promoting certain motherhood over others, changing everyday practices in reproduction itself come to redefine the law as well. Therefore, the concepts also help to locate and scrutinize moments when women demonstrate agency and resolution in the face of restrictive legislation. Foundational studies from law and society provide more precise means for tracking the interactions of law and policy in women’s reproductive lives.

Law and Society

What is “Law” and “Society”? 
Law and society research emerged as a critique of the limitations of doctrinal legal analysis, and the relative lack of empirical studies of law. The intellectual field of *law and society* crosses disciplinary boundaries to explore the multiple and mutually constitutive interactions between law and society. The field moves beyond textual policy or legal analysis to flesh out this relationship, often drawing on social science research to do so. Essentially, the “purpose of socio-legal scholarship is to assess the relevance of law in everyday life” and to “uncover the sources and effects of legal change” (Abel 2010: 11).

One of the main conundrums of law and society research is the complex interaction between both *law* and *society*, and the larger implications. Shifting in definition and context, scholars plot how forms of law play out in various societies. Foundational theorists in sociology including Emile Durkheim, Karl Marx, and Max Weber argued that legal systems developed in tandem with socio-economic organization (Calavita 2010; Marx 1976; Bellah 1973). Legal regulation depends, first, on the kind of social and economic system it is meant to rule, whether social organizations, families, individuals, workplaces and others. Basically, “the idea that different types of society produce, or at least coincide with, different types of law is a foundational element of the law and society framework” (Calavita 2010: 11). While early inquiries focused on law as a mechanism of the state and related institutions, research came to embrace a multiplicity of competing legal codes at play in society, influential in their own ways. This field engages interpretations of multiple types of law emerging from multiple social systems as they change over time (Calavita 2010).
Although socio-legal scholars debate the meaning of law, most agree that it can be defined as a broad set of “meanings, sources of authority, and cultural practices that are commonly recognized as legal, regardless of who employs them or for what ends” (Ewick and Silbey 1998: 22). The complex interaction between law (state and non-state) and social settings continually (re)defines what is normal/abnormal, and therefore legal/illegal. In this sense, one must analyze law as it shifts with discourse and knowledge embedded in specific spatio-temporal social contexts (Foucault 2012). As such, the law of the nation-state aims to concretize a kind of moral compass of the times. Oliver Wendell Holmes states that “law is the witness and external deposit of our moral life, its history is the history of the moral development of the race” (Holmes 1897: 992). Similarly, Boaventura De Sousa Santos argues that law is a system of signs that represents (or even distorts) reality (De Sousa Santos 2005). These scholars begin to reveal the larger ideologies embedded within legal systems. But again, law and society scholars urge us to question: Whose version of morality does the law embrace? What competing moral/legal codes are at play? And how does context impact the ways they play out?

Understanding the delicate interplay between law and society helps reveal the various roles of law and legal processes, including policy reform and implementation, in women’s experiences when seeking contraception and abortion. Law and society research contributes two key concepts that inform this study of the struggle over reproductive politics: the gap problem and the everydayness of law.

The “Gap” Problem
Early on, a fundamental intellectual inquiry of the law and society movement has been the analysis of the gap problem: the distance between law on the books and law in action (Sarat 2004). Scholars of law and society examine the ways that Black-letter-law, or law as written, works in various social settings. Richard Abel suggests that this gap addresses the law’s shortcomings, and the ways that law influences behavior and society, and vice versa (Abel 2010). Carol Seron and Susan Silbey argue that:

By focusing so closely on the gap between the law on the books and the law in action, it turns out that law and society scholars opened the way for a cultural analysis of law, exploring with a variety of methodological and theoretical tools, how that gap provides the space for the social construction of law and legality. (Seron and Silbey 2004)

In this way, scholars are able to examine law and its influence in multiple social settings, and more fully comprehend the interactive relationship of law and society.

More precisely, the gap refers to the divide between de jure law and policy and what is actually happening on the ground level. Thus, the gap problem includes two separate but related definitions. The first gap is the potential difference between what is written in law and how it is implemented.\(^{14}\) In other words, this seeks to analyze and

\(^{14}\) The distinction between both de jure and de facto law captures the first gap. De jure law refers specifically to that which is mandated, or Black letter law and policy, while de facto refers more to what is acceptable in everyday practice. One simple yet concrete example is how the de jure legal speed limit on most highways is 65mph; however, de facto practice shows the majority of the people drive above that. The interactive relationship between de jure and de facto law is not unidirectional; de facto practices may influence de jure law. An illustration in the US is the reality
track the discretionary distance between text and action (e.g. adultery is illegal but no one is prosecuted for it). The second gap is the differential impact of the implementation of law and policy, also described as the stratified application and disparate impact of law (e.g. medical leave that does not include pregnancy, or only allows maternity leave over paternity). More, scholars understand this gap by analyzing law and its social influence as instrumental (a mechanism of imposing sanctions) or constitutive (a mechanism that can shape internal meanings and practices in one’s life). Limiting analysis of law as strictly one or the other neglects the complex interaction between both the instrumental and constitutive nature of law. Additionally, both views embrace a “law-first” assumption, which tends to further over-simplify the ongoing relationship between law and society.

One clear example of the gap between law on the books and law in action is Kimberlé Crenshaw’s analysis of experiences of violence by women of color. She demonstrates that this violence is a product of intersecting patterns of racism and sexism, not as simply one or the other (Crenshaw 1991). Due to the restrictive nature of de jure law, the women experiencing discrimination in the workplace were forced to categorize it as either sexism or racism, but never the compounding experience of the two (Crewnshaw 1991). The formal law, in this sense, is a mismatch when compared with experiences of women of color in everyday workplaces. There is a gap between unique experiences of discrimination and proper legal recourse for those experiences, which only serves to perpetuate oppression and disempowerment for Black women. Even now, structural, political and cultural representations of Black women have failed to adequately

---

that at the federal and many state levels cannabis remains an illegal drug, yet de facto widespread marijuana use is beginning to noticeably impact de jure cannabis legislation nationally.
recognize how the intersection of race and gender plays a key role not only in how Black women experience violence, but also in everyday social interactions. Crenshaw notes that goals of identity politics continue to envision race and gender as mutually exclusive categories (Crenshaw 1991). However, she acknowledges that race and gender are not the only factors that intersect to create multiple forms of marginalization, only further demonstrating the breach between law and everyday experiences.

One last example of the gap problem is observed with the regulation of minors seeking abortions in the state of Tennessee. The US Supreme Court ruled that minors seeking abortions are entitled to petition for relief from state-mandated parental consent requirements (Silverstein et al. 2005). To ensure its implementation, the state of Tennessee put procedural mechanisms into place, whereby parental waivers must be made available. However, almost half of all courts were “unprepared or unwilling” to handle waiver requests, and those that demonstrated preparedness experienced call wait times of over four hours (Silverstein et al. 2005: 400). This issue exemplifies the gap problem because it demonstrates what can be overlooked upon examining only the law-as-written, and what can be gained by studying the law-in-action.

The “Everydayness” of Law and Legal Consciousness

Law and society scholars have shifted away from strictly analyzing state laws and institutions in order to see how multiple legal forms come to impact the everyday lives of people in the US. As a result, scholars have revealed the interworking between law and society not only at the state and institutional level, but also on the ground level, beyond official locations where law is typically encountered. In other words, there are levels of
regulatory mechanisms that play out in our lives, and an over-emphasis on state law neglects the broader picture. Specifically, law and society research on legal pluralism, “cultivates a second kind of learning about law…that emphasizes process rather than rules, and that tries to appreciate the distinctiveness of law against the background of larger patterns of social behavior rather than as something autonomous and self-contained” (Galanter 1993: 298). Hence, a central inquiry of the law and society canon concerns the question over multiple forms of regulation, or various forms of law, at work in numerous social settings.

Various forms of law, including state, non-state, and their overlaps, coalesce in our unique social realities. In essence, the concept of legal pluralism moves scholars to conceptualize a “more complex and interactive relationship between official and unofficial forms of ordering” (Merry 1988: 873). New legal pluralism draws three key contributions of classic legal pluralism. The first of these includes in-depth analyses of interacting normative orders that are structurally diverse. The second is the close attention to examination of customary law as being historically derived. And the last contribution is the demarcation of the tension and interaction between normative orders (Merry 1988: 873). However, with shifting social structures and orders, legal pluralism has had to widen its analytical gaze.

Further, research on law in the everyday aims to emphasize the way that law, in its many manifestations, is infused in our daily lives in sometimes obvious and more subtle ways. Often taken-for-granted, law “has a commonplace materiality pervading the here and now of our social landscape” (Ewick and Silbey 1998: 16). This can refer to interactions with anything from speed limits and parking meters, to marriage and birth
certificates, signs warning against trespassing and more obvious interactions such as engaging in contracts and litigation. In the more formal legal settings, law is more explicitly invoked yet its influence still seeps into our everyday experiences. Law and society scholars often claim the law is both “strange and familiar” (Ewick and Silbey 1998: 16). More, legal consciousness illuminates how one’s own social location influences how we think about law, and how we may choose to engage it (Hirsh and Lyons 2010). As such, legal consciousness is contingent and ever changing (Ibid.).

Contingent upon context, the socio-legal concept of legal consciousness suggests that law is both a potential catalyst and inhibitor for social change. Often an extension of the state, law holds authority and symbolic power, which is maintained by the clandestine and often-confusing nature of law itself (Ewick and Silbey 1998). Patricia Ewick and Susan Silbey offer three general orientations toward the law: 1) ”before the law” where subjects are in awe over the majesty and legitimacy of law, 2) “with the law” where subjects utilize the law instrumentally, as a kind of game, when it favors them, and 3) “against the law” where subjects are cynical and distrustful of law’s so-called authority and implementation (Ibid.). Aside from state law’s discursive and material power, the intimate interaction between de jure and de facto law illuminates ways that everyday social life can also impact the law. In other words, “by relying on ordinary social logics and local cultural categories and norms, legal action reflects, and also reproduces, non-legal features of daily life” (Ewick and Silbey 1998: 18). There are moments when law is powerful enough to influence shifting social reality; however other moments reveal that society will not change just because of legal reform. Therefore, the power of law and everyday social norms (and the relationship between the two) is in constant flux.
Laura Beth Nielsen tests the scope of Ewick and Silbey’s theory of legal consciousness and thus mobilization (Nielsen 2000). Her research offers a more systematic analysis of legal consciousness and asks: what really shapes individual legal consciousness, and how does it vary by the type of problem and context? In essence, Nielsen draws our attention to ways that social status and context impact one’s sense of the law and legal system. In complex ways, “[legal] consciousness develops through individual experience. But this experience takes place inside structures which define people’s lives” (Merry 1990: 5). Here, Nielsen suggests the need to adopt a theory of “situated legal consciousness” (Nielsen 2000). To reiterate, legal consciousness and the way one makes sense of the law is therefore always “situated” in a specific context, as the law’s impact remains symbolic, material and psychological. Our legal consciousness then shifts depending on our own social location, whether in a group or individual, and with the scenario at hand. As a result, scholarly work must account for the kaleidoscopic power of the law in the everyday.

Moreover, the everyday in studies on the life of the law has been outlined in a variety of ways. Basically, “the everyday is the domain of the unalienated experience, the life-world…The everyday is a domain of situated, bounded, local place and time; it is the domain of the human against the technological superhumaness of the modern” (Sarat and Kearns 1994: 3-4). In other words, the everyday is composed of the many, varied experiences within our daily lives. Research on the everydayness of law further demonstrates that the law plays out in the everyday world in “stratified and culturally specific” ways (Sarat and Kearns 1994: 9). Modern examples can range from differential experiences of routine traffic stops to lax punishments for corporate crime. These
everyday interactions are “situated in relation to particular types of laws, particular social hierarchies, and the experiences of different groups with the law,” and come to shape opinions on law’s capacity to prompt real social change (Nielsen 2000: 1055). Whether one explicitly invokes the law, actively resists it, or simply ignores it, “it is assigned a role in people’s everyday lives” (Nielsen 2000: 1060). By widening the analytical gaze outside of state institutions to look at interactions on the ground level, scholars provide a more nuanced understanding of how people think about and interact with law in their lives. This is “so we can turn to the everyday to get a better fix on the ways of the law, on what law is, and what it can be” (Sarat and Kearns 1994: 8).

The intertwined concepts of law in the everyday and legal consciousness get at the heart of how multiple legal systems come into play in our mundane lives and what influence they have (or do not). The past research delves into the ways we exist in a legalized world, even when interacting outside formal legal institutions. Analytical concepts shed light on how people make sense of and understand law as it works in society and in their own reality. The body of research reveals the complexity with which we engage the law in the everyday and the larger implications of this. As such, the concepts from law and society offer another level of analytical richness to studies on pregnancy prevention and termination. More precisely, they can illuminate various ways women encounter the state, and other regulatory mechanisms in order to track impacts of policy in a highly regulated, highly politicized context like Arizona. Ultimately, my project helps clarify the ways that official and unofficial policy may (or may not) complicate everyday reproductive decisions.
Encounters with the State and Social Stigma

Upon linking the research on reproductive politics and law and society, this project specifically investigates women’s ground level encounters with the state along pathways to contraception and abortion services in Phoenix, Arizona. As legal consciousness speaks to how people make sense of law in everyday life, this project reveals the ways women navigate everyday experiences of pregnancy prevention and termination, and how law (state and non-state) may influence these dynamic processes. In other words, “reproductive decisions are socially constructed not only in the sense that they are a function of the social conditions that structure women’s lives but also in the sense that those conditions are themselves produced by government policies and practices” (Ehrenreich 2008: 4). Beyond this, the phrase aims to capture various moments when women may have to interact with the state (e.g. state policy, institution, employee, etc.) in the process of seeking contraception and abortion. Depending on context, state encounters along these channels can act as facilitators or barriers, can be apparent or subtle, and can feel supportive or adversarial.

Encounters are often multifaceted amalgams of all these qualities. In this sense, my project encourages a momentary step back from isolated analyses of problematic legislation in order to interrogate encounters with other (often state-influenced) entities along the path. In fact, women cite many obstacles and confusion with other medical institutions that operate as both part and apart from the state. This is not to discount the importance of state law and policy decisions, but to suggest a bigger, more intricate picture at play here. Essentially, encounters with the state helps locate the role of social location and power in our everyday experiences with both formal and informal legal
mechanisms throughout our reproductive life histories. More, Suzanne Mettler’s work on legal and bureaucratic mechanisms adds to how state power works in obscure ways, often outside of public awareness and comprehension (Mettler 2011). Moreover, the hidden, even alien, nature of state law on reproduction begets what I would call more accurately: *close encounters with the submerged state.*

The submerged state, including its bureaucratic mechanisms, works in tandem with prevailing ideologies on contraception and abortion, and holds larger repercussions for social stigma that women experience. Public and political conceptions of morality reflect socio-cultural assumptions of reproduction that inform state law regulating access to abortion and birth control. In other words, the US retains a legacy of embedded, often religiously derived, beliefs on proper human behavior, including assumed gender roles and social norms. These ideologies underpin conceptions of female reproduction and sexuality, and women’s larger obligations for procreation and childcare. More, orthodox views hold sexual intercourse as solely a means of procreation—not pleasure, and certainly not female pleasure. The interactive relationship between law and society reminds us how state policy can function to reinforce these dominant cultural assumptions. In this way, the moral zeitgeist remains powerful and instrumental as its messages bleed into the realm of US law and politics. Historically and currently, birth control and abortion remain in conflict with national values by allowing women freedom from worry over pregnancy and, thereby, the luxury of sex for pleasure. Current policies on reproduction continue to target women as they wield “assumptions of incompetence, layers of second-guessing, and invasive [and paternalistic] counseling” (Sanger 2012: 862). This framework not only echoes scruples of the past, but also implies that women
are still incapable of making moral decisions about their own procreation (and preventing/terminating it). Even though sample participants encountered the state as peripheral, national ideals and deep-seated stigma still permeate policies and processes of pregnancy prevention and termination.

While *Roe* abolished the criminality of abortion, current restrictions can often feel like sanctions along reproductive avenues. Even among success stories with abortion and contraception, pathways are imbued with ideological and political messages that can influence one’s reproductive life history even after. As such, this project demonstrates larger feelings of social stigma that result from any decision a woman makes on reproduction; revealing discontinuity between national values and lived experience, and the gap between state policies on reproduction and personal health care practices. More, coupled with engrained female responsibility for reproduction, these success stories also speak to the notion of reciprocity (or lack thereof) between women and the state in this context.

That said, my dissertation contributes several key insights that I highlight briefly. Building upon the law and society literature, my project offers a critical look at the law from a different vantage point. I analyze the gap problem in a fresh way by focusing on women’s navigation of contraception and abortion including obstacles and facilitators, and how law and policy factors into ground-level processes. Much past research utilizes a top-down evaluation of law’s influence, but my dissertation centers on a bottom-up analysis of the same phenomenon. Instead of starting at the institutional level, a focus on the human level reveals more about women’s agency, perseverance and influence in the face of increased state regulation and social stigma.
The second and connected contribution of the study is additional inquiry into differential experiences of restrictive regulations of birth control and abortion in Arizona, and useful findings for activists and policy-makers. Marked by some of the most contentious political debates over reproduction and legal restriction to contraception and abortion, Arizona is the *best* state to study the ground-level workings of reproductive politics. Given the rise of anti-contraceptive and anti-abortion ideologies, conducting this study in a particularly conservative US state offers an analysis from which other more extreme and mid-level restrictive states could benefit. More, in the context of modern reproductive “lawfare,” even the more liberal states are not fully immune from barriers to reproductive access, and broader national ideologies to curtail women’s reproductive choice (Hajjar 2013).

Therefore, in light of my findings on legal pluralism, submerged bureaucratic mechanisms, and prevailing socio-cultural stigma along pathways, I argue this research can also be useful for so-called friendlier reproductive states. Investigation of pathways in both legislatively restrictive states and those with outwardly unobstructed access is necessary to understand the reach and complexity of legal pluralism within the health care arena. Reproductive access is not only shaped by state laws, but also by obscure regulatory mechanisms within medical and insurance institutions. As such, women in

---

15 “The Lawfare Project defines the term and its dangerousness as: ‘the use of the law as a weapon of war,’ or, more specifically, the abuse of the law and judicial systems to achieve strategic military or political ends [emphasis added]. It consists of the negative manipulation of international and national human rights laws to accomplish purposes other than, or contrary to, those for which they were originally enacted” (Hajjar 2013: 7). While primarily used in research on the state’s role in military conflict, I argue lawfare to be an accurate term to also describe the legal onslaught over reproductive rights as it works to manipulate legal and judicial realms to achieve conservative political ends across the US.
states without explicit legal restrictions may still face significant obstacles with insurance confusion and medical opacity. Simply put, residing in a state absent constant legislative regulation of contraception and abortion does not automatically guarantee open pathways. So more liberal states that truly care about expanding access must mind how other submerged mechanisms impede women’s options to secure protection from unwanted pregnancy. In the end, if we understand how women obtain contraception and abortion in a legally and politically restrictive environment, we are better able to anticipate ways to foster accessible reproductive health care around the country.
2. Research Design and Method

Debates over abortion and contraception remain central to ongoing politics nationally and within Arizona. While data indicate that abortion rates have declined and reported use of contraception has increased, too much remains unknown about the power of law and policies on ground level experiences with pregnancy prevention and termination. This dissertation helps to explain the extent and type of influence legal changes may have on how women access contraception and abortion in Phoenix. Illuminating ways women encounter the state during these experiences can also help to identify additional tactics for activists, scholars and politicians to maintain open channels to abortion and contraception.

Research Questions

Therefore, the guiding research questions of the dissertation project are:

1.) How has the legal and juridical terrain of reproductive politics changed since Roe v. Wade (1973) in the US, and Arizona specifically?

2.) How has the shifting legal and juridical terrain of reproductive politics shaped women’s pursuit of pregnancy prevention and termination? Moreover, how are experiences shaped not only by the local implementation of old and new laws, and legal decisions and policies, but also by one’s socio-economic position?

3.) What are the effects of women’s encounters with the state on their health, their reproductive needs and their overall sentiments of social stigma?
Epistemological and Methodological Approach

My epistemological position adopts a view that knowledge production should bridge the long-standing gap between a positivist and interpretivist vision of reality. Our bodily experiences are complex interactive processes where sociocultural context is key, and neither the “Biology is destiny” nor the “It’s all in your head” approaches to epistemology accurately capture that (Dan 2013: 164, and see Alcoff and Potter 1992). In other words, social research should aim “to hit that sweet spot between the rigor and theory-building capacities of canonical quantitative social science research and the emergent, open-ended and pragmatic capabilities of traditional field research” (Luker 2010: 2-3). The social world is neither isolated to empirical absolutes nor pure contextual interpretations, but the mutually constituting relationship between the two, and my research approach reflects that perspective.

A concrete example of this necessary integration could be seen in an experience of a woman seeking an abortion at a local clinic. The physical structure of the clinic, the people working inside it and even written procedures for how it operates are, in many ways, reality or fact (i.e. empirical, measureable, observable). However, the ways this scenario plays out and is experienced also depends on context and the meaning people imbue it with\(^\text{16}\), given prevailing discourses on health and responsibility available at the moment and the policies that inhabit the space of the clinic. Borrowing from phenomenology, this project empirically analyzes objects and events in reality, and maintains that those analyses be based on the contextual interpretation of each who differentially experiences (or evaluates) that reality (Hamati-Ataya 2012).

\(^{16}\) For example, this may include the socio-economic position of the patient, staff workers, and doctors, clinic location, time, etc.
While post-positivist research acknowledges experience and biases, it retains a belief in the possibility of an objective truth. Describing themselves as post-positivist realists, Miles and Huberman “think that social phenomena exist not only in the mind but also in the objective world and that some lawful and reasonably stable relationships are to be found among them” (Miles and Huberman 1994: 4). Rejecting the notion of objective truth, this project again calls again to the sweet balance in social research. Acknowledging reality as both empirically observable and contextually experienced produces a more holistic knowledge on experiences with pregnancy prevention and termination.

The project aims for a holistic understanding of women’s pathways to contraception and abortion, which integrates both statistical data and human narratives. Therefore, my research design incorporates the collecting different kinds of data through in-depth interviews, both quantitative closed-ended questions and qualitative open-ended questions. In sum, the goal is to benefit from quantitative closed-ended data, while also embracing rich interview narratives and a constructivist critique thereof. In other words, empirical data and numeric trends, maps and rates divulge one facet of the reproductive experience, while qualitative interview data brings depth and provides a supplementary facet of the same story.

Methods

In-Depth Interviews

In-depth interviews are the central method of this project and are critical to theorizing women’s complex avenues to pregnancy prevention and termination, and their
interactions with the state. Interviews provided rich narrative data from women themselves to better understand these often-nuanced processes. More, in-depth narratives provide “rationales, explanations, and justifications for [participant] actions and opinions” (Tracy 2012: 132). Specifically, these interviews allowed me to analyze accounts of reproductive processes as directly experienced by women themselves. All interviews were conducted either in-person or over the phone.

In terms of sampling frame, all the women in my sample were currently active in seeking contraception and/or abortion at the time of recruitment, or had sought these services sometime in the last three years approximately. This time restriction ensures analysis of current experiences. Specifically, this study parameter also ensures analysis of experiences with more recent onslaughts of restrictive legislation on reproduction since Jan Brewer’s governorship in Arizona. My sample was limited to women’s experiences of obtaining doctor-prescribed hormonal birth control in various forms. Additionally, the sample included experiences of both chemical and instrumental abortion.

Furthermore, the goal was to compose my sample of women to closely match the current demographic distributions for Phoenix to ensure the inclusion of reproductive testimonies from a range of socio-economic perspectives. The lower limit of the age range is 18 years old to allow for an adolescent perspective while avoiding problematic parental consent requirements. The upper age limit is 45 years old because the average age for menopause is 51 in the United States (National Institute of Health 2013). This upper limit accounted for the practical fact that my sample was limited to women actively dealing with pregnancy prevention in the last three years, and women approaching

\footnote{Retrieved from most current US Census data.}
menopause would likely not meet that criteria. All in all, I conducted in-depth interviews with 32 women on experiences with pregnancy prevention, and collected interview data from five women on pregnancy termination. Four of the women in the abortion sample also shared stories on contraception, bringing the total combined sample to 33 participants (not including my own testimony). Interviews questions focused primarily on identifying different barriers and facilitators, and the various ways the state interfered in these processes (see Appendix A).

In terms of sampling strategy, quota sampling was the most practical and effective to ensure data had the demographic characteristics necessary to sufficiently respond to the research questions. To meet quotas, I utilized both convenience and snowball sampling techniques among groups of women I know personally in the Phoenix area. Having lived in Tempe since August 2011 and worked waged jobs off-campus since December 2012, I was connected to different groups of women in the region. Recruitment was conducted in-person at places of work or school, via phone/text with those for whom I had contact information, and over Facebook (FB). On Facebook, I publically posted project and recruitment information on my own Facebook page, which was shared by Arizona friends and initial participants. I specifically used private messaging on FB to reach personal acquaintances whose contact information I did not have. Further, during recruitment, I began sparking conversations with women I met in public at local events and social outings. Even during study sessions at coffee shops, I initiated conversation and asked about study participation. Generally, these women reported not using hormonal birth control, that they had only recently moved to Arizona, or had not experienced abortion in the last three years, in this state, or ever. Lastly, in
addition to convenience sampling, snowball sampling was essential to this project. See Appendix B for recruitment script and participant resources.

By asking all participants about women they recommend for the study, snowballing participants also helped to fill notable demographic gaps in the sample. Many initial participants helped me build my sample by providing names and, when possible, direct contact information for other potential project contributors. In fact, even those excluded from the project based on criteria were helpful in suggesting other possible female participants. The women recommended for the study whom I did not know personally were primarily contacted through private messaging on FB to better introduce myself and the project more largely. Nevertheless, whether contacted by phone, FB or email, a number of these women simply did not respond to invitations, or ceased conversation when time came to schedule or conduct the interview. Still, snowball sampling helped connect me with other women willing to participate in the study, which expanded and enriched the sample.

Therefore, participant recruitment extended beyond ASU campus to different circles of women from varied life experiences. Generally, one circle was comprised of women who had recently graduated from university with Bachelor’s degrees, and were beginning more professional full-time employment – some of which paid yearly salary while others still offered hourly wages. Some in this group were finding independence for the first time by paying all their own bills and renting their own residence. Another circle of women did not pursue any college education after high school, and devoted themselves to saving money by working full-time in primarily service or retail jobs with hourly wages. Active undergraduates working part-time hourly-waged jobs characterized the last
circle. Women in this group varied in that some attended the several community colleges in the area and others went to the four-year university. While all pursued higher education, not all shared their rationale for doing so. Some women seemed to be going to college because they felt it was the standard course for a woman their age—juggling with not only different majors, and amount of student loans to take out, but also whether to just get an Associate’s degree or continue toward a Bachelor’s. Others had concrete direction in terms of their sought major, degree, and career path while others showed less certainty. That said, some part-time positions among these students were connected with one’s desired career path like clerical/administrative work or paid internships, and others were retail and service-industry jobs. Notwithstanding, these three groups of women are generally emblematic of the new middle class in the US.

In terms of analysis, interviews with women were recorded, transcribed and analyzed, both qualitatively and quantitatively. Quantitatively, measures of central tendency were calculated for closed-ended data to determine patterns, trends and even discrepancies in reproductive testimonies. This data included specific statistics on time spent at clinics, cost of services, distances traveled and other quantifiable moments. Qualitatively, interview data was thematically coded to identify emerging tropes in experiences seeking contraception and abortion. This study employed narrative analysis of the interviews, which examined how women created and interpreted deeper meanings in their lives along pathways to birth control and abortion. Narratives are interpretive devices that help piece together experiences, and reveal deeper meanings on how one interprets the world (Lawler 2002). Specifically, micro-linguistic narrative analysis proved most useful, and facilitated a deeper examination of ways women talk about
specific barriers and facilitators, and the role of the state. This kind of qualitative data analysis helps to trace important events impacting paths to contraception and abortion, and identify how each participant imbues those events with deeper meaning. Ultimately, interviews with women provided different kinds of data and therefore several lenses through which to scrutinize experiences of seeking contraception and abortion in the socio-legal context of Phoenix, Arizona.

Auto-Ethnography

Many studies within anthropology embrace auto-ethnography as a useful method for studying experiences in a way that recognizes sociocultural context (Chang 2016). Although auto-ethnography is not without its critics, it offers many benefits to research and this project in particular. This method represents a wide range of written and recorded personal accounts to encourage both self-analysis, and a comparison to other narratives. More specifically, this method helps to quell a power differential between researcher and participants by encouraging a more collaborative and reciprocal relationship (Ibid.). That said, use of auto-ethnography allows for analytical inclusion of my own contraception and abortion experiences as a supplementary perspective to sample data. Adding one’s own narrative cultivates data triangulation for “reaching the height of holistic and in-depth” analysis, which may further foster “cross-cultural coalition building” (Chang 2016: 57).
The Study Sample

In total, I gathered 32 in-depth interviews on contraceptive experiences, five in-depth interviews on abortion experiences, and one auto-ethnographic narrative of both. The following descriptive statistics were generated from the sample of 32 women interviewed about contraception. In terms of racial diversity, the sample is composed of 50% Caucasian participants (n=16), 25% Latina (n=8), 16% Asian (n=5), 6% Black (n=2) and 3% Middle Eastern (n=1). The age range of the sample is 18 to 37 years of age, with an average age of approximately 24. While education levels range from high school completion (n=7) to graduate level work (n=4), most participants reported having some college education (n=12) or a Bachelors degree (n=9). The sample also includes women who have vastly different forms of health insurance. Most are still insured under their parent’s health insurance plan (n=13), some have Obamacare obtained through the government (n=6), some purchased a health care plan through their employer (n=8) or university (n=2), and a few have no medical insurance coverage at all (n=3). The majority of participants are employed full-time (n=19), some are full-time students who work part-time (n=11) and two participants are currently unemployed.

Further, the sample also includes women across the political and religious spectrums. Most women in the sample do not identify politically, describing themselves as “independent”, “other,” “no political affiliation” or that it “depends on the issue at hand” (n=14). The remaining participants identify as generally liberal (n=11), or

---

18 A chart of the contraceptive sample demographics can be found in Appendix C.

19 Specific demographic information of abortion participants can also be found in Appendix C.

20 Native Americans are considered a protected research group by ASU’s Institution Review Board and, therefore, have been excluded from this project for reasons of practicality and access.
generally conservative (n=7). Additionally, with regard to religious beliefs, the majority of participants identify as non-religious or Agnostic (n=12). Others identify as Christian (n=10), Catholic (n=6), and Atheist (n=4). Lastly, most women in the study are currently in long-term relationships (n=21), while one woman is legally married and the remaining participants are currently single (n=10).

All participants in the sample are considered members of the new middle class and the rationale for this analytical decision follows. This term speaks to the hollowing out of the middle class in the US as a lived experience for participants. The middle class as a group lost 23 percent of its wealth since the 2008 recession while corporate profits continue to benefit the wealthiest tier (Peck 2011). More, in 2012, 38 percent of people in the US were living paycheck-to-paycheck (Kristof 2012). Recent studies note changing characteristics of the middle stratum in the current neoliberal market. This class is now defined by “a haze of contrasting career paths, multifarious income sources, and contradictory consumption patterns” (Kravets and Sandicki 2014). Some contend that economic class in the US currently is as simple as “the rich and the rest” as the richest 1 percent of households earned as much each year as the bottom 60 percent combined (Peck 2011: n.p.). Further, not only have jobs for nonprofessionals dwindled, but also have career opportunities for college graduates (Ibid.). Additionally, critiques of parental income as an appropriate proxy for student economic class have become more common (Rubin et al. 2014). Therefore, new middle class does not imply all exist on the same economic footing nor deny familial wealth, but rather calls upon a common experience of financial precariousness among a disappearing middle class in the US.
However, just as these women do not easily fall into conventional middle class definitions, working class categorization is not entirely accurate either. Women share similar sentiments of financial instability, and juggling rising costs of living while working jobs with (at best) average wages. Working class, although debated, often refers to waged workers doing physical labor and those who lack college degrees. Others contend that class standing can be self-identified, and that the difference between middle and working class is discretionary income (Rubin et al. 2014). However, interviews reflect a larger perception that being considered middle class in the US implies higher levels of financial stability than participants currently experienced. One even exclaimed, “How can I be considered middle class when I live almost paycheck to paycheck?!”

Current society is marked by a precarity of the new middle class that is characterized by “multiple forms of…dispossession and injury” (Muehlebach 2013: 298). These women are at a point in life where they are becoming independent and also trying to establish their professional/working lives. Therefore, relegating participants to the middle class based on parental wealth is just as inaccurate as labeling them strictly working class by neglecting it altogether.

Economic rank is not determined in a vacuum but results from the unique interplay between one’s economic milieu, and current context. Social researchers recognize the difficulty in categorizing socio-economic status due to its contextual relationship with “socio-demographic variables” (Rubin et al. 2014). Simply, many people do not really know what social class they belong to. Admittedly, some women in the sample enjoyed parental coverage for college tuition, temporarily lived with parents rent-free, while others were deprived of even the option for higher education. Alas,
college tuition coverage, free rent, and even professional degrees do not guarantee freedom from money quandaries. Therefore, the data and my categorization does not discount the nexus of familial wealth and individual class, but rather acknowledges the reality that parental income does not automatically ensure financial security as an adult. In fact, many expressed anxiety over unpredictable life costs that could swiftly derail their bill-paying routine. An unexpected auto repair or high veterinary bill can leave women without monetary surpluses often used for doctor visits, birth control, or even abortions. Moreover, I decided upon the terminology of new middle class because of how participants expressed their economic circumstances, as “part-time students, part time workers,” “underpaid,” “starving students,” “working paycheck to paycheck,” “in debt,” “working class,” “lower-middle class,” and others.

Research Ethics

The project was submitted for Expedited Review through ASU’s Institutional Review Board and initially approved in July 2015. It was submitted for Continuing Review the following year and approved by the IRB in June 2016. See Appendix D for IRB approval documents. The ethical issue of confidentiality is ensured by use of only pseudonyms and demographic information on interview materials, transcriptions and within the dissertation. Further, the consent forms and confidentiality statements used during data collection were taken directly from ASU’s IRB website.

When asked about economic class affiliation during interviews, many women responded with some variation of, “Are we talking about my class level, or my parents’?” Given that, the interview question on class association was often met with two responses such as “Well, my parents are middle class, but, with my current salary, I am definitely not” or “My mom is considered upper-middle class but I am a starving student right now.”

21
In addition to the basic requirements established by the IRB, I anticipated some ethical risks could emerge during the course of the research. These included psychological risks and privacy risks. There were minor risks of psychological discomfort by engaging with some sensitive topics and questions regarding experiences with contraception and/or abortion. There were also minor risks to privacy as participants were asked to elaborate on medical history and experiences with obtaining contraception and/or abortion. However, the participant was not required to answer any question that she did not feel comfortable answering, and had the option of stopping the interview at any time. They could also opt-out of the research project entirely at any time without negative consequences. All data gathered is kept confidential and anonymous on a password locked computer. After doing the research, I found most women willing to participate in the study were also willing to divulge their experiences comfortably.

Limitations

Recruitment for the project presented many obstacles due to the sensitive and political nature of the topic. First, I hoped to gather a total of 40 interviews on contraception, and 10 on abortion yet faced some setbacks. Unexpectedly, many women I initially approached for the study were not using any form of hormonal birth control. This challenge forced me to change my strategy in order to accommodate for this. In addition, considering the personal and political nature of abortion, I encountered difficulties with locating women willing to share their story with me, as an unfamiliar university researcher. Initially, I thought “cold messaging” Arizona women on Facebook could also be promising yet I realized the difficulty first in determining who actively used birth
control or had recent abortions, and second, in actually getting women to respond and share personal stories with a stranger. Of the women who verbally refused to participate with abortion narratives, some expressed worry over potentially misused or leaked interview data, and the larger consequences if their story was traced back to them. Initially, I also planned to snowball the sample by approaching women at local clinics. However, protester presence and political contention reminded me that this kind of recruitment was both ineffective and inappropriate for the topic and the current state climate. Of the few women I approached, I could sense their hesitation and doubt over the aims of the project and my role as researcher. Ultimately, scheduling interviews, missed interviews and rescheduling all remained practical challenges throughout data collection. Further, some women agreed to participate and divulge experiences with contraception and abortion, but then became unreachable when the time came to schedule or conduct the interview. Specifically, there were seven additional women who could not be reached and therefore opted not to participate (including five with experiences of contraception and two with experiences of abortion).

Originally, this project also hoped to include testimonies from workers in the Phoenix reproductive health community to add another analytical layer to experiences with contraception and abortion. Amid Arizona’s contentious views on reproduction and strict concerns over the patient privacy, this proved a fruitless effort. Some of the staff members that I approached expressed immediate suspicion of my political agenda and larger intentions with the project. Others were unwilling to participate for fear of jeopardizing their employment. All in all, it seems that effectively infiltrating the medical realm requires additional connections and time, which this project did not possess.
However, I contend that this is an important aspect of pregnancy prevention and termination and can offer additional insight into the bureaucratic and institutional challenges faced by those providing reproductive services in Arizona.
3. Arizona’s Socio-Legal Landscape

*There is a fight over birth control that has never really ended, and a battle over abortion that erupts anew in every election cycle. But what the Supreme Court may or may not grasp is that it has on its hands something deeper yet: a struggle over modernity, a battle for the secular state in which women can make their choices, and design what Justice Ginsburg calls their life course, free of obstacles erected by those who would impose their religious views on others.* (Greenhouse 2015: n.p.)

Before turning to women’s experiences with contraception and abortion in Arizona, I will first map the legal and political terrain of this state where elected officials legislate reproductive health on an annual basis. Currently, Arizona has some of the strictest regulations in the nation with regard to both regulating contraception and abortion practices. In many ways, Arizona is a harbinger of what is to come because it reflects national trends of increased constraints over access. As a result, I argue that Arizona serves as the best case study to examine and generate sound theoretical claims on reproductive politics in the US currently. It is within this socio-legal context that women seek to meet their individual needs for pregnancy prevention and termination.

Amid these potential legislative barriers, research on abortion and contraceptive use in Arizona suggests steady use of contraception and decreased abortion and teen pregnancy rates overall. With regard to contraception, in 2010, approximately 180 publicly funded health centers in Arizona provided contraceptive care to about 97,000 women, including 18,000 to teenagers (Frost et al. 2013). In 2011, for example, of the 1.2 million women of reproductive age (15-44) living in Arizona, the state reported approximately 120,000 pregnancies, of which 13 percent resulted in induced abortions (Jones and Kooistra 2011). That is, in 2011, approximately 16,000 women obtained abortions in Arizona, demonstrating a rate of 12.7 abortions per every 1,000 women of
reproductive age. The abortion rate reflects a decline of 18 percent since 2008, which researchers attribute less to restrictive legislation and more to increased availability of long-term contraception (IUD) and emergency contraception (Plan B) (Ye Hee Lee 2014). Additionally, teen (15-19) birth rates in Arizona dropped by approximately 35% from 2007 to 2011 (Hamilton, Mathews and Ventura 2013). Bill Albert of the National Campaign to Prevent Teen and Unplanned Pregnancy associates these decreases with abstinence education, increased contraceptive use, and shows like Teen Mom or 16 and Pregnant on MTV (Hogan 2015).

These statistics ultimately reflect that, even in a conservative climate, some women are still able to access contraception to help prevent pregnancy. Understanding how women navigate pathways and encounter the state along the way sheds light on the real impact of law and policy in reproduction. Arizona is a state that still has its pre-Roe ban on abortion in place if the case were ever to be overturned at the federal level, reflecting the general state sentiment that abortion should be completely eradicated in order to promote life and family (Center for Arizona Policy 2016). Despite Arizona’s steadfast anti-abortion stance, legislative and judicial fights continue over contraception and abortion, and governmental funding for them. Arizona legislators anticipate bills regulating women’s reproductive health to be dropped in January 2017 when the new session begins. At the federal level, recent Supreme Court rulings, like Whole Woman’s

---

22 Ariz. Rev. Stat. Ann. § 13-3603 states “A person who provides, supplies or administers to a pregnant woman, or procures such woman to take any medicine, drugs, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless it is necessary to save her life, shall be punished by imprisonment in the state prison for not less than two years nor more than five years” (NARAL Pro-Choice 2016: n.p.).
*Health v. Hellerstedt (2016)* in Texas, aim to curb some of the more hostile targeted regulation of abortion providers (TRAP statutes) (Liptak 2016). Current presidential nominees, Hillary Clinton (D) and Donald Trump (R), both offer drastically different positions on women’s reproductive health in the US which will further shift the socio-legal landscape depending on the election outcome in November 2016.

Arizona represents an ideal case study to understand how a conservative political and legal context can impact women’s experiences seeking contraception and abortion on the ground level. Amid some of the most restrictive legislation on reproduction in the country, this is the ideal context to more deeply probe the influence of that law and policy. Key concepts from law and society offer a unique analytical backdrop to understand reproductive decisions, and women’s encounters with the state and other institutions. Although immersed in a society structured around the rule of law, we sometimes fail to interrogate the everydayness of law and how it seeps into our lives. This project hopes to gauge women’s legal consciousness of birth control and abortion regulations as they navigate this political and legal terrain in their daily lives. Depending on socio-economic position and context, women can encounter the state as a complex, ever-shifting arrangement of barriers and facilitators throughout their experiences. A study of pregnancy prevention and termination in Arizona can teach us about the influence of the state, and also illuminate practical techniques to open up avenues to women.
Arizona’s Historical Timeline

Contraception and Abortion in the 1960s and 1970s

In addition to the brief snapshot provided, an in-depth look at Arizona’s history with reproductive politics is required to better understand and analyze women’s encounters with the state with contraception and abortion currently. Notably, the analytical timeline for this project begins with the passing of Roe because, only then, did Arizona reform its statewide ban and accompanying abortion policies. Consequently, the tracking of Arizona’s socio-legal history with reproduction will begin here. Roe signaled a national paradigm shift and this changed how women in Arizona would access both contraception and abortion from that point on.

The mid-1960s to the 1970s marked unprecedented national attention with regard to reproductive health, and Arizona proved no different (Melcher 2012: 111). Public and state fear of a national population explosion brought a greater presence of Planned Parenthood and family planning in general to Arizona, especially with the help of Margaret Sanger and Peggy Goldwater. Initially, Sanger was drawn to the region because Arizona ranked second highest in maternal and infant mortality in the 1930s (Ibid.). Specifically, after moving to Phoenix in the 1930s, Sanger worked to open the first Planned Parenthood clinic in the state in October 1937, and increased the figure to eleven PP locations in Arizona by 1945 (Chesler 2007). Actually, Sanger worked with Arizona women to open access to contraception until her death in Tucson in 1966 (Chesler 2007).

That said, while Margaret Sanger’s message on reproductive freedom was (and

---

23 Public historian and consultant, Mary S. Melcher has produced the most comprehensive historical account of reproductive politics in the state of Arizona to date and so her work will be relied upon extensively in this review.
remains) controversial to many, her work in Arizona changed the way women controlled their reproduction. Sanger was generally criticized for normalizing women’s control over their bodies, and also for the eugenic implications of her birth control campaigns.

Nevertheless, by the early 1970s, many women openly embraced the use of contraception. With population scares at this time, accessible birth control seemed a useful option. The Arizona State Department of Health and Maricopa County Public Health also openly supported the use of contraception to deal with the “unwanted population” at this time (Melcher 2012: 124). The Maricopa County Maternal and Child Health Program began in 1965, which provided free family planning as well. “In 1974, leaders in the reproductive health movement organized the Arizona Family Planning Council to administer Title X [federal] family planning funds and programs in Arizona” (Melcher 2012: 126). As seen in previous chapters, state sentiments toward abortion and contraception tend to shift with socio-economic issues at hand, and this remains true in Arizona.

However, not everyone supported the expansion of access to forms of reproductive control in Arizona. Specifically, Catholics, Mormons, Navajos and some Black groups were vocal opponents. Their opposition stemmed not only from religious differences, but also from concerns over the eugenic implications of birth control among women of color (Melcher 2012). That said, women’s views and actions on contraception were never completely aligned in Arizona. In fact, even nationally, “Catholics rely on abortion more than any other religious denomination, perhaps because of the church hierarchy’s ban on contraception” (Gordon 2012: 64). Still, both abortion and contraception remained contentious topics in the state. Arizona State University still
would not allow contraceptive distribution on campus in 1974. Hence, “disagreement between administrators, student, and the Board of Regents illustrated that change was in the wind, but did not arrive without a fight” (Melcher 2012: 128). Even given this political turmoil, one study shows that approximately 44,000 women were using family planning services in the state of Arizona in 1974 (Melcher 2012: 133). That year in Arizona, the US Census recorded approximately 500,000 females at reproductive age (15-44), demonstrating that roughly one in twelve women were using family planning services.

Just as access to contraception and family planning was restricted, access to abortion also looked quite different prior to Roe. Before 1973, Arizona women only had the option of obtaining a therapeutic abortion if there were present health risks to the woman and/or developmental problems with the fetus. Such therapeutic abortions required lengthy judicial reviews and could cost hundreds, if not thousands, of dollars. In fact, in the early 1960s, one New York City hospital reported that 93% of therapeutic abortions were performed on White patients, mostly for psychiatric reasons (Romm 2015). Those women who were denied therapeutic abortions, like one infamous Arizona case, were still able to obtain the procedure abroad for the right price. In fact, “by the early 1970s, some travel agencies had package deals specifically for that purpose” (Romm 2015: n.p.).

The case of Sherri Finkbine illustrates this example of the reproductive hierarchy based on social class. In 1962, during her fifth pregnancy, Arizona resident Finkbine had unknowingly consumed pills containing Thalidomide, a sedative that can cause serious birth deformations in fetuses. By 1961, it was taken off the European market and was
never approved by the FDA in the US (Hoffman 1992). Finkbine went public with her concerns to The Arizona Republic, yet the court still denied her abortion request, forcing her to seek help elsewhere. After being denied a travel visa to obtain the abortion in Japan, Finkbine was able to travel to Sweden, and secured the abortion in August 1962 (Hoffman 1992). In the US before Roe, obtaining access to a doctor-performed surgical abortion was extremely costly, time-consuming and ultimately not guaranteed. This left women who lacked sufficient money, time, and resources with few options: either give birth to a child they cannot afford or risk getting an abortion on the black market.

Although the legality of abortion remained tenuous throughout the 1960s, reform movements gained momentum both nationally and at the state level. By 1967, Colorado, California and North Carolina had begun to liberalize abortion restrictions (Luke 1985). Politicians and activists mainly began addressing abortion through the issues of safety and health concerns over back-alley abortions. Feminist abortion activists’ rhetoric at the time emphasized female bodily integrity (which has currently shifted to women’s health rhetoric, on both political sides) (Rose 2006). Physicians and lay practitioners of abortion in Arizona were being prosecuted until the 1960s, and are currently subjected to numerous restrictions on their practice.

Although the issues of abortion and contraception are intrinsically linked, women from different ethnic groups or generations have drastically different viewpoints on contraception and abortions, adding complexity and nuance to the issues. For the most part, sentiments regarding abortion and contraception were often drawn along political and religious lines. “There was a generational and cultural divide surrounding abortion rights while middle-aged and older women from certain religious and ethnic groups were
more likely to see it as immoral” (Melcher 2012: 160). During the 1970s, data reflects that mainly White, young and unmarried women procured abortions, with procedures among women of color accounting for only 17 percent\(^{24}\) of all abortions (Melcher 2012).

In the late 1980s, president of Arizona Right-to-Life, Dr. Carolyn Gerster, publicly stated that her organization opposed abortion but supported contraception (Ibid.). Neglecting to address the ways that the issues of contraception and abortion intersect is potentially detrimental for women and society in general.

**Post-Roe in Arizona**

*Roe v. Wade (1973)* and its legal right to privacy shifted the socio-political tides on abortion nationally and within the state. In response to the decision, lively debates sparked in Arizona beginning in the 1970s while anti-abortion groups rallied to invalidate *Roe* entirely. Thus, despite legalization driving down the price of abortion, issues associated with access, including the availability of government funds for abortion in particular, remained contentious issues for activists. Following the 1977 Supreme Court decision in *Beal v. Doe*, Arizona legislators worked to ban public funds for abortion by 1980, except in cases where the health of the mother was in jeopardy (Gold 1980). Alongside *Harris v. McRae* (1980) and its safeguarding of the Hyde Amendment’s ban on federal funds for non-therapeutic abortions, Arizona legislators were able to meet their

---

\(^{24}\) This data as well a census counts may be skewed because it is unknown how researchers categorized Latino/a populations, and whether they “included those of Hispanic descent within the racial category labeled White” (Melcher 2012: 159). General estimates from the 1970s show people of color made up approximately 8 percent of the total Arizona population (Gibson and Jung 2002). Further, given potential glitches in data collection and the prevalence of lay midwives (who were often abortionists) within Latina and Native communities, it is difficult to be certain of rates of abortion at this time.
goal (Hardy 1981). By 1984, nationally, the average cost for an abortion was between $350-$550 (equivalent to about $3,500 to $5,500 today) while the median income was roughly $22,000 (Beauchamp 2015; Welniak 1987). In contrast to later Medicaid expansions in the 2000s, Arizona has a history of neglecting the family planning needs of low-income families, considering it was the last state to join federal Medicaid in 1982 and family planning coverage was not added until 1995 (Reinhart 2013). So while abortion was legalized in 1973 at the federal level, paying for it remained a concern for women unable to afford to do so.

Other potential barriers complicated women’s pathways to abortions during this time. For rural women, geography was a significant problem: 80 percent of women getting abortions in Pima or Maricopa resided outside of those counties (Melcher 2012). In other words, one in five women who secured an abortion in the two most densely populated counties in the state lived elsewhere, likely in one of the other 13 counties across the state. The limited number of providers complicated access to abortion services statewide. Moreover, physicians who wanted to become trained in abortion procedures had few options at the time. The University of Arizona Medical School was one of the only locations to offer this training.

Attempts to legally regulate abortion continued to have concrete consequences for women. In 1977, “the rate of abortion in Arizona was low at 17.5 abortions per 1,000 women in Arizona and 26.9 per 1,000 women in the United States” (Melcher 2012: 159). More, in 1975, Arizona reported approximately 170 abortions per 1,000 live births (US Census 1982; CDC 1976). So for every 1,000 children born in Arizona that year, there were 170 successful abortions performed. Bordering states like California reveal very
different rates for abortion in the decade following legalization. Data shows that California performed approximately 30-40 abortions per 1,000 women, which remained constant until the early 1990s (Henshaw and Kost 2008). Also, in 1975, California reported a ratio of 523 abortions per 1,000 live births (Wetstein 1996; US Census 1982; CDC 1976). See Appendix E for US Census data table. In 1980, Arizona reported approximately 15,000 legal abortions while California performed over 250,000 that same year (Henshaw and Kost 2008). Even accounting for vast population disparities, Arizona reported 25 abortions per 1,000 women in 1980 while California reported 43 (Ibid.). These differentials suggest that Arizona’s low number of abortion providers were failing to meet the reproductive needs of its constituents during the years following Roe.

Amid setbacks over the past decades, women in Arizona still made great strides to secure access to contraception and abortion. In the decade following Roe, Democrats supporting abortion rights were joined by “many moderate Republicans [such as the fiscally conservative Senator Barry Goldwater] believing in the constitutional guarantee of privacy, refused to support measure that severely limited access to abortion” (Melcher 2012: 162). The general public seemed to have a more moderate view on abortion and reproductive health services than state legislators. In a 1989 Gallup poll asking overall opinion of Planned Parenthood, 29 percent ranked the agency as “very favorable,” 50 percent considered the organization “mostly favorable” while only 4 percent held a “very unfavorable” opinion of PP (Riffkin 2015). Further, research showed that abortion procedures were also quite safe at this time. The vast majority of abortions at this time were performed in non-hospital settings, and there were no reported abortion-related deaths in Arizona from 1980 to 1989 (ADHS 1990).
However, conservatives made several advances in the area of reproductive restrictions during this time. The New Right coalesced during the 1980s and maintained political power with the help of president Ronald Reagan and his judicial appointments to federal courts. The movement gained momentum beginning with the Supreme Court decision *Bellotti v. Baird* (1979), which allowed states to require parental consent for minors seeking an abortion. Additionally, contraceptive and abortion clinics in Arizona faced almost daily picketing. While facilities secured injunctions to stop picketers’ threatening and intimidating behavior against staff and patients, it was not until 1993 that Phoenix passed an ordinance to create a safe 100-foot “bubble” outside these clinics (Melcher 2012: 165). This mirrored national trends in which courts began to draw limits on protester activity outside of abortion clinics as with *State v. O’Brien* (1989) (Boxerman 1990). Although these activists were ultimately charged with criminal trespassing, national debates on acceptable activist demonstrations continue in the US. Markedly, this time period was met with a splintering of the pro-life movement; the message remained constant but tactics changed considerably. While some activists continued to use state legislatures and courts to ban or restrict abortion, others moved toward more radical (even violent) actions to push the anti-abortion agenda. However, one only needs to walk on campus or to the local Arizona Planned Parenthood to witness the ideological turf wars over reproduction that rage on in this state.

Political tensions between pro-choice and pro-life advocates continued to mount in Arizona, reflecting national trends. Anti-abortion groups in the state backed and lobbied for Republican George Bush, Sr. during his presidential victory in 1988. In 1992, the Arizonans for Common Sense coalition collected enough signatures to include
Proposition 110 on the ballot, which would have banned abortion in Arizona except in cases of medical necessity and restricted all public funds for abortions except in cases of rape or incest (Coury 2014). Although invalidated by 69 percent of voters who rejected the restrictions, its appearance on the ballot signaled the political climate of the time in Arizona, and the ease with which groups could get this kind of legislation on the ballot25 (Ibid.).

Still women in Arizona continued to seek out reproductive health care, although demographics of those who sought abortion changed over time. During the 1980s, it was mainly White, unmarried women under age 25 who sought abortions in Arizona. One study done by the Arizona State Department of Health reported 91 percent of those who obtained abortions during that time had completed at least nine years of formal education (Mrela 1988). Then, from 1985 to 1995, Black women reported the highest rates of abortion in Arizona, which is disproportionate to their population numbers during that decade26. Increases in abortion rates among Black women can be best explained by limited access to contraception and family planning services by low-income women of color in the state (Mrela 1988).

Debates over access to contraceptives and sex education for teens also produced

25 The Arizona Constitution stipulates that the people, in addition to the legislature, also have the power to propose laws and amendments to the state constitution (Ching 2007). Citizens can inform direct legislation through proposed changes to Arizona statutes (initiatives) or attempts to block legislation from being passed (referendums) (Ching 2007). To get on the ballot, petitions must be filed with the Secretary of State at least four months before the general election and have at least 10 percent the number of votes (15 percent for constitution amendments) from the previous gubernatorial election (Ibid.). “Arizonan voters have seen over 200 measures on ballots-making it one of the most widely used direct legislation systems in the United States” (Ching 2007: 22). However, direct legislation is not without criticism as Arizona voters deal with some of the longest ballots in the nation.

26 By 2000, African Americans (both male and female) comprised approximately 4 percent of the Arizona population (US Census 2010).
mixed results in the state. Teen pregnancy rates continued to rise during this time, with Arizona ranking higher than most states (Melcher 2012). Teenage birth rates jumped 28 percent between 1985 and 1992, and the Arizona Family Planning Council blamed “sexual ignorance, lack of family planning or teen pregnancy programs” (Melcher 2012: 172). Arizona still refused to provide family planning services to the poorest segments of the population (i.e. those who exceeded 50 percent of the federal poverty level) (Jones and Kooistra 2011). At the time, only about 20 percent of these teenagers had some form of private health insurance to cover prenatal care, including labor and delivery.

Consequently, from 1980 to 1990, teen pregnancy rates fell among White women but increased for Latina and Black women (McFarlane and Meier 2001). In this context, young women were left with few options for either caring for a baby, or securing an abortion.

During the 1980s and 1990s, securing funds to offer adequate reproductive health care to low income women became a focal point for activists. In 1980, Planned Parenthood was excluded from federal Title X funds by the Arizona legislature because they provided abortion services and referrals (Henshaw 2009). “Financial inability to buy birth control, lack of access to clinics, or embarrassment felt by young women” lead to fifty percent of pregnancies being “unplanned or unwanted” (Melcher 2012: 174). Studies at the time demonstrate that the US, and Arizona specifically, did a dreadful job of meeting the reproductive needs of low-income women (Roberts 1999). The results of one study, for example, showed that 24 percent of Arizona women of reproductive age had neither health insurance nor Medicaid, and only 46 percent of those needing contraception received those services (Melcher 2012). In the early 1980s, the Arizona...
Health Care Cost Containment System (AHCCCS), the state’s Medicaid+ program benefitting families earning 106 percent over the poverty line, was barred from providing funds to family planning services in the state (Melcher 2012). It required a lawsuit against the state in 1988 to renew AHCCCS provision of family planning services. The Arizona state legislature was often characterized by indifference to the needs of low income, women of color.

In 1994, reproductive health advocates gained some ground when the Arizona legislature approved the expansion of family planning services under AHCCCS. The new law did not meet all of the needs articulated by its proponents, but secured extended coverage for reproductive care during pregnancy and the two years following (Melcher 2012: 175). Still, some members of the working poor made too much to qualify for this assistance but too little to afford private health care. This often left clinics like Planned Parenthood as the only method of family planning and reproductive care available for some women and their families. Even at the end of the 20th century, “race, ethnicity and socioeconomic class still greatly influenced health care outcomes” (Melcher 2012: 176). Still, since Roe, persistent advocacy successfully preserved access to contraception and abortion, however stifled. At the start of the 21st century, Arizona governor Janet Napolitano vetoed many state bills seeking restrict abortion access in the state during her 2002 to 2008 tenure.

**Current Trends in Arizona**

However, Jan Brewer completed Janet Napolitano’s term in 2010, and the political tides shifted yet again. Arizona abortion legislation increased, with five bills
regulating abortion enacted during Brewer’s tenure, representing a contrast from Napolitano’s pro-choice position (Roseberry 2012: 398). Rachel Sussman, the director of state policy for the Planned Parenthood Federation of America, stated, “Arizona is a good example…There were hundreds and hundreds of bills [restricting reproductive health care services]. Tracking them alone is a challenge. So then to try to stop them through advocacy in such hostile environments can be very difficult” (Sussman 2015: 230). During Brewer’s time as governor, the Arizona legislature pushed the constitutional boundary of abortion restrictions to its limit on more than one occasion.

Leading national trends, current restrictive policy in Arizona aims to limit access to abortion through a few different means. State politicians—inspired by the self-identified “family values” nonprofit organization Center for Arizona Policy’s lobbying efforts as well as by constituents’ political orientation (or passivity)—have worked to make birth control and abortions not illegal but rather difficult or impossible to access (CAP 2016). One controversial state mandate requires a counseling session and a 24-hour waiting period between this session and the abortion itself. Proponents of the legislation assured the public that this is about providing women with all necessary information on abortion, avoiding coercion and allowing sufficient reflection time (Ertelt 2009). In actuality, this policy can prevent women without the means, transportation or flexible schedule from securing an abortion altogether. In addition to the waiting period, individual medical professionals and institutions retain the right to refuse to perform

---

27 Established in 1995, this conservative organization works closely with the Arizona legislature and other elected officials to “promote and defend the foundational values of life, marriage and family, and religious freedom” (Center for Arizona Policy 2016: n.p.). To date, they have helped turn 151 bills into Arizona state law mainly centered on restricting abortion access and promoting abstinence-only education in public schools (Ibid.).
abortion services.\textsuperscript{28} Similarly, health care providers and pharmacists in Arizona can also refuse to provide contraceptive services\textsuperscript{29}. According to its advocates, these polices were promulgated in order to discourage and limit the number of abortions in the state.

Increased restrictions over birth control and abortions in recent decades have ground level consequences for access, particularly among those rurally located and women in the new middle class. Nationally, by 2008, “10 states had five or fewer abortion providers” while “97% of all nonmetropolitan counties have no abortion services whatsoever” (Gold and Nash 2012: 10). Since the late 1970s, Arizona also faces a steady decline in the number of abortion providers. From a high of 21 facilities in 2001, by 2008, there were only 17 abortion providers in Arizona, showing a 19 percent decrease (Frost et al. 2013). In 2011, 67 percent of Arizona’s fifteen counties had no medical facility that offered abortions, with 14 percent of Arizona women of reproductive age living in those mostly rural areas (Ibid.). This context can leave women without available options to prevent and/or terminate an unwanted pregnancy.

\textit{Legislative and Judicial Regulation}

Governor Brewer and the Arizona legislature used law not to make abortion

\textsuperscript{28} These abortion refusal laws (sometimes called “conscience” laws) were passed by 47 states and the District of Columbia shortly after \textit{Roe}. We have seen a resurgence of this kind of legislation in the last decade. Specifically, in 2004, Congress passed the Federal Refusal Act (or the Weldon Amendment), which “grants a broad variety of health-care entities—including hospitals, insurance companies, and even individual health-care professionals—the right to refuse to provide, pay for, or refer for abortion” (NARAL Pro-Choice America 2016: 1-2).

\textsuperscript{29} For example, the Catholic Church owns hospitals and health care facilities across the state (including Dignity Health, formerly named St. Joseph’s); these facilities reserve the right to refuse contraception and/or abortion if it conflicts with their religious beliefs.
illegal in Arizona, but impossible to obtain. Abortion restrictions and regulations legislatively deplete the fundamental right to abortion afforded by *Roe* by blocking conduits necessary to ensure women can actually exercise this right. “In other words, a right — any right — without the infrastructure and the social conditions that enable its exercise is no right at all” (Greenhouse 2014: n.p.). Specifically, in Arizona, TRAP laws (targeted regulation of abortion providers) continue to chip away at abortion access for diverse women. They essentially aim to regulate the places and people that perform abortions and are in place in 27 US states currently (Althouse 2013: 180). Generally, Arizona TRAP legislation can be separated into three distinct categories: 1) health facility licensing, 2) surgical center requirements and 3) hospitalization provisions (Althouse 2013). While facially neutral, TRAP laws represent a national “ideological crusade masquerading as concern for public health,” which has real consequences for women (Gold and Nash 2013: 12).

TRAP laws determine minimum requirements needed to legally perform abortions in the state, including facility, licensing and physician requirements. Since the 1990s, we have witnessed a legislative shift from opposition to the abortion patients themselves, to the hyper-regulation of clinic operations and facilities. Consistent with rhetorical trends, all of these laws are promoted “under the guise of protecting women’s health,” in light of anti-abortion horror stories (Gold and Nash 2013: 7). Still, data shows that “less than 0.3% of abortion patients in the United States experience a complication that require hospitalization” and “no more than four in a million” are at risk of dying from the procedure (Gold and Nash 2013: 7). This is true even considering that most abortions in the US are performed outside hospital settings with 18,000 abortions.
provided in physicians’ offices in 2008 (Ibid.) In this context, Arizona TRAP laws represent insidious attempts to decrease access to abortions for women in the state.

In 2012 with *Planned Parenthood Arizona, Inc. v. Betlach*, the Arizona state legislature attempted to limit abortion further by revoking Medicaid funding for any services from both physicians and facilities where elective abortions are performed (Breslin 2014). Planned Parenthood Arizona has 13 clinics in the state, treats about 3,000 Medicaid recipients each year, and receives about $350,000 in government funds and Medicaid reimbursements (Ibid.) While the statute never went into effect, the discursive implications only reiterate the conservative climate of the state. Ultimately, “restrictions in Medicaid coverage of abortion send a clear message that abortion is immoral, hence, generating and reinforcing abortion-related [and poverty-related] stigma” (Nickerson 2014: 683). If ever passed, this requirement would not only continue to lessen the number of abortion providers, but it would concurrently force Medicaid recipients to pay out-of-pocket for any reproductive services from abortion-providing clinics. These stipulations on Medicaid coverage for reproductive services can have inadvertent impact on welfare and child health in the US in general (Henshaw et al. 2009). Further, scholars show these laws are “backdoor attempts to overrule the US Supreme Court’s decision in *Roe v. Wade,*” and, more largely, to erode constitutional privacy rights guaranteed by the 14th Amendment (Breslin 2014: 56).

Moreover, in April 2012, Governor Brewer signed into law HB 2036 (or the Mother’s Health and Safety Law), which made several controversial changes to Arizona TRAP laws for physicians and clinics. One requirement is that abortion clinics must post visible signs in clinic facilities that state it is illegal to coerce any woman into having an
abortion. The bill requires that doctors performing surgical abortions have admitting privileges at a hospital within a 30-mile radius of the abortion facility. Additionally, while Arizona already had the ultrasound requirement for abortion, HB 2036 stipulated that this must be done (again) at least 24 hours before the procedure (Althouse 2013). This creates an undue burden and additional cost for women to have to visit the medical facility again before the actual procedure. Another provision of this bill is to determine the gestational age of the fetus before the abortion is performed, and the doctor can ask women any question to help make this determination. The implications for privacy violation are great because physician inquiries may even include “painful or embarrassing memories” and details of sexual activities to determine moment of conception (Althouse 2013: 183). Additionally, if the fetus is diagnosed with a condition that is deemed non-terminal, the physician must give women up-to-date information regarding possible medical outcomes of the fetal condition (Althouse 2013). In situations where the fetus is diagnosed with a terminal condition, this bill requires the woman be informed of all perinatal hospice services available before the abortion (Ibid.). Problematically, this sends a clear message to women that birthing a (terminally or non-terminally) ill fetus is still preferred to aborting.

One of the most noteworthy and controversial stipulations of HB 2036 was the attempt to criminalize abortions after 20 weeks gestation, representing a complete disregard of the fetal viability standards set out in Roe (1973) and then again in Casey (1992). The state bill dictated that abortion is completely prohibited if the fetus is more than 20 weeks gestation, unless the health of the mother is at risk (Althouse 2013). Following this logic, the bill allows the woman, her spouse or the mother’s parents to sue
the physician if any abortion performed was determined to be violation of this state law. If found liable, the physician would not only be charged with a Class 1 Misdemeanor but could have their medical license suspended or revoked (Ibid.). Nationally, this bill has been met with much debate and pushback. In Isaacson v. Horne (2013), bill opponents sued the Attorney General of Arizona, claiming that HB 2036 violated and completely abandoned the viability standards set in Casey (1992). However, the state District Court found that this statute did not create a substantial burden to pre-viability because women still had 20 weeks to obtain an abortion and only encouraged women to make the “decision earlier than they might have otherwise made it” (Althouse 2013: 184). Ironically, the pro-life platform continually emphasizes the gravity of an abortion decision, yet this law forces women to make the decision all the more quickly, especially in light of numerous other abortions restrictions in Arizona.

National organizations such as Planned Parenthood continue to push against these restrictive legislative trends through lobbying efforts, but their most effective tactic is to turn to the courts. The US Supreme Court also assessed the constitutionality of AZ HB 2036 in late spring of 2013. On May 21, the Court of Appeals for the Ninth District reversed the state district court’s decision and deemed the 20-week ban unconstitutional (Althouse 2013). The opinion stated that, “a prohibition on abortion at and after twenty weeks does not merely ‘encourage’ women to make a decision regarding abortion earlier than Supreme Court cases require; it forces them to do so” (Isaacson v. Horne 2013: 1227). HB 2036 is yet another example of how Arizona has tried to use the precedent set in Casey (1992) to fashion abortion regulations that also try to manipulate those previously set legal limits. Basically, Arizona TRAP laws suggest that channels to
abortion not only be riddled with roadblocks but should also be more time-sensitive.

Again, these realities force us to truly question whether the “women’s health” tagline is merely guise by which conservatives pass political and religious doctrine on reproduction, motherhood and life itself. Sadly, it seems that women and their reproductive health are the ones who become disproportionately deprived in this context.

This was not the first time the Court was asked to determine the constitutionality of abortion legislation in Arizona. Also in 2014, they heard the case *Planned Parenthood Arizona v. Humble*, regarding permissible procedures for use of the abortion pill RU-486. State legislation passed in 2012 aimed to restrict its use by requiring abortion providers follow the 2000 FDA protocol for mifepristone, which necessitates that women take a higher dose of the hormone and limits the window for abortion-by-pill to the first seven weeks of pregnancy (*Planned Parenthood Arizona v. Humble* 2014). Arguing that this law comes with no medical benefit and creates undue burden for women, the court deemed Arizona’s attempt to restrict the use of the abortion pill unconstitutional (Ibid.).

From a legal point of view, the “undue burden standard,” coined by Justice Sandra Day O’Connor in *Planned Parenthood v. Casey* (1992), used to be the legal litmus test for determining if a proposed abortion regulation presented a substantial obstacle to women exercising this right. Some current policies have entirely bypassed judicial interpretation of what constitutes an undue burden and these include: “ultrasound requirements, physician-only restrictions, reporting requirements, informed consent provisions, and parental consent or judicial bypass provisions” (Roseberry 2012: 398). In 2007 with *Gonzales v. Carhart*, abortion opponents and conservative politicians coopted the phrase “undue burden” to allow states like Arizona to further limit abortion
access (Roseberry 2012). In *Gonzales* (2007), Justice Anthony Kennedy used O’Connor’s language on undue burden as the rationale to uphold Congress’ ban on partial-birth abortion (Toobin 2014).

Although much attention has been placed on these more visible barriers, regulations of health insurance, the implementation of these policies by insurance companies, as well as their internal procedures affect women’s experiences seeking contraception and abortion. In terms of contraceptive coverage with private insurance, employers in Arizona can opt out of this coverage due to the existence of the religious exemption. This exemption to the federal Affordable Care Act allows employers of for-profit companies with more than 50 employees to refuse contraceptive coverage for employees based on religious beliefs – none of which are Arizona-based corporations (Lee 2014). Since 2012, approximately 70 for-profit employers (in addition to Hobby Lobby, Inc.) have petitioned for this religious exemption. Faith-based non-profits, like the evangelical Christian Wheaton College, now seek the religious exemption as well (Pashman 2015). This context demonstrates that the debate over reproductive health is being constantly fought on political terrain and women’s needs sadly become collateral damage.

Opponents organizing to restrict access to abortion have successfully deployed several different arguments to recruit supporters and win court cases. To date, every state in the US except Vermont has some kind of restriction on abortion, yet only seventeen states fund (some) abortions for low-income patients (Gordon 2012: 62). Upon examination of arguments to restrict abortion, one of the most prominent was “anti-big-government, anti-tax rhetoric” used by those not only against abortion but also those who
condemn government programs such as the Affordable Care Act (Gordon 2012).

Ironically, proponents of *laissez-faire* government seek to block the hyper-regulation of every political arena except reproduction. The second is that the contraceptive coverage requirement of the ACA is a constitutional violation of religious freedom mentioned previously. The final and most popular argument “alleges, erroneously, that abortions, and even contraception, endanger women’s health” (Gordon 2012: 63). For example, pro-life activists claim abortion can lead to depression, substance addition, infertility, broken relationships, suicide and even breast cancer (Pollitt 2014). Basically, this is an anti-abortion message wrapped up and presented as concern for women’s overall wellbeing. “The woman is ‘abortion’s other victim.’ As one Feminist for Life put it to me, how can it not harm a woman to kill her baby?” (Pollitt 2014: 35). With this approach, opponents of abortion have coopted language originally used by pro-choice groups using the same women’s health rationale.

Within this legal context, discussions over contraceptive access and abortion access are intrinsically linked. Often debated politically as distinct issues, ground level experiences demonstrate connections between the two issues. Unwanted pregnancies often occur in moments when we lack access to contraception or failed to take it properly. Contraceptive choices by women can be affected negatively by “provider access, overall legislative hostility and restrictive abortion policies” (Jacobs and Stanfors 2015: 79). In fact, recent studies demonstrate agency in the ways women cope with increased reproductive restrictions. Amid a reality of limited abortion providers and increased abortion costs, women respond by using more effective birth control methods in order to

---

30 In the monumental *Burwell v. Hobby Lobby Stores, Inc.* decision in June 2014, the Supreme Court deemed the contraceptive coverage requirement unconstitutional.
Avoid the challenge of securing an abortion in this context (Jacobs and Stanfors 2015). In this way, we witness another facet of the relationship between contraception and abortion in that legal restriction of one shapes ways women engage the other, and vice versa.

Additional Contemporary Legislation in Arizona

Sexual Health Education

Legislation around sex education in public schools is another realm that can influence pathways to birth control and abortion for women. Arizona remains one of six states that have statutes in place permitting sex education in public schools, but not requiring it (Lashof-Sullivan 2015). Studies show that teens are likely to become sexually active between 15 and 19 years old, and are more likely than adults to use contraception in inadequate and inconsistent ways (Isley et al. 2010). Nationally, “research has shown that abstinence-only education has increased...despite the lack of objective evidence that abstinence-only programming is actually effective in delaying first sex or reducing high-risk sex behaviors” (Isley et al. 2010: 236). Still, discussions over public sex education and teen pregnancy often neglect the significance of race, class and gender inequities inherent in the education system. “As with most states that report high teenage pregnancy and birth rates, Arizona has a high rate of poverty, economic inequality, and problems with education—specifically high school graduation rates” (Vinson and Stevens 2014: 324). While the impact of sex education on teen sexual activity is still disputed, it is important to understand the context in which Arizona teens grow up and learn about sex and its larger influence.

At the state level, individual districts and school boards determine how federal
sex education policies are implemented, often leading to inconsistency in quality and method of sex education in the Arizona. Naturally, “without cohesive or consistent implementation processes, a highly diverse ‘patchwork’ of sex education laws and practices exists” (Hall et al. 2016: 595). Arizona is one of 33 states that include an opt-out provision\textsuperscript{31} for sex education, which “allows parents to remove their children from the classroom during sex education instruction for religious, moral, or family reasons” (Lashof-Sullivan 2015: 266). Arizona law also does not explicitly require (nor prohibit) that public sex education include discussions of contraception, abortion and STI transmission including the prevention of HIV/AIDS (Vinson and Stevens 2014). And those schools that elect to teach sex education must emphasize abstinence as the best way to prevent pregnancy (Lashof-Sullivan 2015: 272).

One specific example from Arizona demonstrates the extreme lengths some will go to control sex education curriculum in Arizona. While considered nationally mainstream, one biology textbook came up for debate because it specifically discusses birth control methods, vasectomy and abortion-inducing drugs. State politicians pushed to edit this honors biology textbook for violating current Arizona law that requires public schools to present childbirth and adoption in a more positive light than elective abortion (Creno 2014: n.p.). In publicly funded Arizona schools, sex education must “stress that pupils should abstain from sexual intercourse until they are mature adults,” “promote honor and respect for monogamous heterosexual marriage,” and explicitly discuss “consequences of preadolescent and adolescent pregnancy’ ” (Vinson and Stevens 2014: 324). Therefore, a 3-2 vote from the Gilbert school board determined that the textbook

\textsuperscript{31} AZ SB 1309, passed in 2010, imposes a need for parental consent in any course where sex and sexuality might come up as a relevant topic.
was not in compliance with state law and must be changed (Creno 2014).

President Obama allocated millions of dollars to teen pregnancy prevention and comprehensive sex education in 2010, yet data shows that formal sex education has steadily declined from 2006 to 2013 (Hall et al. 2016). The Personal Responsibility Education Program (PREP), as part of the Affordable Care Act, provided $75 million to states who implement programs that teach both abstinence and contraception to prevent pregnancy and STIs (Lashof-Sullivan 2015). Specifically, “to receive funding, state programs must be effective or proven, on the basis of rigorous scientific research, to change behavior; be medically accurate, age appropriate, and culturally sensitive; and teach both abstinence and contraception” (Lashof-Sullivan 2015: 277). However, even amid growing national rates of contraceptive use between 2007 and 2014, data shows that teens are “receiving information about birth control and condoms elsewhere” outside of school (Hall et al. 2016: 595).

On the other hand, there remains a great deal of federal money and interest in promoting abstinence-only sex education in public schools. Stipulations from Title V of the Welfare Reform Act of 1996 still offer millions to states who only teach programs that “comply with the federal eight-point statutory definition of abstinence education”

32 To meet the federal definition of abstinence education a program must 1) have the exclusive purpose of teaching the gains to be realized by abstaining from sexual activity. It must teach 2) that abstinence from sexual activity outside marriage is the expected standard for all school-age children, 3) that abstinence is the only certain way to avoid pregnancy, STIs, and other health problems, 4) that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity, 5) that sexual activity outside of marriage has harmful psychological and physical effects, 6) that bearing children out-of-wedlock has harmful consequences for children, parents, and society, 7) how to reject sexual advances and how alcohol and drugs increase vulnerability to sexual advances, and 8) the importance of attaining self-sufficiency before engaging in sexual activity (Lashof-Sullivan 2015).
(Lashof-Sullivan 2015: 275). These funds were set to expire in 2009 but were renewed by the Affordable Care Act, “which allocated $50 million per year for abstinence-only-until-marriage programs from 2010 to 2015” (Lashof-Sullivan 2015: 275). Still, in 2010, a record-breaking 20 states (Arizona excluded) opted out from federal abstinence-only moneys. Federal funding of both comprehensive and abstinence-only programs perpetuates national inconsistency in sex education and bares the enduring contentious nature of the topic. That said, a definitive link between comprehensive sex education and safer sex practices among adolescents is difficult to prove. However, most studies agree that the “curricula used by grantees of the abstinence-until-marriage federal funds contained false, misleading, or distorted information about reproductive health” (Lashof-Sullivan 2015: 286). In fact, 80 percent of some programs were based on inaccurate information on sex and reproduction (Ibid.). This context of early sex education often sets the stage for how women engage both contraception and even abortion in their reproductive lives.

**Contraception and the Affordable Care Act**

President Barack Obama signed the Patient Protection and Affordable Care Act (ACA, also referred to as Obamacare) into federal law on March 23rd, 2010. Once in effect, the ACA required all health insurers and benefit plans to include coverage of preventative health services without cost sharing, and contraceptive services were designated within this preventative category in July 2011 (Cartwright-Smith and Rosenbaum 2012). By executive order, Obamacare does not fund abortions except in
cases of rape and/or incest (Kliff 2016). In response, the federal Department of Health and Human Services (HHS) was commissioned with the task of evaluating and defining “what preventive services are necessary for women's health and well-being” (Bisi and Horan 2013: 278). Still, health insurance companies retained some control especially with regard to brand name and generic drug coverage.

Insurance coverage for contraception continues to be a controversial issue that has material impact on women’s reproductive lives and lacked a clear federal standard until President Obama’s Affordable Care Act. Since 1998, 26 states had enacted their own regulations for insurance coverage of contraception with many proposed amendments to the Medicaid Act to cover reproductive health care (Bisi and Horan 2013). However, other states persisted in pushing back against this political trend. The discussion first reached the federal judiciary in 2001 with *Erickson v. Bartell Drug Co.* where the court held that “Title VII does require comprehensive health benefit plans to cover contraception in order to prevent [gender] discrimination” (Bisi and Horan 2013: 274). Subsequently, in 2002, *Alexander v. American Airlines* and the Northern District of Texas held that there was no gender discrimination by refusing contraceptive coverage. “The court held that the plan was equal in its refusal to extend contraception coverage to both sexes” (Bisi and Horan 2013: 275). A clear analytical over-simplification, this decision neglected both the inherent gender dynamic of a female-oriented birth control market as well as historically gendered notions of reproductive responsibility placed on women.

Many states also passed exemptions for employers who object to contraceptive coverage for religious reasons, allowing states to determine grounds for this exemption
on their own terms. California’s Women’s Contraception Equity Act includes a very narrow exemption for religion, which has required many religious groups to cover contraception for employees (Bisi and Horan 2013). With implementation of the ACA, this debate has now been opened at the federal level as well. The federal HHS included a religious exemption mirroring several state exemptions:

To qualify for the exemption, the employer must (1) inculcate religious values as its purpose, (2) primarily employ persons who share its religious tenets, (3) primarily serve persons who share its religious tenets, and (4) be a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (ii). (Bisi and Horan 2013: 278)

For those who meet religious exemption requirements, the cost of contraceptive coverage is shifted to insurance companies instead of employers.

In March 2012, Arizona’s House of Representatives pushed HB 2625 to extend this exemption for contraceptive coverage to all employers. This state opt-out provision would allow employers to “require female employees to first pay for contraception and then submit a claim for reimbursement with evidence that contraceptives are being used for medical conditions [not just pregnancy prevention]” (Cartwright-Smith and Rosenbaum 2012: 543). The Arizona Senate revised the bill by again limiting the exemption to “religiously affiliated employers” only (Ibid.). Arizona HB 2625 defines these employers as an entities that primarily employ and/or serve people with shared religious beliefs (CAP 2012). It must either be a registered non-profit organization or an
entity whose articles of incorporation affirm it as a religiously motivated organization whose beliefs are central to its operating procedures (Ibid.).

Then, in the summer of 2014 with the Burwell v. Hobby Lobby Stores, Inc. decision, the Supreme Court ruled on the issue. They decided that for-profit corporations that sponsor health plans had the constitutional right to apply for religious exemption from the ACA contraception coverage requirement. Still, “women's health advocates suggest this morally or religiously based opposition infringes on each woman's right to make her own choice regarding prescription birth control” (Bisi and Horan 2013: 279). The material and discursive implications of this decision could be vast as more than 99 percent of sexually active women of reproductive age in the US have used contraception at some point, with 80 percent reporting use of a hormonal contraceptive (Cartwright-Smith and Rosenbaum 2012). Ruth Bader Ginsberg fears that by even discussing the religious exemption for contraception, “the court…has ventured into a minefield” (Burwell v. Hobby Lobby 2014). In her dissent, Justice Ginsberg explains the slippery slope of the religious exemption:

Would the exemption…extend to employers with religiously grounded objections to blood transfusions (Jehovah's Witnesses); antidepressants (Scientologists); medications derived from pigs, including anesthesia, intravenous fluids, and pills coated with gelatin (certain Muslims, Jews, and Hindus); and vaccinations… Approving some religious claims while deeming others unworthy of accommodation could be 'perceived as favoring one religion over another,' the very risk the Establishment Clause
was designed to preclude. (Burwell v. Hobby Lobby 2014)

So while the ACA has made significant strides for contraceptive coverage in the US, it is not without controversy and objection at both state and federal levels.

Ultrasound Requirements

Some Arizona bills require physicians to offer patients the opportunity to view a fetal ultrasound image before performing the surgical procedure or administering the abortion pill. With the passage of HB 2706 in 1999, Arizona required an ultrasound for all elective abortion after 12 weeks to determine the age of the fetus, often performed trans-vaginally (Roseberry 2012). Then, in 2011, Arizona passed HB 2838 which required an ultrasound and listening to the fetal heartbeat for all abortions, where the performing physician must offer women the chance to see and/or hear these medical examinations. These requirements may present a physical undue burden in the sense that trans-vaginal ultrasound can feel quite invasive. Further, many argue that they may also introduce a “substantial psychological burden” by being forced to see/hear fetal activity (Roseberry 2012: 400). In addition to demanding more time of the patient, additional ultrasounds can increase costs associated with abortion depending on insurance coverage. As of 2012, only four states required an ultrasound for all abortions, although states like Texas and Oklahoma are beginning to mimic Arizona abortion regulations (Ibid.).

Physician-Only Restrictions

Other Arizona legislation aims to limit abortion providers to physicians only,
excluding all other medical staff and nurse practitioners from being able to perform (even chemical) abortions. In 2002, HB 2542 restricted physician’s assistants from performing surgical abortions in Arizona (Roseberry 2012: 402). Further, in 2009, HB 2564 (“Abortion Omnibus Bill”) and SB 2155 (“Surgical Abortion Bill”) revised Arizona statutes to stipulate that only a physician could perform surgical abortions, which only further limited the power of nurse practitioners and other medical staff. Exhibiting a rationale of state interest in women’s health, this restriction creates undue burden where women have fewer options for first-trimester abortion, which is much less risky and significantly cheaper than abortions at later gestational stages (Roseberry 2012). This is especially true for women who are geographically isolated from abortion-providing physicians as time, money and transportation shape their access. In 2011, the Arizona physician-only statute was reinforced again in Planned Parenthood of Arizona, Inc. v. American Association of Pro-life Obstetricians and Gynecologists (2011). That same year, 39 states in the US had some kind of physician-only abortion statute in place (Roseberry 2012: 405). More recently, AZ HB 2036 codified an additional requirement that all abortion-performing physicians must have clinical privileges at a hospital within 30 miles of the abortion location (Althouse 2013).

*Reporting Requirements*

Arizona’s SB 1304 dramatically extended state-mandated reporting requirements for abortions performed in the state (Roseberry 2012: 406). In the past, reporting requirements for abortion only included clinic incidents that resulted in the injury of a viable fetus. However, Arizona now requires comprehensive reporting for all abortions,
including patient’s personal information like educational background, race, marital status, number of terminated pregnancies and more. This law also probes women’s reason for having an abortion (either elective or health-related), which some activists contend is the most problematic part of the legislation (Roseberry 2012). Currently, 46 states have some kind of abortion-reporting requirement, with only 16 states (including Arizona) requiring the inclusion of one’s motivations for procuring an abortion (Roseberry 2012). Although some required information is more intrusive than others, SB1304 is another instance of Arizona law repeatedly flirting with undue burden while maintaining official constitutionality. However, undue burden remains a slippery legal slope. Yet Arizona maintains its vested interest in “women’s health” is the central motivation for tracking abortion data statewide (Roseberry 2012: 406). Women’s health rhetoric has become a convenient façade under which legislators aim to monitor, control and limit reproductive options for women in the state.

*Informed Consent Provisions*

The issue of informed consent has created undue burden for many women seeking abortion in Arizona, especially considering there were only 17 abortion providers in the state since 2011 (Roseberry 2012). In 2009, HB 2564 (the “Abortion Omnibus Bill”) required voluntary and informed consent of abortion patients, including a 24-hour waiting period and “and abundance of specifically required information to be provided by the physician in person” including abortion alternatives, and gestational age and anatomical characteristics of the fetus (Roseberry 2012: 409). Across the US, 35 states have some informed consent provision, with 24 requiring waiting periods between the time
information is provided to patients and the abortion procedure itself. Only six states (including Arizona) require two separate clinic visits to satisfy this in-person informed consent provision (Ibid.). In 2011, *Planned Parenthood of Arizona, Inc. v. American Association of Pro-life Obstetricians and Gynecologists (2011)* upheld this legal stipulation. State laws of this sort reflect a more contemporary brand of state-based paternalism as they seek to undermine women’s decision-making process. More, while state law compels women to contemplate their abortion decision for a full day, compulsory time and cost of abortion only intensifies. Specifically, “it is a substantial obstacle for those women who must travel long distances to reach an abortion provider and make [at least] two trips to a doctor” (Roseberry 2012: 410). Therefore, the waiting period for consent often disproportionately impacts those on the lower end of the socio-economic hierarchy. In doing so, these laws symbolically increase the expense of choice itself with regard to abortions (Roseberry 2012).

*Selective Abortion Legislation*

In 2011, Arizona passed the first law in the nation that banned race-selective and sex-selective abortions. Inciting much controversy, the chief sponsor of the bill, Representative Steve Montenegro (R), argued that “abortions were being performed disproportionately among minority populations” (Zeigler 2013: 43). Republican Representative Albert Hale supported the bill because of the eugenic history of abortion and population control in the United States (Ibid.). Some politicians even maintained that certain clinics were receiving financial incentives to decelerate the growth of minority populations in the state (Zeigler 2013). Nevertheless, scholars and pro-choice advocates
understood it as simply another method of fragmenting reproductive rights for Arizona women.

Then, in early 2012, Republican Representative Trent Franks proposed this law at the federal level, called the Prenatal Nondiscrimination Act (PRENDA). This law delineated civil and criminal penalties for anyone “funding, performing, coercing, or transporting a woman across state lines for the purposes of obtaining a race- or sex-selection abortion” (Zeigler 2013: 43-44). To advance his legislation, Franks dared to assert that current abortion policies have brought more devastation to Black communities than the laws of slavery (Ibid.). Insufficient House votes provisionally blocked the bill, yet Congress retains the option of revisiting the issue in future deliberations. Like other TRAP laws, both the Arizona statute and proposed federal bill on sex- and race-selective abortions hold symbolic power and even “chilling effect” (Lee 2003; Zeigler 2013: 44). Employing anti-eugenic rhetoric, this law works to further undermine abortion rights and control over reproduction more generally. Time and again, these laws mark a political move to frame abortion restrictions as necessary for the betterment of women’s health and US society overall (Lee 2003).

Ultimately, Arizona’s conservative political and legal context is the setting in which I examined women’s experiences seeking contraception and abortion. In Arizona, a woman’s choice to use birth control or obtain abortion is made within this state-mandated context. In other words, every piece of state legislation on reproduction tenders rights to contraception and abortion that are “burdened slightly less than the undue burden standard requires, but the sum of the regulations acting together results in a substantial obstacle to women’s choice,” especially given the power of socio-economic
location (Roseberry 2012: 418). More, amid endless political debate on sex education contraception and abortion, we rarely witness politicians acknowledging connections among these various issues of reproductive health, which brings its own set of consequences. Simply put, “as long as abortion remains stigmatized and isolated from other reproductive health issues, as well as from a web of related socioeconomic realities in which women live their lives,” the state will continue to neglect women’s everyday needs (Deeb-Sossa and Billings 2014: 418). It is this context of stigmatization and isolation, which defines reproduction in Arizona, both historically and today. In spite of this, women often use any resources available to manage necessary reproductive care, demonstrating both agency and resilience in doing so. In the chapters that follow, I analyze how Arizona women meet their own reproductive needs for pregnancy prevention and termination amid numerous state restrictions. Particularly, the next chapter centers on understanding ways women plot their own course to hormonal contraception and grapple with the state along the way.
4. Experiences with Pregnancy Prevention in Arizona

A central aim of the study is to better understand women’s experiences seeking and using contraception in Arizona. In other words, what are the noteworthy checkpoints along a woman’s journey to obtaining and using hormonal birth control? Research has demonstrated the ways political discussions around contraception (and abortion, for that matter) often focus on changing law, policy and regulation at the state level – and trends reflect attempts to curb access to pregnancy prevention and termination. As such, the project locates moments when women encounter the state, in its many forms, as it shapes routes in both negative and positive ways by context. Ultimately, the state does show its face but, oftentimes, in unanticipated and subtle ways. And data illustrate how women are often more aware of their encounters with other institutions (medical, insurance and otherwise), without much conscious thought to how state policies may also partially dictate how these same institutions operate in contraception.

Women face the most tangible barriers and institutional confusion when dealing with medical offices and insurance providers, which operate as institutions that are both part of and apart from the state. The state and its extended influence in medical institutions interject in women’s reproduction, and aim to regulate fertile women who lack the desire to reproduce. This urges us to reconsider the heavy focus on contraceptive legislation to look more at transparency within medical and insurance institutions and their dealings with patients. This is not to discount the importance of law and policy decisions here, but to suggest there is a bigger picture at play. Another large part of this is simply the kinds of birth control that are made available to women and their all-too-common negative side effects. My project suggests the need to more deeply interrogate a
lack of investment in medical innovation regarding birth control, and the implementation of law and policy vis-a-vis provisions of insurance and health care institutions. While law is central to the fight over reproduction, my findings suggest the need to examine other (often state-influenced) entities encountered in this realm.

Given this context, women felt disappointed by certain issues throughout their experiences. Specifically, women felt that sexual education in Arizona public schools was largely incomprehensible, resulting from state policy and school board decisions. Most felt left in the dark yet again when it came to accessing contraception and deciding which form to use. Many even reported feeling like medical guinea pigs, testing out a range of hormonal birth control. Further, dealings with medical offices and insurances providers are, at best, inconsistent and convoluted, adding frustration to an already burdensome process. Women demonstrated agency in ways they were able to obtain information on sex and access hormonal birth control. Amid all this, most women reported feeling satisfied with their hormonal birth control – both obtaining it and using it. This project hopes to illuminate this data and the reality that we still have a long way to go before truly opening avenues to birth control for women in the US.

Ultimately, this chapter analyzes women’s pathways to hormonal contraception using the first-hand narratives from women living in greater Phoenix, Arizona. While unique in their own ways, women’s experiences of obtaining and using birth control share noteworthy similar characteristics. State laws are shown to represent only part of the analytical narrative on experiences with birth control as other institutions proved significant. In order to better examine first-hand narratives, this chapter is organized by
these various influential entities throughout the process. Within each thematic section, I elucidate important checkpoints to securing hormonal birth control.

Encounters with the State

*Experiences with Sex Education*

One of the first moments women encounter the state along pathways to hormonal birth control is during sex education in public school. Previous research has shown that higher use of birth control (especially long-acting reversible methods) significantly diminishes the rate of unwanted pregnancy and abortion (Finer and Zolna 2016). Comprehensive and medically accurate sexual health education in school also increases birth control use among young women (Lindberg and Maddow-Zimet 2012). Although it would seem logical for legislators seeking to lower the number of abortions or unwanted pregnancies in their state to support the provision of effective sex education (including information on birth control), this has not been the case. In Arizona, despite continued efforts by groups such as Planned Parenthood and NARAL to reform administrative regulations mandating abstinence-only sex education, the debates in public schools continue.

Sexual health education regulations promulgated by the state only apply to public schools. While three participants attended private, religious schools in Arizona, the majority attended public schools in Arizona. I found vast inconsistency across participant experiences in terms of the content and delivery of sex education they received in schools both public and private. As a result, a large number of participants (n=21) felt uninformed or under-informed about hormonal birth control when they became sexually active.
Helena, a 23-year-old White participant, said of her path to learning about birth control, “I kinda discovered it all on my own…it was basically self-taught.” For many women in the study, it became a matter of their own research on hormonal birth control, and what knowledge they could gain from family members and friends who had gone through this before.

Women recalled that sex education in school was often incomplete, non-specific, and, overall, unhelpful in the larger scheme of sexual life during adolescence. Evelyn, a 23-year-old Latina, said, “I remember the slideshows and the Powerpoints, like what STDs are what, and like how many partners you’ve actually been with…it was informational, but not beneficial to us as like high school kids. Like how to obtain something to keep yourself safe [birth control], like that was not talked about…Schools never really helped [with that].” Jane also noted the inadequacy of her sexual health class, “I think once we hit high school they did tell us about contraception, but it was still very controversial to, like, provide any contraceptives. They weren’t allowed to do that, but they did talk about it.” Oftentimes, sex education in public schools omitted techniques for safe sex.

Notably, women’s experiences did vary. Some women had access to limited information circulated by schoolteachers, while parental waivers hindered others. Many participants (n=14) noted avoiding the sex talk with parents most of the time, which can directly influence access to sex education if schools require parental permission to opt-in. Some did not receive the option to participate in sex education, from either formal or informal sources. Alex, a 25-year-old White participant, recalled, “My high school health class was taught by the football coach and didn’t do shit!...I’ve never had a conversation
with an adult like my mom or a parent or whatever about sex ever.” Laney also exclaimed, “Oh my god! I got the worst! I don’t even think they showed us what a condom looked like.” Melanie, a 19-year-old White participant who went to public school, stated she got “none in school, just my mom saying don’t have sex or you’ll die. She basically scared me until I was 18.” This participant (and others) also remembered young girls getting pregnant in her graduating high school class. Karla, who attended a charter elementary school and a private LDS high school, received no sexual education at school. The silence between teens and adults on the topic of sex has become quite commonplace during adolescence and can have detrimental consequences.

Although access or exposure to comprehensive sex education may not automatically inspire sexual self-confidence or ensure birth control use, gaps in sex education can influence how women engage their own reproductive health. For example, in 2005 the state of Colorado reported 40 percent of all pregnancies were unintended (Ricketts, Klingler and Schwalberg 2014). However, since the 2009 implementation of a reformed Family Planning Initiative using federal Title X funds, both unwanted pregnancy rates and abortion rates declined dramatically. Between 2009 and 2013, Colorado reported a 42 percent decrease in abortions among 15 to 19 year olds and an 18 percent decrease among women aged 20 to 24 (Goldthwaite et al. 2015). Information and resources can drastically change the way one engages reproductive health care and pregnancy prevention.

Notably, this policy reform is not without controversy among scholars and activists. The Colorado Initiative increased information and access to long-acting birth control methods among “young, low-income women, and this improved access was
immediately followed by a substantial reduction in the birthrate among this population” (Ricketts, Klingler and Schwalberg 2014: 129). Some contend that the Colorado Initiative pushes a eugenic agenda by targeting the reproductive control of low-income, women of color. Data show African American women and those without a high school diploma make up the highest percentages of patients in the Colorado program (Goldthwaite et al. 2015). Since its implementation, Initiative data and its purported success tend to imply that Colorado society benefits from the limited procreation of these young women. While teen pregnancy is certainly a pertinent social issue, current policy must be scrutinized amid lingering legacies of eugenics and institutionalized racism in the US.

When more comprehensive sexual education was available to students, it often came too late to help with pregnancy prevention. Lucille, a 24-year-old White participant recalled, it was more “self-teaching, and I feel like, for me, the eye-opening experience was when pregnancy happened and I wasn’t on anything.” Noelle told me, “But I’ve never really had any sex talk. I didn’t even know what sex was until I was doing it. Like I literally didn’t know the penis went inside the vagina. I never had the sex talk! I think Arizona is a state that just doesn’t.” These women’s reflections show how unprepared they felt during early sexual years – for some, their first exposure to sex education occurred after the first time they had sex. Rhonda, a 21-year-old White participant, stated, “Our teacher was one of those ‘abstinence til marriage’ type. And, so there wasn’t too much discussion. And then, in high school, by the time I had a sex-ed class, I was already having sex.” Some high schools and school boards in Arizona continue to push back against comprehensive sexual education in public schools. Jocelyn recalled:
From what the gym teachers told us, they were actually planning to teach this like really comprehensive unit on sex-ed and they were gonna like talk about masturbation. Somebody mentioned masturbation and someone from the school board gasped so they repealed back on what they could present to us. And then when I went to high school it was abstinence only. So they pretty much taught a whole bunch of lies about condoms and had us all sign like abstinence pledges. Then that was it.

Local school district discretion combined with federal funding and state regulations result in vast inconsistency in sex education even in Phoenix public schools.

Oftentimes women were only prompted to learn about hormonal birth control when they started taking it for reasons other than pregnancy prevention. The two most common reasons to start hormonal birth control other than contraception were to treat acne, or to relieve painful or unregulated periods. This was not only an entry point to knowledge on sex, but also on pregnancy prevention for young women. For many, the birth control conversation was only opened with parents through these avenues. Julie, a 24-year-old Middle Eastern woman, said she started using birth control because of “really bad acne.” Maria stated that birth control remained a very “taboo conversation” as they remembered and “nobody really talked about it, and if they did it, was because of acne.” Some participants cited such bad periods or even PMDD as what forced them to bring up the “birth control conversation” with parents during adolescence. Sally recalled:
I was missing days of school because of how bad it was, I couldn’t go to swim practice, I couldn’t do anything because of how bad it was. And so, you know, we finally made the decision, like, okay, you know what this isn’t a discussion of sexuality anymore, this is a discussion of, okay, how can I not be in pain anymore? We at that point, it was still not really much of a discussion mostly because my parents are very, very religious and conservative. And so, I know my dad put his foot down, as...[speaking as her father] ‘If she’s put on this, it’s gonna open the door for her having sex’ kinda thing. [Giggling] Which it did, but... it was a major discussion between them of if we’re going to go through with this.

Ultimately, this participant’s parents conversed heavily with doctors and decided that this was the best route to relieve her crippling period pain. But again, women could only get on birth control after dealing with multiple, potential barriers to it.

What women did not learn in school about birth control, they were compelled to research on their own, ask friends/siblings, or open up to parents about the issue. Noelle, a 25-year-old Asian American participant, remembered that she started birth control for reasons of painful period as well. Karla also noted that around this time she became sexually active so she was essentially seeking out hormonal birth control “for both” – relief from painful periods and pregnancy prevention. When she brought up this issue with her mom, the birth control talk was casual “like dinner conversation.” Having resources to reach out to about safe sex can be an important facilitator to pregnancy prevention even in early reproductive years.
The difficulty of including parents in discussions of birth control can sometimes result from embedded religious and/or cultural beliefs. In this way, parental involvement can also present a barrier to women getting and staying protected from unwanted pregnancies. Lacy, a 30-year-old Black participant, recalled not starting hormonal birth control until the age of 21 in hopes of avoiding the “sex talk” with her parents during her adolescent years. Desiree, a 22-year-old Latina participant, recalled, “But my school did not provide much at all which was really annoying….I grew up very Catholic, so I had to kinda learn about birth control on my own.” Notably, this participant also ended up getting pregnant and giving birth at age 20. She continued, “There’s this weird mindset among like traditional Catholic kids like I’m not gonna sin twice, like maybe I’m having sex but I’m not gonna use birth control.” Religion can factor into pregnancy prevention in very unique ways and, ultimately, women reconcile their beliefs with their health care needs on their own terms (or sometimes their parents’ terms). Another recalled her experience, highlighting a strong cultural stigma. “I think I learned mostly from the Internet,” said Natasha, a 25-year-old Asian American participant. “Most of my friends are Chinese so they didn’t really talk about that. It was more private. If you have sex, your mom will call you a slut.” These narratives demonstrate the power of cultural and religious influences on hormonal contraception practices, but also reiterate the notion that young women craved information on sex and often had to seek it out themselves.

These stories exhibit the reality that women could seldom depend on state-sanctioned sex education for complete information. In this critical juncture in their sexual lives, most women craved autonomy and access to information. Of participants who divulged this information (n=14), the average age of first sexual intercourse was
approximately 16 years of age. This is not to say that most young women are eager to jump into bed, but rather, like most of us, they craved to understand their developing sexual bodies and feelings, and consequently, how to keep themselves protected in this new realm. Women show agency in ways they search out fundamental information about sex and contraception, whether through friends, relatives, or the Internet. The issue of providing proper sex education quickly shifts to one of ensuring access to contraception for young minors.

During adolescence, participants revealed a struggle with birth control that was two-fold. The first involves the task of seeking out comprehensive knowledge on sex if not readily provided and the second concerns the process of getting hormonal birth control while on their parents’ insurance plan, or using no insurance at all. Those who were able to acquire the education they needed often encountered barriers to birth control with parental insurance coverage, or even the parent sex talk. Notably, those who learned about hormonal birth control for reasons other than pregnancy prevention experienced this pathway in unique ways; they were able to get the protection they needed, while skirting the parental sex talk altogether.

While most participants experienced subpar sex education in schools, they accommodated for this in distinct ways depending on their own context. Sex-ed courses left many young women feeling confused, under-informed (often realized in retrospect), scared, and ultimately without sexual protection. Bethany stated, “It would have been nice to know exactly what sex was before I was doing it. I started crying when I first started having sex. It was emotional…and I was religious. So I was like oh my god, I’m

---

33 My own experience with intercourse first occurred when I was 16 years old, but I was about 14 years old when I began experimenting with oral sex and foreplay.
sinning. And also like I didn’t know what was going on. Like I literally don’t remember feeling anything because there was just so much going on. I didn’t know what was happening. I was so emotionally overwhelmed.” Young women are provided less-than-complete sex education, forced to seek out their own information wherever possible, and engage a health system that further discredits their reproductive autonomy. Ultimately, sexual health education (or lack thereof) marks one point in an ongoing process that women experience in trying to control their own reproduction.

Encounters with Medical Institutions

Not “All Women are on Birth Control”

Despite the common perception that all women are on birth control, an overwhelming number of prospective participants do not use hormonal contraception. This prompted further investigation because it remained a common response from those invited to participate. More specifically, 14 women recruited to participate said they were not taking any form of hormonal birth control and had not in the last three years. To clarify, this group included women who had taken birth control prior but did not like side effects of the hormones. The women I approached cited a few central reasons for choosing to opt out of hormonal pregnancy protection. The main reason mentioned by these women was a sentiment that these hormones were unnatural. Overall, the majority did not like how hormonal contraception made their body feel.

Side effects of hormonal birth control remain a significant issue in women’s reproductive lives, as will be discussed in a later section. Helena, a 23-year-old White women who is no longer taking hormonal birth control, stated very strongly that it made
her feel “like I’m getting stabbed in the uterus with a knife!...That’s why I, like, tried them all, to see if maybe like the stomach pains were just based on that one thing I was doing at the time.” Along with pain and discomfort, another noteworthy side effect cited by women who no longer take hormonal birth control was feeling extremely emotional while on hormones. As a result, some women opt for barrier methods or Natural Family Planning (NFP) because some women’s bodies simply “have not gotten along” with hormonal contraception.

Some women described two other reasons for discontinuing use of hormonal birth control. First, some women were not in long-term heterosexual relationships and thought hormonal birth control was unnecessary for them at that moment in their sexual lives. Instead, these women felt comfortable relying on condoms, NFP and coitus interruptus (i.e. “pulling out”) for sporadic sexual activity. Second, women emphasized the sheer inconvenience of taking certain forms of hormonal birth control. Many forms, like the pill, the shot or the ring, require one to obtain their hormonal refills on a strict schedule or contraception can quickly decline in effectiveness. In fact, one participant who was actively using the hormonal birth control pill got pregnant after forgetting a couple of pills during one cycle. Ultimately, the reasons some women cited for not using hormones for pregnancy prevention are telling. They also lead to an important next step to birth control: seeking out a form of manageable hormonal contraception and enduring the side effects.

Just as it is important to understand women’s experiences using hormonal contraception, experiences of those who no longer use it still offer insight on potential obstacles of using hormonal pregnancy protection. Data indicate the need to interrogate
the menu of contraceptive options available and their negative effects on women’s bodies. Women agreed generally that their bodies felt more normal and better when off the hormones. Raquel stated, “I feel so much better when I’m not on the pill….I just feel kinda bloaty. For like the year and a half I wasn’t on it, I felt great.” Ultimately, not all sexually active, heterosexual women use hormonal birth control and the reasons for these decisions are enlightening in the current context. For those who elected to use hormonal birth control, the pathway was peppered with significant impediments and facilitations.

Side Effects of Hormonal Birth Control

Participants shared experiences with a range of negative side effects resulting from various forms of hormonal birth control. While some women have eventually found contraception without adverse reactions, testing hormonal side effects has become a normalized part of pregnancy protection. The reality is that today’s women are offered the same limited array of hormonal contraception as women were in the early 1960s, when the FDA first approved hormonal birth control. And while not specific to Arizona, it is crucial to scrutinize both advancements in pharmaceutical research and ways they are introduced to the market (Watkins 2012). In this arena, the interests of medical, pharmaceutical, insurance and state institutions compound to ultimately dictate the birth control market available to women in the US. This section will examine the impact of birth control side effects on women’s bodies, facilitating a larger discussion on why women remain limited to certain hormonal options. This is not meant to discount the contribution of hormonal birth control to women’s sexual protection and reproductive
autonomy, but instead compels a critical analysis the current market and its direct power over contraceptive options for women.

Of the many side effects cited by participants, among the most common are worsened cramps, heavy or irregular periods, emotional mood swings, loss of sexual appetite, weight gain and hormonal ineffectiveness after extended periods of use. Lucille had three months of straight bleeding while taking the hormonal birth control pill, Yasmin, which affected her life greatly. For example, on campus, she was always concerned with breakthrough bleeding, and having access to pads or tampons. Also, cramps associated with the bleeding affected her school attendance and her social life. Even though she was protected from pregnancy, the constant bleeding from the hormones lowered her sex drive and regularly turned her off from intercourse. She was able to go back to her doctor to switch her hormonal method and the bleeding stopped immediately. Others describe decreased sex drive and the ways it can present larger problems for women. Kassie recalled, “But the worst part with the shot is…I didn’t want to have sex for a whole year pretty much. And it was like crazy painful, like during sex. It felt like a knife stabbing me in the vagina…and this can like cause problems in relationships, you know?” However, upon changing types of birth control, this participant became temporarily vulnerable to pregnancy because the new hormones required a month wait time for full effectiveness. Sally recalled her experience with side effects,

I was on the same one for two, three years. And it was starting to lose effectiveness to where I was having breakthrough bleeding, umm horrific, horrific cramps. And so we went back and tried a couple other ones, and
then I just finally figured out that it was, you know, better when I was off of it. We had talked about switching, but with the way my insurance works, I have to get a referral to an OBGYN every time I wanna switch it. And so having to go get a referral from primary care, then go talk to the OBGYN every three months when you’re trying out different birth controls was hard. But it’s the issue of, you know, you have to make the time to make the appointment with the primary care doctor, going to the primary care, you then go make the appointment with the OBGYN, and then go in…. it took up way too much time.

When women deal with unbearable side effects, it forces them to repeatedly engage medical institutions. Additionally, as with this participant, side effects and the process of switching may eventually turn women off from hormonal birth control altogether. These experiences reveal more than just bodily side effects, but also the time, money and energy to figure out logistics, coordinate doctor’s appointments, and test new hormones. Pathways to contraceptive protection often involve a twisted version of hormonal roulette in which women gamble possible side effects in order to enjoy complete pregnancy prevention.

Others experienced negative side effects on high-dose hormonal birth control pills, but found some relief on low-dose pills. Jane described morning sickness and nausea after she took her high-dose pill as hormones often mock pregnancy symptoms. Similarly, Noelle recalled, “On the higher dose, I like get sick, like I literally vomit.” Interestingly, while the low-dose pills felt more compatible with her body, this participant
needed the higher dose hormones to prevent breakthrough bleeding and to regulate her period. To manage undesirable bodily effects with desired pregnancy protection, she switched her schedule to consume the pill before bed every night in hopes of sleeping through the most noticeable side effects. She continued, “Knowing now the things I know, I’m like, OK I’ll just keep taking it. But when you’re 20 or 22 and you’re going through this, it’s kinda like, what the hell is going on? This drug is making me ill. But it wasn’t it, the pill is just making your body think it’s pregnant.”

Experiences with the pill show how delicate the body’s relationship to levels of artificial hormones can be, and how challenging it can be to find the right method. Feminists like Laurie Penny equate taking the pill with an act of liberation and agency (Grigg-Spall 2013). Yet this enthusiasm for hormonal contraception can be argued as merely symptomatic of female fear over loss of reproductive control. As such, others link hormonal contraception to a legacy of patriarchy and female oppression. Even amid the adverse effects of hormones, society continually reminds women that, “an un-medicated female body is a dangerous, unpredictable and difficult body” (Grigg-Spall 2013: 91). However, I argue that women’s relationships to hormones uncover a more complex story. “Yet even as women experience the emotional and physical side effects of hormonal contraceptives they see this as their only option. Stopping and returning to a sense of lost control is too frightening a choice” (Grigg-Spall 2013: 91). The politics of reproduction is ultimately about control; the control of men over women, and the control of women over procreation. Therefore, it is also important to complicate our conceptions of agency and choice as they occur in this context.
Choice to continue or desist from birth control use is shaped not only by political and social ideologies on reproduction, but also by the pressures of US consumerism (Grigg-Spall 2013). Some contend that the addictive tendencies of hormones also diminish a genuine notion of choice about pregnancy prevention. More, feelings of dependency on hormonal contraceptives only reinforce the ways that they are fundamentally linked to societal conceptions of “what it means to be a woman in this world” (Grigg-Spall 2013: 96). Women then substitute their systematic lack of control in society with (supposed) control over their reproductive bodies, but at what cost?

Lived experience cannot be separated from biology, and hormonal contraception marks attempts to move beyond our own faulty “femaleness” epitomized by periods and pregnancy (Grigg-Spall 2013). The sexual liberation from birth control is said to offer women the luxury of having sex like men, without fear of consequences. Emblematically, the level of sexual freedom akin to men’s in society necessitates women to endure a range of psychological and physical side effects. Concurrently, female choices over contraception are coupled with larger assumptions on modernity that hold science and pharmaceutical technologies as always improving health and bolstering society’s overall well-being. As they experiences hormonal side effects, some women internalize this viewpoint, blaming their bodies as “not good enough for the drugs” (Grigg-Spall 2013: 109). Again, experiences of reproductive choice and control are characterized not only by physical nuisances, but also by psychological propaganda on female defectiveness.

Furthermore, women taking other forms of hormonal birth control shared many parallel narratives of experimenting with the pill. Katelyn, a 22-year-old White

---

34 The birth control pill Yaz was even marketed as a hormonal option as being beyond birth control (Grigg-Spall 2013).
participant, recalled, “I’ve fluctuated between different ones [birth control pills] just because of hormonal issues…they were just like ‘discharge’ stuff.” Jane, a 29-year-old Latina participant, began with the pill and then switched to the NuvaRing, which came with its own annoyances and benefits. Specifically, she commented, “Even with the ring, like, I had to go get it every month, and honestly, it fell out. It would fall out pretty much every time I had sex, and then I had to find it and wash it, put it back in. Like I liked it overall, cause I didn’t have to take a pill everyday.” Additionally, while some women take birth control to help with acne, other women cited having negative skin reactions to the hormones. Tiffany, a 27-year-old White participant, said it “made my face like super fucking oily and break out…and every month I just kept thinking, ‘Like I don’t want to be on this anymore.’ ” These quotes demonstrate not only the numerous difficulties faced when on hormonal birth control, but also how the ways women adapt as needed.

Forms of long-acting reversible contraception (LARC) like the intrauterine device (IUD) are characterized by their own potential side effects. Positive side effects of the IUD were ceased menstruation, and the freedom of not taking a pill everyday. Alicia, 28-year-old White participant currently using the IUD, stated that it “causes you to stop getting a period for the most part, but you have breakthrough bleeding, and a lot of bleeding during sex. But like, I feel like every birth control has some unpleasant side effects, so it’s just picking which one you wanna deal with.” That said, negative side effects of the IUD included mild cramping and spotting during the first few months after insertion. More, Desiree, a user of the copper IUD, had a horrible reaction to the foreign metal object inside her uterus. She recalled, “I think for me it was just a personal reaction to copper that went really, really wrong…[laughs]…I have had so much fun with birth
control! Let me tell ya! It was really, really awful….and my doctor tried to have me tough it out for a couple months.” While some women expressed the discomfort felt in the first three months was ultimately worth the years of pregnancy protection, others starkly differed in their IUD experience.

My own experience with the IUD Mirena has been overwhelmingly positive since insertion in May 2016. In my opinion, the worst part of using the IUD is the insertion process. At the start of the appointment, my female doctor detailed what to expect during procedure and after, including possible side effects. Insertion involves fitting and placing the IUD inside the uterus. Before beginning, she initially sprayed inside the vaginal opening with numbing solution that cause a burning sensation similar to a urinary tract infection. She proceeded to dilate the uterine opening and measure the uterus for correct placement. At that point, I began to feel severe cramping as my eyesight went spotty, and then one intense cramp with the final placement of the device. The procedure took about ten minutes, but involved intense uterine contractions, dizzying discomfort, and lightheadedness.35 Honestly, it was a kind of pain I had never felt before – a deep ache that brought on nausea, dizziness, and blotchy vision for a couple minutes. After she finished, I understood exactly why women frequently faint during insertion. Admittedly, I stayed on the table for a few minutes to process what I had just felt and ensure I didn’t fall to the floor upon standing. The doctor left me in the room to collect myself, redress and apply a pad for possible bleeding. After the procedure, I continued to experience heavy cramps for the rest of the day, but have had zero negative side effects since the day

35 Before the IUD insertion procedure, patients must eat a snack or meal and take an adult dose of Ibuprofen to manage pain and prevent fainting.
of the procedure. Most days, I do not even think about my IUD; a luxury I never thought possible in light of my own tedious history with hormonal side effects.

Testing hormonal birth control to find one compatible with your body can be a vexing process between patient and doctor. Encounters with medical staff and health institutions are hugely influential in the process of finding the right birth control. In fact, some women experiencing negative side effects asked about changing methods, and were met with physician insistence that adverse feelings were normal and would subside after the first three months. This professional stance not only normalizes negative hormonal side effects, but also neglects the reality that bodily repercussions with certain methods never diminish for some women. Moreover, Kassie, one 24-year-old White participant went from using Depo-Provera (a three-month hormone shot) to the birth control pill, citing “side effects that I didn’t like. And I also didn’t like not having a period…I didn’t like the feeling of not knowing if I was pregnant or not because it’s not a hundred percent.” This participant suggested switching birth control yet her doctor pressured her to do a whole year of the treatments to really get a full effect. Katie, a 28-year old White woman, recalled her first experience with a birth control pill that also served as an iron supplement. She remembered, “I was sick a lot…I was on it for three months straight and it was the worst experience ever. I had to insist, ‘you know, I’m not taking it anymore. You have to give me something else.’ I do remember feeling kinda some pushback from my doctor on that. And I suffered on it almost three months.” The involvement of medical staff and clinics is imperative to locating a compatible hormonal birth control and ultimately enjoying stable, effective pregnancy protection. Encounters with medical institutions can facilitate access or institute impediments to experiences with birth control
that are not characterized by unwanted side effects. If and when women find a well-suited hormonal method, they are often content to stay on it. In other words, Tiffany stated, “I had a really hard time finding that right pill, so I’m on it and I’m gonna stay on it, and I don’t wanna try anything else.”

During this process, some women cited feeling most frustrated about the lack of information and options available when it came to contraception. The process has been described as a kind of hormonal trial-and-error. Alex stated:

I just don’t know the answers to things that I want and so I don’t know how to get that or talk to somebody. Right now, I literally for that past four months been contemplating getting off of it… and some people have told me it’s not good to be on it for so long and stuff. But at the same time, like what does everybody else do? I just don’t know about a lot of stuff in women’s health. Like if there was some education more out there to help people decide stuff like that cause I don’t know what to do with my own self.

Along this same line some women complained about the limited options for birth control presented by their doctor. Carissa, a 21-year-old White participant told me, “That’s kinda how it was for me though. They don’t tell you what options. To be on different options, I did the research myself and be like ‘Can I try this?’ ” Noelle recalled of this experience:
They just gave me the pills and I didn’t know what anything meant. They were like, ’This is the low dose. This is what this is.’ And it’s like, well how does that affect me? Like, why would you give me this pill and not this pill? What does this pill do? What are the differences? And, like, they just always gave me a different pill. And I don’t know what any of these pills do. I don’t even know what kind of pills are out there. I know I’ve been switched a couple of times but…I just take them cause it’s what they give me.

Additionally, Korinne recalled, “I feel like the first time that’s what they did. They were kinda like, ‘We’re just gonna give you this one.’ But I think the issue with that was, when I got my first method, it was at Planned Parenthood.” This participant correlated the lack of birth control options given to her with the nature of PP clinics. In other words, she expressed confidence that PP staff members were professional and knowledgeable but felt they might not be as invested in patients as one’s primary physician. Additionally, staff members at Planned Parenthood do not typically see patients on a regular basis like other medical facilities. So women expressed sentiments that they “just kinda throw whatever [birth control] in your face,” in hopes that women actually use it. These quotes reveal that mismanaged side effects may result from misinformation from and limited dialogue with doctors concerning hormonal options available.

Conversely, some women did not cite any hormonal side effects. This is the ideal result from more individualized hormonal recommendation resulting from a more interactive doctor/patient relationship. In many ways, my data show there is no one-size-
fits-all birth control option; therefore women often require specialized attention to what hormone would be best for their unique body. Natasha raved about how much she loved being on the Depo-Provera shot because of the convenience and protection it offers her. “I loveeeeee having it,” Karlie stated of her IUD. When asked about side effects using the pill, Jocelyn, a 26-year-old Asian American, stated, “No, I think just the benefit of feeling regulated. It’s kinda awesome.” She has been on the same hormonal birth control for the past six years and is happy with it. Haylee, an 18-year-old White participant, stated that she had no negative side effects and only experiences normal period symptoms when she is menstruating. Again, these are just other examples of how different women’s bodies can react to hormones and how individualized medical attention and adequate birth control options remain a shared concern for many women.

These diverse narratives paint a vivid and complex picture of just how significant side effects can be on a woman’s journey to hormonal birth control. For participants, hormones offered relief from problems like acne and painful periods. Nevertheless, physical and mental side effects are widely and intensely experienced, and, in a way, have become expected, even normalized part of birth control channels. These hormonal tribulations not only disrupt one’s natural bodily functions, but also influence one’s social life, intimate relationships, and professional performance. Desiree ultimately said,

I’m just kinda done with artificial hormones right now. I think we need to reexamine what we are putting into our women with birth control because men would never put up with these kinds of side effects! Never! And women put up with horrible side effects to maintain being on birth control,
and I just don’t think that’s fair…Cause you’re basically going against a healthy, functioning system and saying ‘Here’s a bunch of artificial stuff and we’re gonna trust it not to hurt you!’ …Pharmaceutical companies need to be held responsible for that because you wouldn’t put out any other class of drugs with these kinds of side effects, you just wouldn’t!

This again speaks to the problematic ways that side effects of birth control have become a regularized checkpoint on routes to hormonal contraceptive use for most women.

Moreover, there continues to be very little, if any, public scrutiny of the existing birth control market, including drug availability, and the physical toll some methods cause. My point is not necessarily to endorse homeopathic birth control, but instead spark a much-needed evaluation of hormonal options available. Are these really the best birth control options to offer women? Even during initial trial phases in the 1960s and 1970s, studies showed that women experienced side effects at noteworthy rates. *La Operación* involved the forced testing of the first contraceptive pill, Enovid,36 on hundreds of poor Puerto Rican women (Hartmann 1985). Studies revealed 17 percent of women reporting side effects from the pill like vomiting, abdominal pain, nausea, dizziness, depression, and headaches (Squires 2016). Three women even died during the study yet their bodies were never autopsied (Ibid.). In 1970, journalist Barbara Seaman published *The Doctor’s Case Against the Pill*, which garnered public and political attention. At that time, activist Alice Wolfson contended:

36 Manufactured by GD Searle & Company, this was the first version of the hormonal birth control pill on the market. It was said to contain ten times more hormones than needed for pregnancy protection (Seaman 2000).
It must be admitted that women make superb guinea pigs. They don't cost anything, they feed themselves, they clean their own cages, pay for their own pills, and remunerate the clinical observer. We will no longer tolerate intimidation by White-coated gods antiseptically directing our lives. (Squires 2016: n.p.).

This analysis is not about a critique of hormonal contraception per se, but an evaluation of the means of developing it and the loftier consequences. Accordingly, senator Gaylord Nelson championed legal bills concerning patient’s right-to-know, which mandated the reduction of hormones in the pills and information on side effects added to every package (Squires 2016). This also prompted Seaman and Wolfson to found the National Women’s Health Network in 1975.

Furthermore, recent studies have shed additional light on the consequences of outdated hormonal birth control. One Danish study showed that women on hormonal birth control (including the pill, ring or IUD) were far more likely to be concurrently prescribed anti-depressants (Squires 2016). In fact, approximately 80 percent of teens started taking anti-depressants after they began using hormonal birth control (Ibid.). More recently, researchers are more acutely examining links between hormonal birth control and breast cancer, infertility and high blood pressure (Seaman 2000). However, amid ongoing reports of side effects over the last five decades, many question why we are only now obtaining concrete data on these experiences. While studying mood and bodily
effects can be complex, the absence of data until recently reflects enduring shortage of concern over women’s health issues in general (Grigg-Spall 2013).

Lingering hormonal side effects of outdated methods speak to the lack of priority and basic funding placed on women’s reproductive health innovation. During the 1970s, 13 major pharmaceutical companies (nine in the US alone) pursued research and development on hormonal birth control (Ibid.) Yet this number dwindled to four (with only one in the US) by the early 1990s, and the figures have changed little since then (Watkins 2012). Big Pharma has not necessarily retreated from contraception, but from any new research and development. In other words, the “status of contraceptive research and marketing today results from decisions made by the pharmaceutical industry to maximize profits and to minimize [economic] risks (Watkins 2012: 1464). As a result, the US contraceptive market continues to disperse methods based “on science that is more than 50 years old” (Watkins 2012: 1462). Even at the close of the 20th century, drug corporations strategized to increase profits from existing contraception while avoiding costly research and development for new methods. As a result, birth control innovation remained stagnant, while marketing strategies proceeded to shift. This empathizes the contingent, even contradictory, nature of Big Pharma’s broader corporate strategies.

With research and development stalled, companies had to market products in new ways, which initiated the branding birth control (specifically the pill) as a lifestyle drug. During this time, The Drug Price Competition and Patent Term Restoration Act of 1984 (or the Hatch-Waxman Act) set up a more efficient system for approving and regulating generic drugs (Watkins 2012). So, by 2007, we witnessed a market expansion of more
than 90 generic and brand name forms of oral contraceptive alone (Ibid.). Still, this period was less about pharmaceutical innovation and more about financial survival in a flooded birth control market, leaving women with the same limited birth control menu. This contraceptive re-branding did inspire pharmaceutical conglomerates to tweak their product in order to stand out, but not necessarily to minimize risks associated with hormonal birth control, as recent lawsuits over Yaz and certain LARC’s make clear. Many began testing lower-dose hormones to produce fewer side effects, and pills that promised relief from regular menstruation and pre-menstrual dysphoric disorder (PMDD). Soon after, the IUD was lauded as the most effective hormonal contraception with the least side effects, yet its use has remained relatively low until recently (Daniels et al. 2013). Ultimately, the market of available birth control continues to be dictated not by contraceptive innovation, but by profit-driven corporate agendas.

It is a serious problem when side effects of hormones are so unbearable that women are turned off from birth control altogether, or, even worse, continue to suffer the adverse effects for the sake of pregnancy prevention. More largely, “questioning the pill [and other hormonal contraception] is inextricably linked to questioning present social structures” (Grigg-Spall 2013: 94). In addition to the stagnant pharmaceutical market, this speaks more broadly to the reproductive responsibility assigned to women, and the perseverance to fulfill their duty as conscientious procreator. In this context, the ideal of reproductive choice becomes constrained. The narratives reflect a common predicament

---

37 This is primarily attributed to the device’s controversial history, inadequate marketing campaigns, and Republican classification as an abortifacient (Daniels et al. 2013; Haskins, Sawhill and McLanahan 2015).
of opting to remain vulnerable to unwanted pregnancy or experiencing a hormonal roller coaster ad infinitum – tell me, which would you choose?

Encounters with Insurance Institutions

*Accessing Contraception*

Interactions with insurance providers mark additional checkpoints along avenues to birth control. This analytical area may seem obvious, but it is often overlooked in larger public discussions on contraceptive access. Most women are obliged to engage insurance companies to access primary physicians and the hormonal birth control they need. Individual or parental insurance coverage (or lack thereof) often determines the first place women go to obtain birth control. Overall, participants expressed confusion when dealing with insurance providers and figuring out coverage for women’s health services including contraception. Most people, myself included, lack sufficient knowledge of insurance jargon and the fine print of health insurance policies to ever question them. Women expressed the sentiment that health care coverage is something they *need*; yet they do not fully understand how that coverage works. Some cited avoiding calls to their insurance provider because it was often time-consuming, and fruitless; much gets lost in translation during discussions of co-pays and annual deductibles. Narratives speak to the frustration in navigating this realm, mainly due to lack of transparency of coverage and limited accessibility for contacting insurance representatives.

The women who remain on parental insurance may experience unique barriers to birth control. Many women in my study will remain on their parent’s health insurance
until age 26, and, while discussing sex may get easier with age, it remains a concern for many. Haylee continued, “it was definitely difficult when you’re talking to a health care provider trying to get on birth control, and them asking you all these questions, and your mom’s sitting right there. And, it’s like, ‘I really don’t want her to know this.’” When asked about what could have made the process of getting birth control easier, Ashley, a 26-year-old Asian American participant, told me, “ Probably….not having to ask my mother. Cause you can’t really go before 18 without your parents’ consent or whatever.” Natasha reiterated she was thankful for what she could learn about contraception on the Internet. “Even when they’re like 25, 26, once their mom finds out they’re like on birth control their mom freaks out. So it’s probably good for the girls to be able to research online anonymously cause sometimes the adult is not an adult.” Again, the context in which women seek out birth control is shaped by the kind of insurance coverage. Parental insurance can complicate these processes and can even prompt women to circumvent insurance altogether.

Naturally, some decided to go outside their parent’s insurance for increased privacy or because they have aged out of eligibility; others simply do not have health insurance. Navigating birth control outside of insurance can increase vulnerability to pregnancy and overall financial burden. Per se, local clinics like Planned Parenthood become key resources for young women with few options for reproductive health care. Some participants even began using these facilities for reasons other than birth control as well, including pap smears, breast exams, and comprehensive STI testing. However, underfunding of these clinics is having a real impact on the ground level. Evelyn explained, “They say that there is no one ever at the clinic, there’s so lack of funding for
it that it’s getting to the point where it’s like drying itself out. Women are going in there trying to get help and no one is ever there so it’s like ‘Fuck dude, what are we supposed to do?’ People with no insurance.” Of her experience at Planned Parenthood in Arizona, Carissa explained, “It was ok. It was a long wait. I just remembered I had to sit around for a while.” At PP Arizona her birth control was free as well, but long wait times were a common experience at these facilities. Jocelyn recalled, “When I went to Planned Parenthood the first time, it took me an hour and a half, maybe two hours…and I had an appointment. Yeah, it took forever.” Further, women expressed how grateful they were for clinic staff that offered much help along while seeking out birth control. Rosaline, a 21-year-old Latina participant, explained, “You know, I’m thankful for the kind people at the clinic, who could help me when I didn’t know a whole lot about that [birth control].”

Moreover, many participants specifically cited concern with access to Planned Parenthood and other local clinics. Political debates over federal funding for clinics like PP can put those without insurance in increasingly precarious situations with regard to reproductive health care. Evelyn stated,

---

38 Since the passage of the ACA, debates over federal funding for women’s reproductive health services have raged on. In fact, both houses of Congress have even proposed a complete elimination of federal Title X and Medicaid funds for the approximately 4000 clinics serving women’s health needs across the US, including PP and WIC (Annas and Mariner 2011). Stemming mostly from conservative groups, these cuts would result in approximately 860,000 unintended pregnancies and 810,000 abortions per year among low-income women (Ibid.). Further, 17 states have adopted or proposed some form of this PP (and other abortion provider) exclusion from state and federal funds with Texas being the first to enforce such legislation. In 2011, this implementation led to closures of approximately 80 health clinics, one-third of which are PP affiliated (Stevenson et al. 2016). This initial research suggests “that the exclusion of Planned Parenthood affiliates from the Texas Women’s Health Program had an adverse effect on low-income women in Texas by reducing the provision of highly effective methods of contraception, interrupting contraceptive continuation, and increasing the rate of childbirth covered by Medicaid” (Stevenson 2016: 858).
I just seen a lot of things on the news lately about how they are trying so hard to get places, like Planned Parenthood, no more funding and all that. I just keep hearing all this crazy stuff about that and shit. I’m like, that’s gonna suck for these women out here like me that doesn’t really have any other options.

Many people in Arizona are becoming more aware of political fights to defund clinics like Planned Parenthood. More, many fear the worst as Kathy stated, “I just think the main concern is all this issue with Planned Parenthood. That’s what worries me because…it’s going to definitely affect how women get birth control. So it’s sad to see they’re like going through all this turmoil.” About half of research participants demonstrated awareness of political issues related to contraceptive politics in the US and Planned Parenthood specifically. These clinics provide reproductive services to women not only in my sample, but also throughout the state, and the government defunding of these clinics will have real material consequences.

Many women in the study who work or attend school full-time purchase health insurance through their employer or university. With this insurance coverage, women have more options and are able to go to their own primary doctor for the reproductive health needs. Although convenient, this insurance can also be quite costly. University health care can cost upward of $1000 each year for an out-of-state student. Women in the study who purchase insurance through their work pay an average of $100 a month for health coverage, from a low of approximately $80/month to a high of $200/month. Women also pay an average copay of $30 for each woman’s health office visit (to obtain
birth control, obtain a pap smear, have a breast exam and/or get an STI screening). While women’s exams were generally covered, some paid out-of-pocket for lab tests, which can sometimes total up to $500. The reason she has to pay for these tests is because yearly insurance deductibles had not been met. One woman stated her annual deductible was $2500 with insurance through her employer. On an annual basis, data show that women can spend over $1000 on combined reproductive health care costs.

Some participants opted to get insurance through the federal government, or Obamacare (n=6). When President Obama signed the Affordable Care Act into law on March 23rd, 2010, it sparked much national controversy. Much of the political backlash came from the stipulation that insurance companies must provide full coverage for contraception and preventative women’s health care. As discussed previously, these political actions led to the famous Hobby Lobby Supreme Court ruling that corporations can opt out of this clause for religious reasons. However, even when women signed up for Obamacare through Healthcare.gov, how much they paid for birth control still varied. Of getting an Obamacare health plan, Alex stated, “It’s pretty easy but it’s hard to, like, figure out what you need.” Those with Obamacare were still paying an average of $130 per month for health care coverage and show confusion over actual coverage for contraception.

These experiences show real moments when women encounter their insurance provider directly, for better or worse. They express general confusion over variations in coverage and out-of-pocket cost, and how they are determined. We will cover this fully; provide half coverage for this, and no coverage for this. But why? When women do inquire further some get answers, while others receive longwinded explanations of
eductibles, co-pays, health claims and other words with only half-meaning in this context. Narratives of avoiding contact with insurance providers reveal the ways women feel too intimidated, frustrated or tired to even call. Ultimately, why do we almost-blindly throw money at health insurance providers without demanding clear description of what we are paying for? This discussion leads to a deeper look at the actual costs of hormonal birth control.

Costs of Contraception

Financing one’s contraceptive needs is a central concern for women in the sample. Even with the new contraceptive clause of the Affordable Care Act discussed in Chapter 3, coverage and cost of birth control remains inconsistent, depending upon the type of birth control and the quality of insurance. Within my sample, participants reported a range of out-of-pocket costs for their contraception every month. Inconsistency in price and insurance coverage for hormonal birth control remain significant concerns for women in Phoenix.

Of those signed up for Obamacare (n=6), many cited confusion over how much hormonal birth control was going to cost. Ashley recalled, “It’s ten dollars a month without insurance, but even with my insurance was actually free. But I didn’t know that and I was paying for it. And I was like, well I have health insurance and then one time they did it and they were like, ‘you don’t owe anything.’ And I was like ‘What the fuck!’ ” Rhonda, another participant with Obamacare, claimed “it’s usually free, but every, like four to six months they charge you like ten dollars or something.” Korinne stated, “my birth control is free. I think if I wanted to get multiple packs at a time, I have
to pay for it myself, which is ten dollars per pack. Yeah, but if I wanna get them for free just once a month….” Kathy also cited confusion over which women’s health procedures were actually covered by Obamacare and which were not:

With the insurance [Obamacare], I get one free health and women’s exam per year and that’s usually when I get my prescription refilled. They let me know from the beginning that I had that free exam. Like it was written, but I didn’t understand it so I had to like call and see what it entailed. And when I was there they told me that like the STD test was free but blood test, like the HIV test wasn’t free. And then I told them I only want the blood work if it’s free and then I got charged a hundred and thirty dollars! And the place I went to told me it was the health insurance’s fault and then they told me it was the place’s thing.

Health care providers seem to lack complete knowledge of how Obamacare and the ACA operate which restricts pathways for women. Even health insurance obtained through the federal government exhibits inconsistency in coverage and cost.

Some women have to opt for cheaper health insurance options, which include remaining on a parent’s insurance plan (n=13). Women are eligible to use their parent’s insurance until age 26, an experience that brings unique advantages and challenges. In order to get this coverage, some had to deal with uncomfortable sex discussions with parents. Carissa stated, “I had a lot of problems with my insurance at first. Like, I didn’t want my dad to know about it and my dad at the time was paying for insurance. And then
my dad, out of nowhere, was like ‘Well, are you on birth control?’…So I was first doing it [going to a local clinic] to keep it off the insurance.” However, many are able to access increased benefits with low (or no) costs to them when on parental insurance. Not only did most avoid insurance costs, but experienced low co-pays and complete coverage for preventative women’s health including birth control and pap smears.

Lastly, some women without insurance were able to get birth control for reduced costs at local clinics (n=3). Evelyn stated she paid about $20 for birth control packs with previous insurance, but now, lacking health insurance, she is more likely to go to clinics like Planned Parenthood. She continued, “For the first six months, I was going in every month [for birth control refills], and once I hit like six months and they seen that I was like a regular customer, they legitimately gave me a whole year supply.” Oftentimes, local clinics offer women’s health services and contraception for free, or with a small donation, to those without insurance or in a certain income bracket. While Planned Parenthood and local clinics can have drawbacks, they represent vital reproductive resources for women with limited options.

Other participants have student health care plans through their university (n=2) or purchase health care through their employers (n=8). These health care plans can oftentimes be costly, but offer more thorough coverage for reproductive services. Alicia with university health care noted that it cost her nothing to get the IUD implanted after the ACA went into effect, “None. ASU puts the IUD in free, so it literally has never cost me a dime.” Lacy purchased insurance through her work, which only offered full coverage for generic birth control. Additionally, she could not obtain as many packs at a time with the brand name birth control. She described, “Once I came to this employer and
started the United Health care plan, my brand was preferred and I think I pay like fifteen dollars. But instead of giving me the 90-day like they used to on my old insurance, they only give me like one month.” Considering the tedious process of finding birth control that is compatible with one’s body, this participant was willing to cope with the cost and limited accessibility of the name brand contraception. Noelle also purchases insurance through her employer and she recalled, “So I think it’s 25 dollars…25 or 30 dollars every time I see her [participant’s women’s health doctor] and I see her once a year. And then my birth control is actually free. Now, now with the whole Obamacare.” The ACA has changed coverage for contraception nationally, yet those with private insurance still face issues with drug coverage and meeting yearly deductibles.

The ACA impacted health care for women with a variety of different insurance plans. Some participants with private insurance received clear coverage of hormonal birth control from the Affordable Care Act contraceptive coverage beginning in summer 2012. Jane recalled, “My pap smears are free, aren’t everyone’s? Yeah, like a few years ago I went, and it used to be like ten dollars, and so then all of a sudden I started going and I was like yeah, it’s the new Obama-thing.” Initial research suggests that between fall 2012 and spring 2013, the proportion of women paying $0 out-of-pocket for the pill jumped from 15 to 40 percent (and 23 to 53 percent for those who use the birth control ring) (Finer, Sonfield and Jones 2014). On the other hand, some women did not have any change in coverage after the ACA. This often signaled that they already had contraceptive coverage before Obamacare. Another select group of participants stated that they only received coverage of hormonal birth control and women’s health doctor visits after they contacted their insurance company and specifically inquired about ACA
contraceptive coverage. Tiffany described, “But there’s a loophole and I feel like I only got this loophole one time. It’s where if you go in for a preventative, like for a pap smear or something like that, then you can get it for free, but that only worked one time. So shady.” Unfortunately, the implementation of the ACA has brought some troubling violations of federal Medicaid law and little improvement of cost sharing for the IUD (Ibid.). The bureaucratic insurance apparatus was transformed with the ACA and unpredictable application of its policies reflects that reality. Regardless of insurance type, engaging providers on the pathways to birth control can be burdensome, confusing and expensive and ACA policies add to this complexity.

*Limits on Birth Control Prescriptions*

Operating in cooperation with insurance providers, pharmacies are another significant stop on the road to contraception. While local pharmacists have some sway in administering medication, oftentimes they function as a distribution center for doctors and insurance companies. In doing so, they determine final payment and how much hormonal birth control one can obtain per visit. Narratives reveal how accessing birth control can become an overregulated hassle, riddled with bureaucratic roadblocks. While inconsistency in coverage of birth control is problematic, another common issue with birth control is the number of prescriptions one can pick up at a time. This is especially true with hormones that need to be consumed daily like birth control pills, or changed every three weeks like the NuvaRing. Hormonal birth control only remains effective if taken on a strict schedule, and limiting access to one pack at a time can easily jeopardize pregnancy protection. Lucille mentioned that, “The one…complaint I would have about
that is they…make you go there [doctor’s office] every three months, and if you forgot, they wouldn’t refill your month. So there’d be that gap where you can get pregnant. Like, and I did…” This participant ended up getting pregnant a couple months after the glitch in the birth control refills, demonstrating tangible consequences of this convoluted process of picking up birth control.

Women on employer insurance plans demonstrated inconsistency in number of packs they were able to obtain at a time. Of using the NuvaRing, Jane recalled, “I had friends who picked up their birth control like three months at a time and I could only get one month. And I hated having to get a new prescription all the time. I think like every six months I had to get it re-prescribed again and I had to pay for that visit.” The process can become not only tedious but expensive as well. Lacy stated “There have been times where like I’ll forget to schedule my appointment with the doctor and I won’t find out from the pharmacy that like I need a refill ‘til like the weekend. So I’ll just like go without…so I’m just like off of my pill for a few days.” Raquel, who purchased insurance through her employer, could usually only get a pack at a time but was able to get more when she asked in a special circumstance. She recalled, “They only give me a pack at a time, but I never asked for more. Well I went on vacation once and I was like, ‘I need another pack’ and they were like ‘OK.’ ” Women can have an increased risk for unwanted pregnancy when they do not have easy access to renewing and obtaining birth control prescriptions.

For those using Obamacare coverage, most participants could get one pack of birth control pills at a time. Ashley recalled, “I’ve asked about getting more than one at a time, but they said that that particular one, you can only get one. And the insurance won’t
allow you to get more than one.” When asked the possibility of getting more than one pack at a time using her Obamacare plan, Alex stated adamantly, “No, and it’s inconvenient as fuck! Like they won’t let me have anymore! Cause like back in Illinois I could get three months at a time and like, that’s fine. And in Illinois, it was Planned Parenthood [that she went to for hormonal birth control].” Local clinics can be helpful options for women to get around this inconvenience, even for those with health insurance. Laney recalled, “They [Planned Parenthood] would try to give me one month at a time but since I did have to get there driving and I didn’t wanna have to worry about it, I just asked them for three months.” She was able to get the three-month supply with no questions at no cost or with a small donation. When restricted to getting one pack at a time, women are forced to change strategies for how they navigate passages, which can include using local clinics and PP.

Those participants that were covered by parental health insurance exhibited as much variation in cost as they did in the number of packs of hormonal birth control one could obtain at a time. Of her parent’s health insurance plan, Haylee recalled,

I think it’s something weird with the insurance policy. Yeah, it was like the first month it had happened and like they only gave me one pack and I was like ‘I usually pick up three’ and I had the prescription for the whole year so it didn’t seem like a big deal to give me three. But then they were like, ‘It’s your insurance. They won’t let us give you more than one. And my mom looked into it and apparently if you want it free, you can only get
Another woman on a parental insurance plan stated she was able to get three months at a time while another was able to get a nine-month supply. Carissa, still on a parental insurance plan, recalled that although her birth control is free, “the most I’ve ever gotten from them is three packs at one time, then they started dropping me down to one after that. Now I have to go back every month…so insane.” When she inquired if she could get more they “said that there was like a policy they just initiated…it’s like you have to be part of a certain program with CVS to get them three-a-time.”

One common finding is that most participants cited being required to revisit the doctor or clinic before being able to have birth control prescriptions refilled – again, having the tendency of putting women’s pregnancy prevention at risk. Regardless of insurance coverage, most only had to visit their doctor once a year to obtain renewed prescriptions for birth control. Moreover, the average copay for these visits among all participants with private insurance is approximately $25 dollars per visit. The appointments usually take about an hour total with doctor/clinic locations an average of 15 miles from participants. These visits often included a full women’s health exam during these appointments including a Pap smear, STI testing and a breast exam. Karla stated, “They wont give me birth control unless I do that [women’s health exam].” Even scheduling these appointments can sometimes present a challenge for women. Melanie stated, “Right now I can’t get an appointment until like three months in advance so I need to find a different doctor. So I made the appointment like two months in advance and like
the week of my appointment, I got my period…they said I could come in, but I didn’t wanna sit in those stirrups bleeding all over.” Overall, data show women experienced little stress with attending these doctor appointments annually. Instead, women had most trouble in dealing with inconstant medical costs, insurance coverage and prescription refills.

Ultimately, compared with other developed nations, the US “is unique in its complexity of health insurance designs, mix of public and private insurance, and relatively limited insurance market regulations” (Schoen et al. 2013: 2). In fact, the administrative complexity and cumbersome bureaucracy result from intricate coverage compliance and restrictions, which increase costs, time, and resources for patients and physicians alike. In fact, 54 percent of primary care physicians even reported time spent on coverage restrictions as a “major problem” (Schoen et al. 2013: 8). US citizens not only reported time-consuming paperwork and a lack of institutional transparency, but three in four agree that the entire health insurance system needs to undergo fundamental change, or be rebuilt from the ground up (Schoen 2013). In addition to already spending thousands more on health care per person, “…in 2011, US health insurers spent $606 per person in administrative costs—more than two times the amount in the next highest country participating in the survey” (Schoen 2013: 7). Markedly, other developed nations working within competitive private insurance markets do not exhibit such mounting institutional barriers. The plethora of overlapping, composite internal policies, state laws, and agency regulations in the US must be replaced with increased standardization across insurers and more centralized quality control (Schoen 2013).
In this context, the state power and influence, while ever-present, becomes obscured by ground level interactions with health care and insurance institutions. In this sense, law and policy of the state is submerged, and hidden from plain sight. In her work on policy changes of the Obama administration, political scholar Suzanne Mettler describes the characteristics of the submerged state: a context where existing policies within the federal system “lay beneath the surface of US market institutions” (Mettler 2011: 4). As such, policies of the submerged state work to exaggerate the role of the market while concealing the larger role of the state. This context propagates not only the general public’s misapprehension of power, but also their ability to trace its complex interworking within various US institutions. This arrangement is a way of perpetuating state power and authority as government laws go unnoticed and, therefore, unquestioned by US citizens. I argue we witness this explicitly in the boundary making occurring on multiple levels in the realm of reproduction.

More, it prompts an analysis that acknowledges the ways relevant regulatory mechanisms, though potentially influenced by government policy, are not entirely state-derived. In other words, what does law look like in the submerged state? The administrative variant of the submerged state further “perpetuates the ideology of the US as a quasi-stateless society” (King and Lieberman 2016: 242). In fact, the federal government often uses actors in the private sector to hand down policy changes, which shield the state from accountability and scrutiny (Ibid.) More, the intimate relationship between the economic market and state policy has submerged the state even further (Strach 2016). Market mechanisms not only have come to shift power over political process through lobbying, but they also “give industry a key role in selecting and framing
issues” and therefore in shaping how the US addresses public problems (Strach 2016: 2). This replacement of “political conflict with market competition” says a great deal about the utility of the submerged state for social justice, and democratic process more generally (Strach 2016: 9).

These multiple ordering systems at play continue to shift power depending on context and actors involved. The inherently contradictory nature of state law and its interaction with regulatory mechanisms results from, what Marc Galanter calls, legal unref orm: the “ambiguity and overload of rules, overloaded and inefficient institutional facilities, disparities in the supply of legal services, and disparities in the strategic position of parties” (Galanter 1975: 148). This context perpetuates the “dualism of the legal system” in that it uses its power and authority to broadcast universal messages at the symbolic level, while fostering particularism on the corporeal level (Galanter 1975: 148). The law’s complexity encourages more legal rules, or unref orm, that serve to increasingly obscure the workings of power within, and beyond, state institutions. Both Mettler and Galanter reveal fundamentals to a holistic conception of state power; it is perpetuated by surges in legal regulations coupled with the covert nature of how those policies operate in society. In this way, legal pluralism not only posits multiple, competing legal boundaries but also seeks to analyze the relationships and power differentials between them (Merry 1988: 879).

This context also begs supplementary investigation into what agency looks like along reproductive pathways in the submerged state. Exposing the submerged state compels heightened visibility and command of state power, and other systems of legal ordering in society (Mettler 2011). As such, as engaged citizens work to demystify the
legal apparatus of government, they not only demonstrate political agency, but they also come to challenge dominant ideologies on reproduction. Further, “markets can expand the policy space and create new frontiers for action” as well (Strach 2016: 178). Hence, recognizing the submerged nature of the state, and expanding concepts of governance to systems outside it, is crucial to an accurate interpretation of close encounters with the submerged state throughout pregnancy prevention and termination currently.

This scenario encourages a shift in scholarly thinking from a top-down approach of state and customary law to a bottom-up analysis. From this analytic vantage point, one can scrutinize the ways “plural systems are often semiautonomous, operating within the framework of other legal fields but not entirely governed by them” (Schiff Berman 2009: 228). This prevents research from being restricted to “this top-down conception…[that] captures only part of the picture of how law operates globally” (Schiff Berman 2009: 232). Still, state law remains fundamentally different than customary law in the way it exercises coercive and symbolic power of state authority. The overlaps of multiple legal structures play out in various social settings, and new legal pluralism aims to accommodate this complexity. Ultimately, “legal pluralism…explicitly denies that juristic conceptions of law are universally adequate and adopts some wider conception of law that can embrace…private or ‘unofficial’ norm systems of various kinds” (Cotterrell 2004: 18).

This section shows how the interworking of the state, medical institutions, and insurance providers is multifaceted, and has a real bearing on women’s pregnancy prevention. Inconsistency in cost and confusion over insurance coverage continue to be significant hurdles. This context epitomizes legal pluralism in the way operating
procedures of medical and insurance arenas interact with state policies. In navigating various legal mechanisms and procedures, women in the study demonstrate agency as they were able to access contraception for little to no cost. However, amid other everyday demands, practical impediments like returning doctor visits, ordering prescription refills, finding transportation, paying for health care and picking up birth control every month represent the tedious, ongoing processes of pregnancy prevention.

Encounters with Societal Pressures

Reproductive Responsibility

Within this context, women certainly reported feeling responsible for pregnancy prevention in their relationship. I wonder: would women go through all this if they did not feel some pressure, obligation and even desire to prevent unwanted conception in heterosexual relationships? The reality is that because women feel such responsibility for birth control, they undergo long, tedious and sometimes painful processes to get and stay on this hormonal protection. Women expressed stress and concern over feeling solely responsible for pregnancy prevention as the female in the relationship. Among my sample participants, partners were mostly seen as uninvolved or indifferent; many simply wanted pregnancy protection and trusted women to be in charge of that. Partners in the relationship remained aware of the birth control, but took a more hands-off approach. None reported partners as inhibiting birth control use or impacting use in a negative way. However, if a pregnancy scare occurs, the feeling of guilt, fear and uncertainty falls mostly on the woman, especially if she was taking hormonal contraception at the time of conception. So even after women go through the whole process to get and actively use
birth control, they often experience lingering feelings of worry, fear, and guilt around pregnancy prevention.

Importantly, a few women (n=3) noted that their partners actively participated in their process of obtaining and using hormonal birth control. Some partners did research on birth control and voiced opinions when they did not feel comfortable with their partner using a certain hormones. Lucille recalled, “But you know he’s definitely vocal on things that he’s not really comfortable with, things like that.” One other participant noted her partner preferred her to be on the pill. Kassie told me, “He’s definitely for the pill, because everything else seems more scary.” Natasha stated, “Yeah, he is involved. He is the one who told me about the shot [Depo-Provera] in the first place. I had never heard of it before.” Noelle stated of her boyfriend’s role in pregnancy prevention, “He’s always been very conscious and scared of that. I remember when we first started dating he like didn’t wanna have sex at all because he was so afraid of, like, getting pregnant. And I remember he would say, ‘Like are you gonna get on birth control?’ And I remember saying back to him, “Well why don’t you wear a condom?’”

Further, these partners helped most with managing side effects and staying on schedule. Evelyn noted, “From the transition from all three of the different ones that I’ve tried…and was like an outsider looking in, telling me like, ‘look, this is how you are acting.’ So he was a big involvement with what I actually decided to stick with.” Karla explained how helpful their partners were in keeping them on schedule with their hormones. “Yeah, pretty much like every day this week, he’ll be like ‘Take your pill!’ and he’ll bring me a glass of water. I think he’s the reason I’ve been taking it on track this whole time.” Maria stated that her partner would sometimes “go get my birth control, like
if I ask him.” All in all, some partners do take active roles in contraceptive decision-making, but the expectation and onus remains on women to access and consume hormones for pregnancy prevention in the relationship.

Most participants in the study said that their partners were involved either a little or not at all in their birth control experiences. When asked about the involvement of her long-term boyfriend Julie stated, “Oh no, he just doesn’t care. Straight up, this is real.” Others note that as long as the woman is protected from getting pregnant, partners seem to remain content. Kathy stated, “Ummm, I mean, whatever I wanna do, he really doesn’t care. I mean, obviously, he doesn’t want me to get pregnant, so…we’re on the same page.” Bethany reiterates this point as she described, “He enjoys the fact that I am on birth control! But, I mean, he has no real say…it’s not that he has no say. As long as, I’m on the pill and he is able to trust me, we’re fine.” Alex stated that her partner “doesn’t really talk” and that he is “Mexican and now a Jesus Catholic and doesn’t believe in birth control,” including condoms. While the responsibility is on women, most partners exhibited a great deal of trust in women to properly take hormonal birth control. This is especially true in a social and cultural context where sex without condoms is preferred.

Participants also described how stressful it feels to be in charge of pregnancy even when single. Bonnie explained, “Almost every time I have sex now the guy’s like, ‘Did you bring a condom?’” When I probed further about whether past partners would provide condoms, Laney woman stated, “No, so that was the issue like we were, you know, in the moment and he was like ‘well I don’t have anything.’ He’s like, ‘I can run to the store real fast’ and then we just ended up having sex.” Lacy recalled, “I’ve had guys try to pressure me into sex without condoms and it’s just not happening.” She also admitted
that no man has ever brought a condom to her sexual experiences, “I usually kinda have guys show up to the party without. So like having to set those boundaries is something that I’ve had to get like really strong with.” Reproductive responsibility is intensified by social and cultural expectations and influences how women engage hormonal birth control.

Regardless of marital status, women express the common sentiment that pregnancy prevention is, above all, a female concern. Katie even admitted, “It’s our responsibility to not get pregnant! They [men] wouldn’t stand for it!” Evelyn stated, “It just sucks being the girl you know. It’s like, ‘can you, as my boyfriend, go figure this shit out? And I can just stay at home and nut in you all the time.’” Men have the luxury of sex and ejaculation absent larger concerns over pregnancy. Karlie asserted, “I think a lot of guys, you know, take it for granted that you’re on birth control and stuff, and it makes you more sexually available. And I think guys need to respect birth control and how it protects both them and us.” In this context, shared responsibility for reproduction seems a tall order. Helena explained, “Yeah, dudes would never tolerate that shit. And it kinda sucked cause it feels like he doesn’t even care, as long as he gets to get off. They don’t feel any shared responsibility.” Only a significant paradigm shift could change how we envision the duty for pregnancy prevention, and, until then, women almost exclusively carry the responsibility and larger consequences.

Overall Satisfaction with Contraception

In light of these experiences, this project is interested in whether women ultimately feel satisfied with their birth control. This question delved more into whether
women felt their overall contraceptive needs were being met. The process of finding the right hormonal birth control can put women’s bodies and minds to the test for the sake of protection from pregnancy. In fact, the findings show that women said some of the worst parts of obtaining and using birth control are “finding the right one,” describing the process as “painful,” “annoying,” and “frustrating.” Still, despite the many issues with accessing and using hormonal birth control, most female participants cited general satisfaction with use and protection.

Many participants thoroughly enjoyed the security and regulation that hormonal birth control offers. Jocelyn stated, “I mean I just love being regulated all the time…like it forces my body to tell me what’s happening.” When asked about the best part of being on birth control, Kassie unsurprisingly stated, “Not getting pregnant! And regulating my period too.” Other women were also satisfied by the ways that birth control offer relief from other problems like acne and painful periods. Bonnie concluded,

It definitely cleared up my problems with the pre-menstrual dysphoric disorder. I like the security I have like with the birth control…No nausea or weight gain or anything like that. And I guess that’s kinda what’s supposed to happen when you find the right birth control. You know, if you’re not experiencing any symptoms then this is the right birth control for you.
Ashley echoed those sentiments stating the best part of using hormonal birth control is “regulated periods and no acne.” Many women enjoy the sexual freedom the pill offers, but also have a hard time keeping track of taking the pill everyday.

Lastly, women enjoy the luxury of feeling at ease about pregnancy prevention while not have to interrupt sexual intercourse with putting on a condom, or coitus interruptus. Desiree (an open pro-life supporter) commented on my research, “Thank for picking something very relevant to the world we live in, especially in this state, you know?...Birth control gives me peace of mind in the end and makes me feel really safe and secure.” When asked if she felt her contraceptive needs are currently being met she stated, “I think they are because I made them that way, but I know that’s not always the case. And, like I said, better sex-ed, in this crazy state, where we just defund everything left and right. There’s a lot of women who don’t have what I have and I acknowledge that and it needs to be fixed.” Generally, birth control became a part of daily life for many women, for better or worse. Ultimately, Noelle stated, “I couldn’t imagine not being on birth control. I don’t know if I’d be able to make it to work. I don’t know what I would do without it.” Pregnancy protection and other benefits seem worth the troubles encountered with birth control.

Amid general satisfaction, women expressed general worry for the future, signifying the often-impermanent sentiment of hormonal pregnancy protection. Women feel very much in control of their reproduction and sexual freedom once they have the birth control. However, narratives reflect the ways women are plagued by worry and anxiety over potential glitches in this process. The confusion, pain and sheer nonsense that typify experiences do not deter all women, as many say that sexual freedom and
pregnancy prevention are worth it. Still, women’s overall satisfaction reflects the
discursive power of this context and the broader normalization of a broken reproductive
health care system in the US.

Conclusions

Ultimately, this chapter illuminates the intricacies of women’s pathways to birth control in Phoenix, Arizona. The conservative climate of the state and dominant ideologies of reproduction serve as backdrops to an analysis of women’s experiences with obtaining and using birth control. This context, marked by restrictive policies on reproductive practices, incites a deeper look into when and how the state and other key institutions inform this process. While narratives show that avenues can be frustratingly complex at times, women in the sample persisted in successfully navigating them, and remain generally “happy” with it.

This chapter offers a few central conclusions. First, encounters with the state in contraception are much more layered than anticipated. While at times very direct, the role of the state often remains hidden on the periphery, not just in terms of how it regulates operations of other key institutions, but also the ways women themselves interpret and even internalize those problematic policies. Second, while women had a range of experiences, I argue there are key commonalities with birth control experiences that can inform activists’ work and legal reforms. While past research emphasizing differential experience is foundational, highlighting similar experiences and encounters with the state illuminates barriers and facilitators to birth control in a fresh way. Conclusively,
contentious politics and powerful social ideologies of reproductive responsibility often incite women’s engagement with birth control, and thus, their navigation of options to it.

Data reveal the state remains a more nuanced entity in contraception, which holds larger implications for women’s legal consciousness. State laws both regulate reproductive practices and standardize operations in other relevant institutions including medical and insurance agencies. This bureaucratic arrangement positions the state as simultaneously present and clandestine on pathways to contraception, which buttresses its power and authority as arbiter of moral reproductive practices. While most women are aware of the power of state law to dictate our lives, convoluted medical and insurance protocols make the reach of state influence difficult to locate in those interactions.

Therefore, in terms of legal consciousness, I argue women exhibit more a state consciousness than a legal one. In other words, they are quite conscious of the state’s presence and influence in reproduction, but lack knowledge of actual governmental law and bureaucratic mechanisms that define reflecting the convoluted role of the state and the difficulty of pinpointing exactly how creates and/or breaks barriers to birth control.

Despite investigation of differences among women, race and age as variables within my small sample did not unveil any generalizable findings, so I argue women’s experiences as linked to their socio-economic class offers the most insight here. However, this is not to say that Black women or older women do not confront reproductive health care differently. Kathy, a 37-year-old White woman in my sample, experienced some hostility and judgment from her doctor regarding hormonal birth control use at her age. While the doctor’s comments may simply reflect larger health concerns, this participant recalled insolence for being unmarried and childless at 37, with
no intention of remitting her birth control use. Additionally, Lacy, a Black participant, recalled an uncomfortable situation with her conservative doctor. She explained,

I did have a doctor, which was really weird…where he tried to convince me to get an IUD. He tried to pressure me. And I had been on Yaz for a while, and I felt really invalidated by the experience. He told me I have to get off Yaz because I was having migraines. Then he accused me of lying about not having migraines, which I don’t. It was just a really unpleasant experience including the Pap smear so I never went back. I felt like he was trying to talk down to me too…He was trying to cram the IUD down my throat.

While these scenarios may not characterize the experiences of all Black women or all women in their late-thirties seeking birth control, they can speak to the ways women engage their surroundings as the intersection of all vectors of their identity. Latina working-class women do not navigate life as solely women, or a member of a particular income level, but, instead, as complex bodies assigned meanings based on multiple identity facets (especially visible ones). Ultimately, context shapes the shifting salience of those identity markers and how they inform the everyday for different women. While my sample is much too small to generalize experiences by identity facets like race or age, certain narratives add meaningful insight into ways these aspects can shape experiences.

And given the close ties between race and class in the US, it is critical to remain conscious of ways racial politics inform public debates and individual experiences with
reproductive rights, both today and historically. The project recognizes there are limitations with the data, specifically in terms of sample size and representativeness. Although not the goal of this project, the small sample prevents any kind of generalization about experiences by socio-economic groups especially age and race. This does not suggest them as irrelevant, but instead acknowledges that when age and race were invoked, I lacked sufficient data to make a solid argument about their impact. That said, I kept the above examples that speak to show awareness of their significance without attempting to draw extreme generalizations from them. This is part of the reason I highlight commonalities, as my data is able to lend richness to this discussion. Most research on reproductive politics extensively analyzes differential experiences by one’s socio-economic location, so coming back to key commonalities can offer unique insight in this context. Again, this is not to say that the narratives noted above do not hold ideological implications for identity and reproductive health care. But rather that my projects can suggest ways that women of the new middle class can ally themselves across other identity lines such as race, religion and age in the struggle for reproductive freedom.

Aside from state law, the social and cultural context of Arizona presents unique challenges with contraception. Specifically, some feel extra pressure and worry when visiting Planned Parenthood clinics in the Phoenix area due to the presence of conservative protesters. Depending on the PP location and day/time, protester presence varies but remains a concern even for those just getting birth control. Mostly the protesters stand on the sidewalks away from the main entrance and hold signs with a variety of pro-life slogans. This can create a hostile environment in which one must seek
out reproductive health care. One participant even continues to deal with her parent’s confusing and costly insurance company just so she will not have to visit the local Planned Parenthood. Carissa stated, “It does make me uncomfortable [going to Planned Parenthood here], just cause. It doesn’t help that I’m going in there to pick up medicine or whatever and there’s people throwing pictures in my face that I don’t really wanna see.” Additionally, women also have come upon some very conservative doctors in Arizona, which can become problematic in pregnancy prevention experiences. Jane recalled,

The only thing I would change would be my doctor experiences. Yeah, I continue to go there because it’s convenient, but...it’s a clinic that is specifically for women’s health and family and so they’re very oriented around birth plans and pregnancy, not really preventing pregnancy. I never really thought that my doctors were very forward thinking…You know being a single, sexually active person was always an awkward topic.

In Arizona, women not only confront problematic legislation, but also experience social stigmas, which frame certain reproductive behaviors as devious or problematic. While not necessarily unique to Arizona, this context has real consequences on the ground level. However, narratives also reveal moments of agency in their navigation of birth control and ways they (re)negotiate the socio-legal terrain.

Again, the analytical backdrop of these experiences is a society that reinforces the notions that women should be responsible for birth control. Women in my sample echo
the sentiment of accountability for being responsible reproducers (and non-reproducers). Reproductive health no longer involves strapping women down and performing questionable medical experiments. Women now almost-voluntarily subject themselves to a health care system that is characterized by normalized contraceptive side effects, stifled pharmaceutical innovation and convoluted health insurance coverage. While society reinforces reproduction as a woman’s duty, legislative over-regulation complicates the process and often leaves women lacking genuine choice and control. The sense of duty for pregnancy prevention simultaneously positions women as the controllers of reproduction while forcing them to engage contraceptive paths punctuated by state restrictions and institutional regulations; begging the question of how much reproductive control women really have. Importantly, women still faced the pursuit head-on and found ways to meet their own reproductive health needs, and my data elucidates this resilience and agency. Ultimately, experiences are shaped by the interaction between law and policy, and embedded socio-cultural ideologies. Yet women can come to (re)define this interplay and pregnancy prevention itself as they engage it. This reality leads to the next analytical chapter on participant experiences with abortion in the Phoenix area and the role of the state in these processes.
5. Experiences with Pregnancy Termination in Arizona

Across the US, public and political debates over restrictive abortion legislation have only grown louder and more contentious. As laws regulating abortion surge in record numbers, I faced a personal and academic curiosity to understand their influence on abortion experiences. History has shown that political and cultural attitudes towards abortion (and contraception) shift depending on the reigning zeitgeist (Critchlow 1999). During population scares in the 1950s, for example, the state encouraged reproduction, at least among favored populations. The rise of feminism in the 1960s was characterized by battles for women’s bodily autonomy and access to reproductive health. The 1970s and the Roe decision prompted the newly empowered Christian Right to organize against rights to legal abortion. The 1980s were met with concerns over heightened rates of national poverty that were disproportionately plaguing communities of color. Shifting over time, laws and policies have the potential to greatly shape women’s access to abortion. This chapter investigates abortion experiences and locates when and how women encounter the state throughout the process.

Research has pointed to the link between contraception and abortion in terms of health care treatments, yet so rarely state officials or even activists link the two in terms of politics and organizing. Both birth control and abortion remain common segments along women’s extended reproductive history, and so the two issues are not only linked but also intrinsically related. The reality is that, nationally, “over 50% of women will

39 Not all abortions are the result of the failure or absence of birth control. Some women obtain abortions due to pregnancies resulting from rape or incest. Other women may get pregnant intentionally and then decide to abort later for personal or medical reasons. Although the minority, these examples can signal instances where birth control and abortion are not necessary related in the ways analyzed here.
have had an unintended pregnancy by the time they reach the age of 45, and 30% will have had an abortion” (Nickerson 2014: 673). Amid the billions spent nationally for family planning, politicians continue to neglect, more largely, the interconnection between unwanted pregnancy, contraception and abortion. Coupled with an onslaught of restrictive abortion legislation, this trend continues.

As abortion restrictors tout women’s health as their broader rationale, the internal contradiction between anti-contraception and anti-abortion becomes all the more palpable. In a US Senate debate in the late 1990s, one politician declared, “It is a very arguable assumption at best to say that the declining abortion rates are a direct result of pregnancy prevention services” (Marston and Cleland 2003: 6). However, research shows that, over the last two decades in the US, publicly subsidized family planning and contraceptive use have prevented 20 million unwanted pregnancies, approximately nine million of which would have resulted in an abortion (Deschner and Cohen 2003: 10). Research also demonstrates that restrictive abortion legislation does not automatically lead to lower abortion rates. Yet instead of reforming comprehensive sex education and opening family planning services, politicians and pro-life activists continue to peddle legal overregulation as the sole means of reducing abortion.

If contraception and abortion were to be considered hand-in-hand within public debates over reproductive rights, we could more appropriately frame abortion as an

---

40 Those countries where abortion is legal and is paid for by national health insurance policies exhibit some of the lowest rates of abortion while many South American counties, where abortion is still illegal, have some of the highest rates. Specifically, abortion rates in the Netherlands, where abortion laws are more liberal, are approximately six times lower than the Dominican Republic. Additionally, “the abortion rate in Germany is less than one-quarter that in Colombia” (Deschner and Choen 2003: 8).
additional method of fertility regulation. Thereby, we can begin to normalize abortion as a part of reproductive lives, just as contraception has been previously. Further, connecting the two paints a more accurate picture of pregnancy (and its prevention) as a process. In other words, “Common sense and an elementary understanding of the biological determinants of human reproduction indicate that contraception and induced abortion represent alternative means of achieving the same aggregate level of fertility in a population” (Marston and Cleland 2003: 6). Perhaps more significantly, this approach also regards reproduction itself as a spectrum, encompassing a range of issues women encounter. Although this dissertation has (ironically) separated experiences with contraception and abortion into distinct chapters, I contend it is more an organizational decision than an analytical one. Delinking the concepts not only cultivates deeper initial examination into each realm individually, but also preludes and then fortifies the greater connection between the two.

More precisely, this chapter will examine women’s experiences of securing an abortion in Phoenix, Arizona. The sample size is small (n=5), stemming in part from the difficulties associated with recruiting women to share their experience about such a personal and stigmatized medical procedure. Indeed, a recent initiative calls for women to “come out” and disclose that they had an abortion in order to relieve some of the stigma surrounding the procedure. Still, “…there's not one kind of abortion story. We're all very different people and we all have different experiences and different emotions. And all of those experiences should be honored and heard and listened to and shared….So we feel safer to tell our stories” (Madera 2016: n.p.). One supplementary account I have chosen
to include in the analysis is the story of my own abortion experience in March 2016. Utilizing auto-ethnography not only offers invaluable insight into abortion in Arizona, but also complements participant data. This, combined with my in-depth interviews, can offer a first-hand look at the processes by which a woman handle unwanted pregnancy.

Like the previous chapter on contraception, this analysis proffers a better understanding of the role of the state in creating barriers and/or facilitating passages to securing abortion. Narratives demonstrate agency in the ways women procure information on sex, face restrictive policies, unravel intricate bureaucratic mechanisms, and ultimately reconcile their choice to abort with the current landscape of restrictive policy and social stigma. Compared to women’s experiences with contraception, isolating where and when the state “shows up” in abortion is more palpable. The state is not only a central determinant of access to birth control (and Plan B), but also a conduit to the availability and workplace practices of abortion providers. Women directly encounter the state along pathways as they grapple with the presence of abortion protesters, mandatory wait periods, and ultrasound requirements.

In the end, research shows that abortions are often a common part of women’s reproductive lives. However deciding to abort is a complicated process, in which personal beliefs and socio-economic location transpire on a backdrop of tangible regulations and public hostility towards abortion.

\footnote{Italics mark my personal narrative throughout the chapter.}
Before the Abortion

I knew I was pregnant. I just knew my body felt different than normal – physically and mentally. I missed my period, and had intense tenderness and pain in my breasts. My mind was processing differently too. I was unusually sensitive and weepy about inconsequential things. Even as I took the first test, I tried to convince myself pregnancy was impossible. As someone who had taken her fair share of false pregnancy tests, I figured this would be a repeat experience. Unfortunately, after three minutes passed the pink plus sign in the results window gave me the biggest shock of my life. “Holy shit, I’m actually pregnant.” Since this was the first time I’d ever been pregnant, part of me felt a little relieved knowing I could actually conceive. The relief was short-lived for while I realized I could biologically create life, I also knew I did not want to take this pregnancy to term. The context was this: it was about 8 months shy of my PhD graduation, my partner and I were in a brand new relationship, and I was not financially stable enough to support another life. While my first inclination was to abort, I did consider what keeping the fetus would be like; a process of playing a game of “hypothetical life visions” with yourself. In the end, all trains of thought led to abortion. For me, the decision to have an abortion was simultaneously the most selfish and selfless act of my life – revealing just how complex these situations can be.

The moment that a woman discovers she is pregnant can produce an assortment of emotional responses, and represents another point in one’s reproductive life course. Met with a range of thoughts and emotions, women often express suspicion that they are pregnant before confirming it with a home pregnancy test. Kelly recalled, “I started crying… I was so panicked and it’s, like, such a moment of disbelief because you never think it’s something that’s actually gonna happen. And, like I said, I took the test to rule it out – and casually flipped it over, and it was positive. So I, honestly, like hyperventilated, like couldn’t breathe.” Others reacted with laughter instead of tears. Helena recalled that when she discovered she was pregnant, “I laughed…then I cried. Like are you fucking kidding me? I could believe it, but I couldn’t at the same time.” Another participant remembered not knowing enough about reproduction to even consider pregnancy a possibility at that time. Korinne recalled, “But being an only child…from divorced
parents, neither of them wanted to be the one to talk about it. So I went to the doctor and originally I thought I was just sick, or something like really wrong with me. I went in and the lady is like, ‘Could you be pregnant?’ And I’m like ‘No, that’s silly.’ Like I didn’t even think that was an option. She came back and was like, ‘Well, you are….so here’s the options.’ ” Overall, women reported just how abruptly the reality of an unwanted pregnancy struck them. These initial moments involved a mix of feelings including the reality that a decision must be reached, one way or another.

Realization of pregnancy is one point where the state’s explicit influence is noticeably absent. In other words, the moment one’s discovers she is pregnant is characterized more by inward introspection of one’s life and less by outward anxiety over legal restrictions and state politics. This is not to say that differential experiences of state law do not shape one’s economic security in the context of abortion, or lack thereof. But rather, upon detection of a pregnancy, prevailing social ideologies of reproduction and stigmatizing state legislation often remain peripheral as women process their current situation on a more personal level. Women weigh their options based on available financial resources, social support, and individual circumstance. Half of participants knew immediately they wanted an abortion, while the other half was less sure at first.

Contrary to popular tropes wherein women agonize over the decision to abort, some were quickly quite sure of their decision. Korinne described, “There were a lot of factors that went into that. I was 18, living on my own, I didn’t have any parental help, my boyfriend was a loser; he had no job, I was paying for everything. At that point, I hadn’t really spoken to my dad in years. My mom was oblivious. So for me, like, I felt very alone and like nobody was there.” She continued, “The first thing she said was,
‘Here’s the options if you wanna keep it.’ And I was like ‘NO! I need another option.’ It’s so strange to me, and like I think it’s a little sad that I was like never on the fence. I was like, ‘No, this isn’t happening.’ ” Again, her decision was mainly based on life circumstances at the time, stating that if a pregnancy occurred now, she may make a different decision. Moreover, others felt an immediate need to remove the fetus.42 Alicia recalled this initial sentiment, “But yes, like my immediate reaction…the first thing I said was, like, ‘I need to get rid of this. I need to have an abortion.’ ” Deciding to abort can invoke a range of thoughts, but is not always the tormenting, selfish choice frequently depicted.

In contrast, other women required consideration of other factors before committing to a decision. One woman wanted to see the ultrasound before committing to a decision. Helena stated, “I, like, did an ultrasound cause I’m like, if I see the baby and still feel the same, then I’m making the right decision.” Sally weighed her options by what would be best for the growing fetus before deciding. She remembered, “It bothers me too is when people say, ‘Oh give it up for adoption.’ Then what? Kick it into our foster system? When I was in elementary school there was a foster kid in my class…and he was f*cked up. I had seen first hand what foster care does.” After personal deliberation, she expressed a sentiment that having an abortion was a selfless decision, not a selfish one as often publically portrayed.

42 Similarly, when I discovered I was pregnant, I also felt a very strong and immediate urge to get the fetus out of my body as soon as possible. Aside from clearly wanting an abortion, pregnancy made me feel as if my body was being invaded by a foreign entity. Additionally, since I am hyper-aware of the timeliness and costliness of the procedure, I wanted to start the process sooner rather than later.
While some were surer of their decision than others, it is these initial moments that often lead to a first visit to a doctor or clinic for abortion. Still, at this stage, narratives suggest that the state and its influence merely lingered in the background. Aside from general knowledge about law or awareness of political debates over abortion, women seemed to live their lives without much consideration for regulations on abortions in the state. In fact, none explicitly mentioned Arizona abortion policies as influencing their decision to have (or not have) an abortion. Personally, even though I was nervous about the process of aborting in Arizona, the political and legal hostility did not deter me. Even in times of illegality, women with economic means who experienced unwanted or risky pregnancies persisted in obtaining abortions. Currently, as abortion is now legal but both restricted and regulated, women from varied socio-economic footing face a different set of challenges yet continue to persevere when termination is preferred. Ultimately, once the decision has been made, most women will put themselves through the process necessary to obtain the procedure regardless of any requisite legal, financial, and cultural hurdles demonstrating a kind of agency and tenacity.

Contraception, Plan B, and Abortion

Not only have I tried almost every hormonal birth control available, but I also took Plan B a handful of times. In more recent years, I stopped taking hormonal birth control because of physical side effects and inconsistent sexual intercourse. When I began a new relationship, I stayed off the hormones but we actively used condoms, coitus interruptus and ovulation tracking to avoid pregnancy. Even on the one instance that the condom broke, we drove 20 miles out of the way to find the Plan B pill. A month later, I realized I was pregnant for the first time in my life.
Conservatives often attribute national declines in abortion rates to restrictive legislation, yet others argue this results from other factors. In addition to Arizona, national legal abortion rates among 15-44 year olds have been declining steadily from about 22,000 abortions per year in 1991 to approximately 12,000 in 2015 (Sagna, Gupta and Torres 2016). Jodi Liggett, director of public policy for Planned Parenthood Arizona, contends that access to long-acting reversible contraceptives (LARCs) such as the IUD explains much of that downward trend. Additionally, Arizona State Health Director Will Humble believes growth in awareness of and access to Plan B also has decreased the number of abortions across the US (Ye Hee Lee 2014). Since 2013, emergency contraception is available over-the-counter without proof of age (Sifferlin 2013). Additionally, the ACA along with many state Medicaid programs increased coverage for LARCs, while national initiatives like the Contraceptive CHOICE Project worked to expand access (Secura et al. 2010). While access to these hormones has been significantly expanded, both also agree that culture around teen pregnancy has influenced the change. “Aside from Plan B, young women are focused on the fact that teen pregnancy is not a good thing, it can be avoided ... and planning a family is important” (Ye Hee Lee 2014: n.p.).

Many women in the study cited relying on the Plan B from time to time, especially when they had not properly taken birth control hormones or did not use any contraception. Helena recalled, “Oh yeah I’ve taken the Plan B pill. I’ve taken it like three times.” Alicia also said that clinic staff was interested in Plan B use before the pregnancy. “They were mostly interested in if I used Plan B. And I did, and it failed. So they were pretty interested in that. And it’s fucking expensive - like seventy-five dollars.”
Notably, three participants in the study (Helena, Alicia and myself) cited taking Plan B after unprotected sex and still getting pregnant. However, I have taken the Plan B approximately 8 times in my reproductive life and pregnancy resulted only one time.

Raquel, from the contraception sample, expressed a guilty sentiment over taking Plan B, comparing it to having an abortion. She went on to describe that even though she understands the hormones in the pills she takes everyday serve the same purpose, she reacted more emotionally to taking the Plan B pill. Because women rely on a range of interventions to prevent pregnancy, and because emergency contraception has become staple in recent debates over abortion, awareness and access to Plan B remains pertinent.

Finding an Abortion Provider

After the positive pregnancy test, the first thing I did was schedule an appointment at Planned Parenthood. Honestly, PP was the only place I even considered to do the abortion because I always had pleasant experiences at their facilities and I knew they were actually able to perform abortions at that facility. Within a short time, I found the direct number to Planned Parenthood AZ. This number connects to an operator for all PPAZ locations and luckily she was able to book an appointment for pregnancy confirmation at my preferred location. I did not have to wait on hold at all and was able to talk to a real person, which was helpful. This call was easy, seamless and immediately made me feel more relaxed about the whole situation – like I knew the process to get an abortion had been started.

I went in for initial appointment to confirm pregnancy in the morning on a Saturday. There were a handful of protesters outside the facility every time, which always set an uneasy tone as I walked in. Being screamed at by a man on a megaphone is unsettling regardless; being screamed at about what my “unborn baby” would say to me elicited a deeper emotional reaction. Their presence in no way triggered reconsideration of my abortion decision, but instead momentarily pissed me off. Even now, I have the deep urge to yell, “Fuck you!” to the man with the megaphone. The staff spoke of protesters as less of a real problem, and more as an annoyance for PP patrons. “What do they think yelling at young women is going to accomplish?” one commented to me. Not only do they use morbid signs and megaphones, in my experience, they also try to talk to and approach you upon exiting the clinic. It is one thing for someone to disapprove of or even condemn abortion, but this brand of protester doggedness borders extreme and
irrational. This was a true test of my patience, especially in a context of unknowing outsiders actively passing judgment on my life decisions.

After making the decision to abort, women needed to find out where to obtain the procedure. This marks the first point that women encounter the state more directly along their journey to abortion. State policies ultimately govern which Arizona health clinics are able to perform abortions, and consequently establish the pool of potential locations available to women. Regulations that limit the number of abortion providers (e.g. Arizona TRAP laws) can be detrimental especially for women living in rural areas with limited health care options to begin with. Currently, there are 19 clinics in Arizona that are able to legally perform the surgical procedure or prescribe the abortion pill (Sagna, Gupta and Torres 2016). Luckily, the women in my sample had relatively close access to abortion providers by living in the Phoenix area, traveling fewer than 15 miles to clinics on average.

Notably, all women, myself included, obtained abortion services through Planned Parenthood clinics in Arizona. Initially, concern with finding a clinic location and scheduling an appointment was more imminent than fretfulness over insurance coverage and cost associated with the procedure. Kelly recalled going to Planned Parenthood because that’s what she normally associated with the abortion procedure. “I mean if it was me for sure keeping the baby I would have called an OB or a regular doctor, but I knew I wasn’t going to.” Moreover, making preliminary appointments with PPAZ were easy for some and more stressful for others. Sally remembered that one of the hardest parts of getting an abortion was making that first, initial appointment, stating, “It really was [the hardest part]. Once you were there, you made all the appointments through them
really.” Other participants were able to make this first appointment online or over the phone. After accessing the initial appointment, subsequent office visits were scheduled in person. PP facilities are often seen as invaluable and affordable resources for many women seeking abortion.

Although convenient for women, relying on Planned Parenthood in Arizona increases the likelihood of encountering protesters outside of their clinic locations. About half the women in the sample experienced the presence of pro-life groups demonstrating outside a PP medical facility. Kelly, a devout Catholic who struggled with her abortion decision, was appalled with protester activity. While she largely claimed an anti-abortion stance, to her, protester harassment seemed both counterintuitive to the pro-life agenda and unrepresentative of broader religious values. Protester presence is viewed more as an annoyance than a threat, despite the severity of the messages like: Babies are murdered here, PP ≠ women’s health, What would your baby say?, How will you deal with the guilt?, Honk if you condemn PP, and others including graphic images of aborted fetuses. Sally also recalled, “So there was only two of them….but they had a megaphone. I put in my headphones and listened to music. So they had signs like ‘You’re going to hell!’ ‘Leave this place of death!’…all this stuff. I was a little bit nervous, but mostly just about the procedure. I didn’t have any doubts that I wanted to do it or anything.” None of the female participants who confronted protesters had second thoughts about the abortion as a result of these interactions. However, this is not to say that their presence and their words cannot incite emblematic feelings of social stigma for women. In fact, state regulation of protester activity outside clinics speaks to the potential burden and psychosomatic corollary of their presence. Protesters at Planned Parenthood have become
nuisances that women seeking abortions in Arizona are forced to tolerate throughout multiple compulsory visits prior to and even after the procedure.

Mandatory Wait Period for Abortion

Mandatory waiting periods before obtaining an abortion is a controversial regulation in Arizona because of the multiple burdens it places on women. The logic of these laws is to force a period of reflection upon women seeking to terminate pregnancy. In Arizona, patients must wait 24 hours after the ultrasound to obtain an abortion. According to Alicia, she had to wait “twenty-four hours from when we called to make the appointment.” However, these regulations imply more than just extra time to think in the context of abortion. The mandatory wait period “usually means a second visit, often requiring another day off work for women and extra staff for the clinic.” (Zerwick 2014: n.p.). In fact, with the way abortions are scheduled by PP, the 24-hour wait window seemed nearly routine among sample participants; women expected that they must go in to confirm pregnancy and then return for the abortion procedure another day. Although the women interviewed felt mostly unburdened by the waiting period, other women may find it more daunting or onerous, especially those seeking abortion at later point in their pregnancy, or those living more than 15 miles from a local clinic. As clinic abortion fees are determined by gestational age, these wait periods may also potentially increase the costs of abortion for women.

However, among my participants, the general consensus from participants is that they should not just walk into the clinic and get an abortion the same day. Their sentiments reflect less a legal consciousness, per se, and more a consensus that abortion is
a morally contentious decision and being required more time to think is acceptable. Korinne recalled, “They said, ‘OK, we’re gonna give you a day or two to think about it and then we’re gonna make another appointment and you can come back. Which is fine, I mean, that’s a big decision; you should probably go think about it.” Further, since many women were aware of the wait period requirement prior to their own abortion, they came to experience it as a normalized part of the process, representing a moment where women came to internalize certain laws regulating abortion. Although my sample seemed relatively accepting, these mandatory waiting periods are not without contention and controversy as research divulges the ways they do, in fact, create an undue burden on women seeking to terminate pregnancy.

During the Abortion

*Abortion Facilities and Clinic Staff*

The ways abortion facilities operate are in large part determined by state policies in Arizona. Since recent TRAP laws, both the physical building and staff protocols have become standardized, creating a unique context in which women engage abortion in Arizona. With pro-life protests outside, Alicia felt that the conservative political message followed her into PP. She specifically commented on the setting in the waiting room of the clinic, “I can’t remember if it was called the 500-Club or the 700-Club, on. It’s this really religious show with like these preachers and pastors, like right wing, and it was on in the waiting room. Because it was such, like, conservative rhetoric.” Her partner even asked that the channel be changed and staff claimed not to have control over the TV channels. While most research focuses on women’s access to the procedure itself,
terms of legality or location, the seemingly minor detail of what is broadcast on the TV in the waiting room indicates how many less obvious aspects of the process can shape women’s experiences of getting an abortion.

Further, understanding interactions between staff and patients in this context are key parts of analyzing women’s encounters with the state. Women expressed generally positive experiences with staff at Planned Parenthood Arizona. Helena specified, “It was that they let you know everything that’s gonna happen before it happens. And that you don’t ever feel judged. I mean I know it’s their job and they deal with it everyday but still.” Of her experience with Planned Parenthood staff, Korinne stated, “What I liked about them, like they didn’t make you feel like you were making the wrong decision. Like I feel like they were supportive in whatever way.” Sally shared similar sentiments of safety and consolation as she recalled, “And they ask you every time you go in to make sure you are not being coerced, that this is your decision, that you feel safe in your relationship. They really go above and beyond making sure that this is your decision.” In addition to nurses and medical assistants, Kelly reported positive interactions with the doctor as well. She felt ease when she was able to see the same physician upon returning visits, recalling, “She’s really sweet, she’s really nice, no judgment, she’s very good at what she does. She definitely has a passion for what she does.” Some even explained that the staff seemed well prepared to deal with the conservative political climate around the facility. For example, after the abortion procedure, they called her partner to pick her up from a back entrance to avoid protesters. Sally explained that this was “really professional. It’s really great. It shows that they know what kind of environment they are dealing with here in Arizona.” By using this back service entrance and security
precautions, PP remains painfully aware of the political context in which they operate and act accordingly to protect women. Narratives show the lengths that PP staff members go to make women feel supported and comfortable in the context of pregnancy termination.

Others described their experiences with staff as pleasant but more mechanical, robotic or scripted. In fact, it was quite obvious to some that the staff has a strict protocol to follow for dealing with abortion in Arizona, beginning with how ultrasounds are handled. Alicia stated that medical service staff members at Planned Parenthood,

...weren’t overly, like, understanding or sympathetic. Not that you’d like expect people to sympathize with you, but if anyone would, it’s probably the folks at Planned Parenthood, But they were really, I would say, neutral to cold. Not like judgmental necessarily, but just very... mechanical. Like ‘This is what we do.’ Like, no regard for, like, how you might be feeling.

Helena recalled a similar experience with her ultrasound reading, “They read this thing to me and they were like, ‘Just so you know your baby has this and this. And webbed fingers, webbed toes and at this point in the stage.’ Like they have to tell you all this stuff and I think Arizona requires them to tell you.” Sally also described the protocol of the staff interaction as determined by the state, “[The staff member said] ‘Like ‘I am legally required by the State of Arizona to tell you there are three options: you can go to term, you can adopt, or you can abort. If you go to term, we can provide these resources. If you choose to adopt, we can provide these resources for you.’” Women noted the robotic quality of these interactions as off-putting. So while staff members do have some say in
how they interact with patients, they operate according to strict guidelines, especially when facilitating pregnancy termination.

Interactions with facilities and staff constitute the most public and interactive component of the abortion process. Here, women potentially encounter the state in a number of ways. First, state law determines physical operations of the facilities and although women do not feel/see this directly, it can change the experience. These laws have the power to dictate how staff interact with and provide information to patients. They also delineate which medical staff members can perform certain tasks in this context. For example, one participant had to return for an intra-vaginal ultrasound a second time because a certified technician was not available that day. She recalled that they informed her that others in the clinic could perform the ultrasound, but state law required the certified staff, which required more time and money. Ultimately, while most reported staff as pleasant and professional, their often robotic and mechanical nature was distasteful for some. This segues to the ways Arizona law also determines the ultrasound screening required to obtain an abortion, including staff protocol on the information offered and questions asked.

**Ultrasound Image Requirement**

*First, I paid for the office visit and my copay was $35 dollars with university health insurance. This appointment was to confirm pregnancy through intra-vaginal ultrasound, which is necessary before one can proceed with scheduling an abortion. Before the ultrasound, the medical assistant asked me a series of questions about my medical history and sexual health: Am I in a relationship currently? Does my partner know about the pregnancy? Have I ever been physically abused? Ever been forced into pregnancy? Forced into this abortion? Ever had a positive STI test? Etc. In addition, she asked if this was an unwanted pregnancy, and then whether I wanted to view and/or print the ultrasound image during the visit.*
Ultrasound (or fetal) image requirements, deployed by the anti-abortion movement since the 1970s, remain controversial within the legal debate over abortion (Petchesky 1987). Those who support image requirements argue they will help to deter women from abortion, while opponents argue they represent yet another state interjection between patient and doctor. Phoebe Zerwick, an award-winning investigative journalist, argues,

Sonogram restrictions are unique in that they target women, with the intention of changing their minds. Pro-life advocates believe that seeing an image of the embryo or fetus will persuade patients to carry their pregnancies to term. Pro-choice proponents view the laws as insulting; they also argue that these restrictions can add unnecessary costs for a patient and intrude on the privacy between her and her doctor. (Zerwick 2014: n.p.)

More, scholars contend that fetal imaging before abortion is a governmental apparatus of the “panoptics of the womb,” which aims to maximize medical control over pregnancy and establish normative behavior for the fetus at various gestational stages (Petchesky 1987: 277). In terms of cultural implications of this technology, ultrasound images problematically represent the fetus as primary and autonomous, and the woman as absent, or peripheral, or as solely a womb. In fact, pro-life activists in the 1970s and 80s campaigned for fetal personhood using ultrasound images to increase public presence of
the fetus in a visually oriented society (Ibid.). Still, what impact do ultrasound images really have on ground-level abortion decisions?

Researchers at the University of California, San Francisco suggest that sonogram image requirements rarely change a woman’s decision to abort. In one of the largest studies to date, out of 15,168 pregnancies at 19 abortion clinics, only 1.6 percent of women who opted to view fetal images decided not to terminate (Zerwick 2014). Of those who were less certain of their choice, only 4.8 opted to continue the pregnancy (Ibid.). Currently, there are three states43 in the US that mandate women seeking abortions to view the ultrasound and hear it described to them; Arizona is not one of them (Zerwick 2014). Instead, Arizona regulations require that women are offered the option to see the sonogram, and some even must sign a waiver if they opt out.

Regardless of personal preference, Planned Parenthood standard practices require that every woman terminating pregnancy must first confirm pregnancy with intra-vaginal ultrasound. Following Arizona law, each patient is then given the option of viewing the fetal image and obtaining a printout copy. Sally participant remembered the awkwardness of this interaction, “…this was really weird; they asked me if I wanted a print-out of like, is it called a sonogram?” Kelly recalled this moment, “Yeah, I didn’t have to look at anything. But they asked if I wanted to see it.” Although none of the women in my sample were forced to view an ultrasound image of a fetus during pregnancy confirmation, participants express that this moment in the process was still intense. Alicia recalled her experience of the ultrasound,

43 These states include Texas, Wisconsin and Louisiana.
I could see everything. And they were like ‘Ok, here’s the head.’ Blah, blah, blah. And then they were like, ‘Here, do you wanna listen to the heartbeat?’ I remember that and I was like, ‘No.’ They didn’t say like, ‘Absolutely, look at this sonogram. You’re forced to.’ But…it’s like right here. And they’re pointing out, ‘Oh, here’s the head.’ Yeah, whereas [her partner] would’ve definitely had the option to leave the room. You know, they don’t give a shit if he is looking at it or not.

This speaks not only to the place of fetal images in the abortion process but also to partner roles. Being given the option to see a fetal image may potentially influence the entire abortion experience, even if it does not alter a woman’s decision. For some, just knowing the image was on the screen next to them was uncomfortable. The data show that even state laws that allow women to opt out from seeing the ultrasound may still influence the process in unforeseen ways, and can add a level of intensity to the experience. Yet for some, the ultrasound, including fetal image viewing, was regarded merely as a mundane, routine medical procedure. Here is another way that women come to encounter the state and its policies along pathways to abortion.

Cost of Abortion

The cost of abortion abruptly became a central concern during the process of securing pregnancy termination. The moment women discovered pregnancy and settled on abortion, monetary cost mattered little. In other words, once decided, women were

---

44 While outside the scope of this project, the absentee or flexible role partners play in both contraception and abortion requires further analysis.
unlikely to be swayed even by staggering abortion prices, especially considering that the cost of child rearing is exponentially greater. National research shows that average first-trimester abortions cost approximately $470 in 2009 and that “most patients pay for their abortions out-of-pocket, although some use Medicaid [20 percent] or private insurance coverage [12 percent]” (Kliff 2016: n.p.). Planned Parenthood Arizona sets the price of the abortion depending on gestational age of the fetus, and whether one opted for the abortion by pill or via in-clinic procedure. Basically, “Both were the same exact price.” The PPAZ uniform price sheet\(^\text{45}\) plots out the price increases by gestational age; naturally, the farther along, the more the procedure costs. According to the PP document, the fee for in-clinic abortions ranges from approximately $515 to approximately $1225, which must be paid prior to the abortion. Alicia remembered, “They made us pay first. – I remember that. Yeah, like they ran his credit card through the machine, it made it through. Like, it was \textit{very} clear that if you didn’t have the money, like, you’re outta there. Very clear.” In this context, once women locate an abortion provider, they can face a large financial burden that only increases the longer one waits.

Therefore, depending upon insurance coverage, personal income, and gestational age, the cost of an abortion varies greatly by patient. Kelly woman got full coverage of the procedure from her insurance and paid nothing out of pocket. Sally was eligible for a state grant to help with the cost of the procedure. She explained, “Total I paid $260, which was cheaper than they had originally told me because we called to see if we qualify for a grant. It’s called the AAF Grant I think.” While Sally got financial

\(^{45}\) This document can be located in Appendix F. Unfortunately, there was little official explanation for rationale behind this payment breakdown, but I presume it is because these later procedures come with higher risks and require more medical attention, staff, and aftercare.
assistance for the abortion procedure, she still had to pay $75 out-of-pocket for each ultrasound during the process. As such, one must not only consider the price of the abortion itself, but also out-of-pocket costs associated with office visit co-pays, blood tests, urine analysis, and ultrasounds needed beforehand. Helena, a 23-year-old with no health insurance, recalled paying $500 out-of-pocket for the abortion procedure, and had to pay approximately $100 for the pregnancy test and intra-vaginal ultrasound prior to the abortion. Costs can begin to add up relatively quickly especially if any complications or time-delays arise.

Initially, women lacked even general estimates on expected costs of the entire abortion process, which can be more troubling without insurance coverage. Alicia explained, “It was seven hundred dollars. It was like if the pill didn’t work, you agreed to the procedure they do after nine weeks. Yeah, that was like…three thousand dollars.” This participant had parental insurance that offered complete abortion coverage, but she could not use it; she was not prepared to tell her father about the abortion. Others had issues with insurance providers refusing to cover elective abortions. Sally explained, “It’s a nightmare getting through to my insurance….With my insurance, the only way they will cover any kind of abortion procedure is if it comes from rape or incest. So everything was kinda on us for it, which is kinda the main reason we went to Planned Parenthood….They do try and help you with whatever.” Others do not have health insurance coverage at all which comes with its own consequences. Helena was still not eligible for state funds as she recalled, “I didn’t qualify for even a dollar of assistance, because I make too much money.” In fact, she told me that, in the long run, it actually ends up being cheaper for
her to *not* have health insurance, avoiding monthly fees and large yearly deductibles. The vast inconsistency in abortion cost presents yet another potential roadblock to abortion.

Although women elected to get the abortion, concerns with monetary costs lingered throughout the process. Further, many were surprised to discover how costly abortions actually are. Alicia said, “I had, like, the misconception, not that it was free, but not seven hundred dollars, and certainly not the three thousand if I would have been nine weeks.” While the PP cost breakdown implies standardized pricing, closing costs of abortion, including co-pays and medical tests, can end up being much more than planned. Women often had to financially plan and strategize in order to afford the abortion, amid day-to-day expenditures. She further expressed relief over her partner covering the cost, “Yeah, I can’t imagine… if I went through this on my own, or he didn’t have the money. I wouldn’t have had the money. I don’t know what I would’ve done.” This speaks to a larger societal issue where class and reproduction intersect in a nation where you can have anything as long as you can pay for it:

> There are certainly women who have an unwanted pregnancy, and wish to terminate, and don’t have the funds to. I’ve seen people that are as much as 20 weeks, and when we get to that point, our services are jumpin’ to roughly $2,000, and if they don’t have $340, they may not have $2,000…That might be financially impossible for the patient to get in a timely manner. (Dennis and Blanchard 2013: 245)
As past research focused on situations where women are unable to obtain abortion, success stories shed a different light on these processes. Again, the cost alone of abortion can place some women in precarious situations in terms of reproductive decisions. In fact, when asked about the most burdensome part of the process, Helena stated outright, “The money.” While all the women in my sample successfully obtained abortions, it remains crucial to consider the larger implications of a system that makes abortion such a burdened and costly process. Ultimately, it is key to denaturalize women’s duty for reproduction and scrutinize state reciprocity (or its absence) amid the onslaught of restrictive policies on reproduction.

Two Types of Legal Abortion

In the context of terminating pregnancy, women must determine whether they should have an abortion by pill or surgical procedure. In 2011, US abortions by pill accounted for 23 percent of all non-hospital abortions, and 36 percent of abortions occurring before nine weeks (Jones and Jerman 2014). However, more recent studies in Arizona show increases in surgical abortion procedures and decreased use of chemical abortion. Specifically, “about 72 percent of abortions for Arizona residents in 2013 were surgical — the highest since 2009” (Ye Hee Lee 2014: n.p.). I surmise the high rate of surgical abortion is because the surgical procedure allows for later gestational age, requires less recovery time and fewer offices visits unless complications arise, all of which save patients time and money overall.

Still, participants made their decision concerning chemical or instrumental pregnancy termination for various reasons. Sally described that, for her, it mostly came
down to time frame, “They do it [the abortion] within like specific times. So like before the first three months, you can take a pill.” Korinne decided that she did not want to have the procedure at all, “And I said to myself, if it’s anything after three months where it’s surgical, I have to…like they’re not like inserting anything in me to suck it out. That was my, like, line. Like that was the line I drew…So I decided to take the pill.” This participant found herself is a rather precarious situation with this pregnancy – she was 18, had a heroin-addicted boyfriend, oblivious parents and no money. She was almost 10 weeks along when she sought out abortion services, and found herself on the cusp of being able to have the abortion by pill versus procedure. She was able to stick to her own line drawn in the sand, but even the slightest of delays could have reduced her option to only the abortion, demonstrating the complexity and time-sensitivity of the abortion process.

For others, the decision primarily involved concerns over added costs and length of recovery time. At first, women often required additional information on both methods of aborting, “I said ok, ‘So what’s the difference between the in-clinic and the pill?’ She says, ‘If you do the pill, it basically forces your body to miscarry, so it will go on a lot longer than the procedure would and you have to come back in another couple of weeks to do an ultrasound to confirm the pill is working.’” With her limited insurance coverage, the ultrasound would have been an additional $75 for this participant. Another recalled that they would be required to undergo surgical abortion if the pill was not successful. Amid advanced gestation, this context has the potential to upsurge out-of-pocket costs by hundreds, even thousands, of dollars. Lastly, another participant opted for instrumental abortion based on reduced recovery time. Helena stated, “With this one, I’ll at least be
able to go back to work.” The option to have the abortion by pill or procedure simultaneously adds a dimension of choice and of complication to women’s exercises of abortion.

The option to procure a chemical or instrumental abortion holds larger implications on the notion of choice within reproductive health. Typically, an abortion by pill is viewed as a more modern way of aborting – less invasive, more private, and perhaps even a bit too easy, for those opposed to abortion. However, the choice to have the abortion by pill is only available in a narrow time window (typically 10 weeks), which can hinder it as a viable option. To illustrate how quickly this time limit can approach, I was already six weeks pregnant on my first visit to Planned Parenthood46. Consequently, many women may discover pregnancy too late to plan an abortion before 10 weeks gestation.

Opinions on the surgical abortion varied among participants. While politicians, abortion opponents or other outsiders frame RU-486 as more convenient, one woman communicated sentiments of increased confidence with surgical abortion and fewer worries over effectiveness of the procedure. Coupled with time constraints, she opted for instrumental abortion because of the added security of being at a medical facility, and having health clinic staff readily available. Conversely, two of the women expressed unique concerns as they refused abortion by surgical procedure. One a devout Christian and the other a devout Catholic, both articulated that the pill seemed more natural as it essentially induces a miscarriage. Already forced to reconcile religious beliefs with abortion, they expressed feelings that instrumental abortion would be more traumatic and

46 *My whole process was finished in approximately one month.*
emotional for both them and the fetus. In fact, one of them reported that she would forgo the abortion altogether if the pill were not a viable option. Their shared perspective reveals the hierarchy of morality associated with the two types of abortion; one dimension of abortion ideology derived from religious discourse. Fundamentally, abortion is imbued with personal values, political dogma, and religious doctrine, and is, therefore, never straightforward.

*Abortion by Pill*

With chemical abortion, patients take one hormonal pill at the clinic, and then another 24 to 48 hours later. Abortion by pill is administered by clinic staff (not pharmacies) and requires a health clinic appointment to ingest the first pill and obtain the second for later use. Korinne remembered many questions from staff before taking the first pill, “Like ‘Are you sure you wanna do this?’ And then, I remember, they put, like, the first pill in their hand and they’re like ‘Ok, this is your last chance.’ ” Women describe how clinic staff stayed to observe them ingesting the pill. Once they took the initial pill, women were given literature to describe side effects one can expect throughout the process. Then, PP required that women be accompanied home. Alicia remembered, “They made somebody come with you to the appointment to drive you home. Then my boyfriend had to watch over me like after to watch for the effects.” Although this appointment required the consumption of one pill, participants cited this office visit taking up to three hours.

Once at home, women described the experience as a painful, heavy menstruation. Kelly recalled, “…then, so when you take it [the other pill] two days later, you have like
really, really heavy bleeding and cramping – like the worst period imaginable. And at some point like that sac of cells passes, and you see it. It was weird.” Korinne remembered the induced miscarriage from the pill as, “… the most painful thing I’d ever gone through. I literally slept because I couldn’t do anything else. It was so painful. Cramping was so bad – but it only lasted a day.” Then, these patients were required to return for a follow-up ultrasound to ensure all fetal matter was effectively passed. While uncommon, one risk is the possibility of remaining fetal matter that may need to be removed through surgical procedure to prevent infection. Fortunately, none of the women in my sample experienced this.

**Abortion by Surgical Procedure**

On the other hand, surgical abortion is a quick in-clinic procedure in which fetal tissue is removed from the uterus via medical vacuum. After payment is processed, clinic staff members take patients back to get a medical wristband, and begin basic triage like blood pressure and temperature. For all PP appointments, only patients are allowed in the back area of the clinic to maintain security, privacy, and a sterile medical space. This rule reflects both the potentially hostile environment surrounding PPAZ, and the need to preserve professional and sanitary medical practice. Some women noted this rule was somewhat inconvenient and annoying as they would have liked the company of a partner or friend, yet others recalled that it made the experience feel more safe and secure.

Next, the staff provided step-by-step instruction on how the procedure would go. While anesthesia is then typically administered intravenously (via IV), one participant reported slight complications. Sally described, “Then she tried to hook me up to an IV
but that didn’t work. So they just had to use the speculum and do three giant needles of Lidocaine. It opens you up pretty wide because they need to be able to see the full cervical opening. I think they kept the Lidocaine needles there to be able to keep putting more in.” Aside from the pain of the needle insertion, she recalled intense cramps and contractions throughout. Helena recalled, “I could hear the vacuum turn on…So you basically just lay back and try to listen to what they’re telling you to do. It took like 3 minutes.” Of the pain, Helena reported little discomfort while Sally explained a drastically different process. Even with the Lidocaine, Sally remembered,

It hurt really bad like while she was doing it because your body is having the contractions and the cramps and it’s a lot a lot of pressure. I don’t even know how to describe the pain. It’s basically like the worst menstrual cramps you’ve had in your life, times ten. That deep, hard-set, cramping pain. And it’s like that for three minutes straight, just really intense pain.”

Helena, who was 12 weeks pregnant at the time of the abortion, remembered her experience as being less painful. She stated, “It was really quick. I remember being in-and-out of there in an hour and half. And I had to have a friend pick me up.” She continued, “Like you don’t feel pain…it’s just a lot of cramping especially after the fact when they’re done. But it wasn’t a bad procedure during. That night I went out and got drunk.” Similar to my own experience, this participant began to miscarry four days prior to her procedure appointment. However, due to gestational age, Planned Parenthood still recommended she have the procedure to ensure all fetal material was removed from the
uterus. Helena recalled, “I had been bleeding for like four days before and I hadn’t passed everything yet. I just wanted it to kinda be done with.”

Once the procedure is completed, patients are taken into a recovery area. They are offered a pad for any excess bleeding. Sally described, “She said it [bleeding] could go on anywhere from three to five weeks. But they do a pad check to make sure you’re not bleeding too much after. They take you into the recovery room just to basically make sure you’re recovering ok.” Patients are then given a variety of different antibiotics and anti-inflammatory medications including Azithromycin, Promethazine, and Ibuprofen. Sally recalled feeling so nauseous after the procedure that she ended up vomiting up all the medicine she was given. “So, of course, right after the procedure I turned to the nurse and was like, ‘I’m going to throw up. I’m letting you know now this is gonna happen within the next 10 minutes.’ So I threw up everything they gave me.” Unlike the abortion by pill, women who got the procedure did not have to return to the clinic for a follow-up ultrasound unless they exhibit signs of infection.

After the Abortion

_Ultimately, I ended up experiencing a miscarriage along my pathway to abortion. Some have commented that I’m lucky I didn’t have to go through an abortion, or that it’s better I miscarried. In all honesty, I just wanted the fetus removed and I would have gone through an abortion to obtain that end. So in no way do I claim to have taken some moral high ground or that “my body knew what was right for me” with this miscarriage – it was simple biology. The miscarriage undoubtedly saved me from the $500 I would have spent on the abortion. But some could argue that miscarrying is just as trying emotionally and physically – experiencing an extended, heavy period pain and bleeding coupled with the fact that I watched myself pass the fetal mass at home alone. Ultimately, this is not a contest to decide which is more traumatic._
Aside from the physical and emotional recuperation, women commonly encounter other consequences following pregnancy termination. After the abortion, participants were solicited about going on hormonal birth control by clinic staff. Helena recalled, “Then after, in the recovery room, they talk to you like about birth control. Like, do you wanna be on birth control? When I told them no, you know, they asked why. And I just had to tell them you know it made me so sick, and I’ve been off birth control this long and haven’t gotten pregnant. I know how to prevent it. I was just an idiot and didn’t.” Korinne woman described staff insisting on birth control to such an extent that they provided her some at that clinic location. She stated, “Another interesting thing that they don’t tell you about at Planned Parenthood after that happens is, after you’re done with that whole experience [the abortion], when they make you come back for your follow up or whatever, they make you get on birth control. Like, it’s not an option.” Although it was offered to all participants including myself, this was the only woman who felt birth control was being forced upon her after her abortion.

Sally’s experience shows how complex and often painful histories with contraception come to inform their abortion experiences as well. She noted that PP staff “ask you 20 times” about getting on birth control after the abortion procedure. She continued,

We’re doing what’s called NFP where it’s natural family planning and you track your ovulation cycles and everything. And so of course she lectured me extensively about how that doesn’t work and that’s basically the same as doing nothing. And it’s like, OK we actually knew we fucked up, but thank you! I knew the exact day we had fucked up. And she’s like ‘well
obviously if you guys had been on birth control this would have never happened.’ She was this old, 75-year-old woman. Thanks grandma! But we’re gonna discuss it more, we just wanna get through this part first. I don’t wanna suddenly have a rush of hormones.”

Raised in a conservative, religious household, this participant had a complicated history with birth control and miscarriages. Painful periods forced her to broach the birth control conversation with her parents early on, which resulted in a tedious process of testing out different hormones that worked with her body. Also, during this time of trying out different forms of hormonal contraception, she got pregnant for the first time and miscarried. At that time she resided in Tempe while her primary physician was in Tucson, which only complicated the process further. This personal history forced her to become health conscious and research more natural ways to prevent pregnancy. She knew she needed to avoid pregnancy (again) and NFP seemed her most promising option. This participant’s personal history with birth control fostered confidence in her knowledge about how not to get pregnant, and allowed her to discern the moment she slipped up. Along reproductive life histories, past experiences with birth control can come to influence multiple moments along the continuum.

Women also shed light on some emotional and relational issues after the abortion. Kelly recollected the worst part of the experience as, “the emotional [part]… like, the fact that he doesn’t have to carry it with him and I do… and telling new romantic partners is nerve-wracking every single time. Cause like you never know someone’s stance on it. They might end it with you, or judge you.” In addition to social guilt, the act of disclosing
an abortion to new people in her life continued to be a major concern. Further, it is
important to interrogate the larger reasons this participant felt a responsibility to reveal a
pregnancy termination in the first place. Alicia found herself particularity bothered by
abortion protests on campus and even comments online, “And sometimes, this seems like
stupid…ok, I’ll say the two scenarios that bother me are the protesters on campus with
the fetus pictures and, umm, internet comments. Like just never read those if you’ve had
an abortion.” Social and cultural stigma surrounding abortion can affect women long
after the abortion procedure is over.

Experiencing an abortion can also influence relationships with friends, relatives
and even employers, especially if time off is required for the procedure or recovery. Sally
explained her interaction with loved ones after the abortion:

I think the most difficult…was going down to Tucson and my mom was there, and not telling her. We made the decision to tell her together, not
that I had an abortion, but that I miscarried, which is the same thing we
told [her pro-life best friend]. Yeah, it’s definitely a difficult thing like
cause I want my mom there for me for it, but at the same time, I don’t
want to feel judged for it. My mom was raised Baptist and converted to
Catholicism.

However, Sally also noted that having the support of her managers at work made the
process easier by simply knowing she could get time off and still keep her job. Her
general manager even gave her more shifts to help out with extra money. “They were
really great about everything.” Because of the enduring stigma and shame assigned to women who abort, sharing an abortion experience with those close to you can elicit varied reactions, and cause both anxiety and comfort.

Conclusions

This chapter illuminates the intricacies of seeking abortion in Arizona. While marked by state law and policy, abortion experiences are also shaped by cultural and political ideologies of pregnancy termination. First, legal regulations of abortion not only impact the ways women prevent pregnancy and navigate abortion, but also their larger legal consciousness. Encounters with the state are signaled not just by legal protocols, but also in the political meanings imbued in abortion experiences, and reproductive lives even after. More, these ideological messages can amplify women’s sense of social stigma. Lastly, not only does the constructed hierarchy of “good” and “bad” abortions remains problematic, but so does the political and public classification of abortion and contraception as morally and biologically distinct. Ultimately, pregnancy prevention and termination mark phases along the continuum of one’s reproductive life history, which prompts a more holistic understanding.

Restrictions on abortion not only shape access, but also inform women’s legal consciousness, and experience of full citizenship with the guaranteed rights that accompany it. Under its current definition, abortion access has been a protected legal right since January 1973 yet women who abort are socially labeled as criminals and murderers within the extended legal fight over abortion. While my data show that some women are still able to access abortion, we must consider at what cost. In Planned
Parenthood v. Strange (2014), Judge Myron Thompson tried to put the right to abortion in terms that everyone can understand, conservatives and liberals alike. His opinion asks us to imagine that “the federal or state government were to implement a new restriction on who may sell firearms and ammunition and…that further only two vendors in the state of Alabama were capable of complying with the restriction…The defenders of this law would be called upon to do a heck of a lot of explaining – and rightly so in the face of an effect so severe” (Planned Parenthood v. Strange 2014: 168). Thompson’s opinion reminds us that some rights cannot be fully exercised without the assistance of others (Greenhouse 2014). Amid impeded abortion rights, experiences of success with abortion can also influence legal consciousness and change the way women think about and engage those rights. This exhibits agency in the face of opposing constraints as they take on the “punishing process” of complex bureaucratic mechanisms and lingering social stigma around any decision over one’s reproduction.

Stifled avenues to abortion are met with cultural and political constructions that also frame experiences. General opinion often treats abortion as if all women experience it homogenously, or, at the very least, suggests good versus bad abortions. Many continue to draw the “dividing line between ‘good abortions’ (such as an abortion in the case of rape or incest) and ‘bad abortions’ (such as those that occur at later gestational ages and those had by women who have had multiple previous abortions)” (Nickerson 2014: 682; and see Rapp 2000). We also witness the ranking of those who have the abortion by pill
and those who have it by surgical procedure. I argue that there is also a tendency to
differentiate between women who abort and those who miscarry unwanted pregnancies.47

Either way, these views neglect the reality that abortion depends very much on
individual context. Korinne stated, “A lot of people act like that kind of thing is very
black and white, but it’s not. That’s why…I get very defensive. And it’s like, ‘You don’t
understand what that person’s going through and you have no idea what’s going on in
their life…” None of the women in my sample expressed disdain for other women who
had abortions; one woman was only comfortable with abortion by pill but did not link
this to a larger sentiment condemning all surgical abortions. More, one woman’s views
on abortion drastically changed once she was faced with the decision herself, prompting a
more full awareness. Understanding the contextual nature of abortion further reveals how
problematic it can be to not only over-restrict access, but also perpetuate the ranking of
abortions and the powerful social stigmas surrounding them.

For those women who have abortions by choice over necessity encounter another
problematic stigma with abortion: the assumption that abortion is always traumatic for
women. Despite the entrenched legal battle and persistent public stigma, abortion is a part
of many women’s reproductive lives48. New US initiatives to disclose, including “I had

47 I experienced a miscarriage during the process of seeking an abortion. Interestingly, I felt the
need to explicitly note in my self-reflection that, by having a miscarriage, “in no way do I claim
to have taken some moral high ground.” This comment stemmed from a larger assumption that
miscarrying is “better” and “more natural” than aborting when a pregnancy is undesired. Even
upon sharing my experience, I received many reactions that echoing sentiments that I was
“lucky” to have a miscarriage over an abortion. In my own mind, whether miscarriage or
abortion, the fetus was bound to be removed.

48 Some women may experience repeat abortions during their reproductive life. Specifically, in
2012, the Center for Disease Control “reported the number of previous abortions for women who
obtained abortions in 2012 indicate that the majority (55.7%) had no previous abortions, 35.6%
an abortion” or “Shout your abortion,” report that roughly three in ten women will have an abortion sometime in their reproductive lives (Quart 2014). And, perhaps more significantly, not every woman considers this a distressing process as commonly maintained by abortion opponents. While the decision may be troubling for some, others experienced it as almost mundane. Helena stated, “It was just another part of my life. You know, I’m not really upset about it. It was simple. I mean, it was a pain in the ass cause it was expensive…but I feel like it was just any normal procedure you’re going to the doctor for.” Political and public misconceptions that abortion is both rare and always traumatic lay the groundwork for increasing federal and state restrictions on the procedure.

Problematically, abortion is often discussed as an isolated, even exceptional, event in one’s reproductive life. The reality reflects that current reproductive experiences are shaped by those previous and, as such, abortion can inform one’s life before, during and after the procedure. Kelly told me, “People assume you are a murderous person or you have a lack of morals and it’s like, no, that stays with you for the rest of your life…It’s not like it’s just gone.” More, the tendency to assume abortion as completely separate from contraception or even antithetical to childbirth is also problematic and counterfactual. Nationally, approximately 61 percent of women that get abortions already have at least one child (Quart 2014). In essence, reproduction is a continuum along which women may experience multiple reproductive issues at different points throughout their lives. The same women who used birth control and obtained abortions are those who later come to deal with fertility hurdles and eventual childbirth. So continuing to discuss and legislate these topics as if they were mutually exclusive is problematic, and signals a

had one to two previous abortions, and 8.6% had three or more previous abortions” (Pazol, Creanga and Jamieson 2015: n.p.).
clear gap between law and social reality. However uncomfortable, politicians, academics and activists must acknowledge that some of today’s mothers are yesterday’s abortion patients.
6. Conclusion

Central Arguments

Currently and throughout US history, the state has been a central presence in debates over and regulation of reproduction, prompting a broader analysis of the ground level impact of law and policy. State legislation shapes sex education in public schools, access and coverage for contraception, where and when one can secure an abortion, and steps towards procreation even after. In doing so, they not only influence pregnancy prevention and termination but also reinforce larger ideological messages on reproduction that come to perpetuate social stigma surrounding women’s choices.

Public and legal discourse must shift to parallel ground level experiences, and the normalcy of both contraception and abortion in women’s lives. Our reality is constructed by a combination of cultural conditions, political philosophies, socio-economic markers, and imbued attendant meanings. So the point is not to say simply that decreased state interference would make the reproductive health care more straightforward and guarantee access. Instead, I argue the need to track the influence of political and public discourse on social stigma, in addition to legal regulation of reproduction. Legal scholar Carol Sanger invites us to consider: what would a society look like that “treated [abortion] as just another medical procedure, one women should not have to conceal or apologize for having?” (Sanger 2012: 859). Within reproduction, the state gets in the business of passing legislation of morality while neglecting the reality that birth control and abortion are ubiquitous in women’s reproductive life histories. In order to fulfill reproductive responsibility, women are compelled to engage contraception and abortion, and more largely, reproduction itself as a socio-legal construction.

186
More, state policies that regulate women’s access to birth control are premised upon a key contradiction: women carry a social imperative to control their reproduction while restricted pathways make it routinely more difficult to do so. As it may seem natural for women to fear an unwanted pregnancy given their biological and subsequent social liability for it, we need to reevaluate onus for reproduction placed exclusively on women. While some could say this sense of reproductive duty reveals women’s larger desire to maintain control of their own reproduction, it signals more than that. Amid convoluted processes, what kind of reproductive control and choice do women really have? The logic goes like this (and I use logic loosely here): First, legislators restrict education on sex and reproduction in adolescent years, often forcing women to blindly seek information on their own. All the while, society places clear expectations on women to prevent pregnancy in light of the lack of education on their own body, the biological processes by which pregnancy occurs, and the possible methods to prevent it. Next, a confusing and tedious process of finding and obtaining the right birth control awaits them. For the sake of pregnancy prevention, women subject their bodies to experiments with various combinations of artificial hormones, and maintain a medication schedule to stay protected. After all this, blame is placed almost entirely on women if an unwanted pregnancy does occur. In fact, my data shows the lengths women will go and the burdensome processes they will endure to prevent having to face an abortion. However, when elected, a supplementary range of barriers and facilitators characterizes experiences securing abortion.

Abortions, and the women who obtain them, are often discussed in an all-or-nothing context, which is dangerous and counterproductive given the current reality. The
decision to have an abortion is linked to all other reproductive experiences in one’s life, and is thus nuanced and complex. The business of ranking abortions distracts from limited accessibility to reproductive health care, as women in my sample were extremely conscious of the state’s neglect of low-income mothers. Alicia stated that, “Pro-life people seem more…pro-birth…because they don’t care what happens to the child after it’s born, they just care what happens to it before.” The state refuses to reflect on the ways this may not only influence the tendency to seek abortion, but other reproductive decisions as well. Lastly, a rigid, all-or-nothing evaluation of abortion experiences neglects the complex reality that, “Arizona women’s decisions concerning reproduction…reflect their diverse views in relation to motherhood, sexuality, religion, and family” that occur along the reproductive spectrum (Melcher 2012: 177).

Furthermore, prevailing ideologies and state policy on contraception and abortions hold larger implications for national values. Religious disapproval of fertility control not only influenced social and cultural customs, but also came to shape (outwardly) secular state law. From this perspective, there is no logical contradiction between restricting information on how to prevent pregnancy, constraining access to contraception, and condemning women for pregnancy out of wedlock or opting to abort. Instead of illegality and criminalization, current regulations create a context where “the process is the punishment” (Feeley 1979). Both historically and today, “individual preferences, private and public conceptions of morality, and political maneuvering swirl around one another in a perfect storm of contention,” to shape reproduction (Sanger 2012: 863). Nevertheless, moral, religious, and political debates rage on over which is worse: hormonal contraception, abortion, or their mutual regulation.
While biochemically similar, distinctions between birth control and abortion remain politicized in the US. Historically, as biological processes, women often understood contraception and abortion to be indistinguishable, and virtually two sides of the same coin in terms of pregnancy prevention (Koblitz 2014). However, due in part to a fundamental misunderstanding of reproductive processes, politicians and activists have worked to legislate and organize around them as distinct issues. More specifically, the political distinction often drawn is that contraception does not involve “killing” a fetus while abortion does (Tonti-Filippini 1995; Mastroianni, Donaldson, and Kane 1990). This simultaneously benefits pro-life groups seeking to limit abortion, while pro-choice groups also use this distinction to help keep hormonal contraception accessible. However, current debates over IUDs, hormonal implants and the abortion pill (RU-486) have further blurred the lines between contraception, abortifacients, and abortion even for conservatives (Mastroianni, Donaldson, and Kane 1990: 50-51). This has important pragmatic implications that will be discussed later.

State law and socio-cultural norms concurrently affect reproduction of women who are unable to obtain contraception and abortion, and those who are successful in accessing them. The United States has a long, complicated history of deciding those “fit” to procreate or not, and in doing so, communicates larger messages about potential mothers “fitting” with national values in the US. Analysis of the impact of regulation has predominantly focused on consequences when women are unable to acquire legal abortions. However, by overlooking stories of those who successfully terminate pregnancy, we risk a more holistic grasp of the bearing of legal regulations on the ground level. More, “There has, however, been little public discussion of the harms women
suffer by virtue of abortion regulation, even when they are able in the end to obtain a legal abortion” (Sanger 2012: 875).

In fact, I argue that those who have had abortions may experience not only a financial deficit from the procedure, but also lingering social stigma. Alicia echoed, “Specifically, I will say, like, the most traumatic part, is not any guilt I feel, it’s like the guilt society tells me I should feel and, like, the shame they say I should feel…”

Terminating a pregnancy can affect women’s relationships and trigger social stigma even years after the procedure as they disclose their abortion to friends and romantic partners. This reality perpetuates views of abortion as rare and eternally traumatic, and widens the gap between legal mechanisms and lived reality. Furthermore, the state denies its own reciprocity in reproduction as it points to other countries as examples of what not to do.

All the while, the submerged US state never affirms how it will foster reproductive health care to match the social responsibility placed solely on women. Ultimately, as data reflects the normalcy of abortion in women’s reproductive lives, experiences of successful abortion should no longer be silenced or relegated to the private realm.

Further, the lingering zeitgeist is that men only want a stake in reproduction when they are pushing more legislation to regulate it. As such, national values reinforce female responsibility for reproduction (and its prevention), and implore women to embrace hormonal birth control and its physical corollaries. All the while, powerful institutions continue to forsake their role in contraceptive research and development, amidst an expanding drug market for erectile dysfunction that offers men 14 different options (Loe 2006). In tandem, health insurance conglomerates invoke legal loopholes to negate ACA requirements of contraceptive coverage. Insurance and pharmaceutical interests
epitomize the male perspective, and in this light, one can confidently argue that men would never tolerate what women regularly encounter. Jane stated, “They wouldn’t stand for it!...If you can put a man on the moon, you can fix these issues. Come on!” This conveys the reality that our society has the scientific and technological proficiency for space travel. Yet it renounces any innovative exigency for confronting the outdated contraceptive market and its myriad of hormonal side effects. In other words, women belong to a society that is amply equipped yet perpetually disinclined to advance modern methods of contraception.

More, reproductive technologies incite examination of the relationship between state law, medical science, and the economic market. Imagining a hypothetical circumstance where men openly use birth control, and have an equal stake in reproduction, still seems quite farfetched in current US society. What would men’s pathways to birth control even look like? Biologist Gregory Pincus investigated the possibility of male birth control in the 1970s while hormones were being initially scrutinized through human testing. However, at that time, contraception was prohibited for male use due to numerous side effects like testicular shrinkage (The Pill 2003). Only recently have we seen additional public discussion on male-oriented contraception. In late October 2016, popular media was flooded with news of a male-oriented birth control study being cut short due to reported side effects (Coulehan 2016; see also Behre et al. 2016). The side effects reported from the injected hormones were “depression, mood swings, increased libido and acne” (Coulehan 2016: n.p.). Although we have seen the correlation between birth control and depression in women (about 30 percent of women
experience it), the study was terminated entirely when 3 percent of male participants experienced this side effect specifically (Behre et al. 2016).

Furthermore, what would abortion look like if the impending, unwanted fatherhood was under male control? Like female reproduction, would their decisions be regarded as “mistaken, ill informed, or too hasty” as to require comparable legal restriction (Sanger 2012: 862)? There is much to gain from conceiving how vastly different birth control and abortion policy would look if men were its focus. While making cultural strides with increased publicity and market presence of male birth control, the dismantling of gendered ideologies of reproduction requires much more. Ultimately, the current paradigm on reproductive responsibility, and the reality it constructs, speaks volumes on current US society and women’s place as (non)reproducers within it.

This dissertation tells the American story of regulating reproduction, and the embedded legacy of racism and sexism in current policies that dictate who gets to reproduce in the US. State law certainly constrains access, but in doing so, it also seeks to normalize paternalistic restrictions on pregnancy prevention and termination in the US. This relays larger messages over who gets to reproduce or not reproduce, as women are chastised for any decision they make. Women who are “unfit” to give birth are unable to access and afford abortion, and then lack government support for childcare – they are branded bad mothers (and more, irresponsible reproducers). The woman who is able to secure an abortion is also stigmatized for not properly protecting herself from pregnancy and for “murdering” a fetus. However, social stigma is often more nuanced in everyday lives as it implies women’s selfishness, irresponsibility, and ineptitude in numerous
reproductive decisions. Women *wrongly* opt to have non-procreative sex, choose the *wrong* sexual partners, get on the *wrong* birth control, *wrongly* use that birth control, *wrongly* use emergency contraception, make the *wrong* decisions with unwanted pregnancy, *wrongly* opt to have an abortion, choose the *wrong* type of abortion, *wrongly* disclose pregnancy termination to others, choose the *wrong* family planning method after abortion, and so on as the cycle of *wrong* repeats itself. This story of reproduction is a socially and politically constructed lose-lose for US women, which must be denaturalized. In this sense, the state sends messages about reproductive behavior not only by its black-letter policies, but also through its stake in maintaining certain stigmatizing ideologies regarding women and their procreative choices. So if the state is a central part of the problem and, in fact, comes to shape the realm of reproductive politics, what is the utility of the state for social change?

Participants rarely saw the state as a central actor, and as such, narratives reflect a complex cluster of both state and non-state influences that convey larger patriarchal messages to women throughout the process. Historically, basic rights and freedoms of US citizenship are derived from the social contract (think, Rousseau, Hobbes and Locke), incorporating the exclusion of women as a means of establishing modern patriarchy. With women as its subjects, men used the (sexual) contract to establish a civil patriarchal right over women (Pateman 1988). As contracts generate political rights in the form of both freedom and subordination, they reflect larger messages on how the entrenched gender hierarchy informs contemporary politics. The social contract also established the male-controlled duality of public and private realms – the natural and the civil domains.

This dichotomy strengthens male conceptions of the proper order of nature, including the
sexual and political classifications foundational to gendered domination. Essentially, “How can beings who lack the capacities to make contracts nevertheless be supposed always enter into” the sexual contract? (Pateman 1988: 6). Certainly, there is much to scrutinize in terms of reciprocity between women and the state in this scenario. In our current context, we must ask: how can women who lack the capacity to decide on abortion be supposed as the arbiters of reproductive responsibility?

In this context, state law can function as a double-barrier for some. First, explicit state laws dictate reproductive health care and, second, complex bureaucratic regulatory mechanisms control medical and insurance organizations. Here the state is both ever present and functioning in the background as its abstruseness shields it from real scrutiny by women. More, the various institutions engaged in contraception and abortion should not be viewed as isolated. Instead these institutions, and their multiple legal levels, are not only connected but also mutually constitutive, which makes it increasingly problematic to isolate state interferences in these processes. This further speaks to the notion that law and the state can seem both familiar and foreign, holding loftier implications for legal (and perhaps state) consciousness. However, past research reveals there are multiple systems of ordering and various legal forms at play here, so it is key to avoid an over-emphasis of law and policy derived exclusively from the state. In particular, absent public criticism, confusing bureaucratic mechanisms not only become normalized but also internalized by those who navigate them. Even amid the legislative focus within activist organizing, there is still much to be done in terms of promoting transparency and accountability within insurance and medical institutions.

Nevertheless, the state remains invested in its prevailing beliefs over pregnancy
and motherhood, and, in doing so, preserves itself as the gatekeeper of human existence (Sanger 2012). And while there is no singular American stance on abortion (or any topic, for that matter), reproduction’s relationship to power reveals that current experiences are framed by historically gendered assumptions. In other words, constructions of normative experience remain wholly grounded notions of male citizenship in the US. State ideology coupled with abortion’s “unmissability in American culture” reflect broader political campaigns that reinforce the belief that abortion itself is more harmful to the health of women and society than the legal regulation of it (Sanger 2012: 870). Even the labeling of state policies in certain ways (e.g. the Unborn Child Pain Prevention Act of 2005 and the Women’s Right to Know Act of 2011) reflects rhetorical maneuvering to further limit abortion, while transmitting broader symbolic messages on gendered roles in reproduction (Andaya and Mishtal 2016). Hyper-regulation of reproduction is not only intended punitively, but also emblematically. The current context communicates that women must be “told when human life starts” as they “do not quite understand what they are doing when they decide to end a pregnancy” (Sanger 2012: 877). Experiences with contraception and abortion are shaped by the values and social assumptions that underlie a “claimed national identity” (Sanger 2012; Nakano Glenn 1994). Women face consequences of social stigma when their reproductive decisions stray from these dominant ideologies.

However, I argue women demonstrate considerable resilience and agency in the ways they confront and navigate contraception and abortion. This project allows a deeper look at the intricate relation between “the corporeal body and the body politic” and the ways “human agency (and its limits) can be seen in even the smallest activities”
(Ginsberg and Rapp 1995: 11-12). Women in the sample were successful in meeting their own reproductive needs and so, in a sense, examining social stigma and legal regulation only reveals part of the story. In contexts of both failure and success, I argue women’s engagement with contraception and abortion offers insight for future navigation of reproductive needs. With either outcome, agency and tenacity in overcoming obstacles are key to understanding reproduction as a socio-political construction that can be (re)negotiated and (re)defined through women’s engagement.

Future Research

In the wake of the ACA, the convoluted interworking of insurance and medical institutions further complicates reproductive health care for women and thus necessitates additional research. Essentially, why are sheer lack of transparency, under-accessibility and inconsistency accepted (and even expected) characteristics of the US medical insurance apparatus? Fundamentally, medical and insurance providers are in the business of selling health to the public. Thereby, the intrinsic social value of health as a human ideal permits medical, pharmaceutical and insurance institutions to functions with certain assumptions. The modern insurance corporations operate on the conviction that people will dimly pay the necessary amount to maintain personal health, regardless of whether they comprehend how that health coverage works. This is yet another branch of the submerged state apparatus in US reproductive politics.

Considering the high costs for even basic health care coverage, it is crucial to scrutinize insurance policies especially given fluctuating co-pays, inconsistent medical coverage, and prescription limitations for the kind of medication, and refill amount. The
selective menu from which women can choose hormonal birth control is also reflective of this reality. Ultimately, this fosters limited legal consciousness on pluralistic medical and insurance policies, with added difficulty of locating the state’s concrete role in our interactions with these institutions. Roadblocks along routes to hormonal birth control are really symptoms of loftier deficits of the US health care system, where women’s reproductive health becomes collateral damage. More extensive research on the interworking of state law, medical protocols, pharmaceutical interests, and insurance practices could prompt much-needed scrutiny of these overlapping systems of ordering to promote transparency, uniformity and unencumbered reproductive pathways.

Moreover, in our pill-oriented society, the pharmaceutical industry must also be probed with additional research. Narratives prompt additional research on the gap between the priorities of Big Pharma and lived experience, and its broader impact on reproductive choice. The drug industry sends larger messages about lifestyle and identity choices, and, in doing so, “reinforce[s] social conventions and fuel[s] social pressures in order to create markets for their drug” (Loe 2006: 170). The current pharmaceutical emphasis on anti-aging drugs has come to neglect reproduction for the sake of billions in profits from the 178 new drugs for symptoms associated with growing old. Birth control development (or lack thereof) transpires “on a medical terrain where the male body is still the universal standard and attention to ‘the woman surrounding the vagina’ is clearly lacking” (Loe 2006: 174). Considering nearly all women must manage reproductive capabilities for the first half of their lives, Big Pharma still stands much to gain from a modern birth control market.

Additionally, it is important that future research analytically trace recent debates
over contraceptive coverage of health insurance and their influence on Big Pharma’s attitudes toward contraceptive innovation. In the context of pregnancy prevention, there is much to gain from supplementary investigation of tenuous relationships between insurance companies and pharmaceutical conglomerates, and their interaction with state law and policy. We face ongoing national discussion over basic reproductive health care coverage like birth control and emergency contraception, while insurance providers offer complete coverage of drugs for erectile dysfunction like Viagra (Loe 2006). This conveys larger ideological messages on the gendered priorities of both Big Pharma and the modern health insurance apparatus. As employers and insurance companies assume (or seek legal exemption from) financial responsibility, it seems likely that most coverage for birth control would be limited to the cheaper, or generic forms. This could imply that even if companies developed new birth control, its coverage, its use, and thus its profits would be constrained, imploring additional scholarly examination. It is critical to understand the powerful interests of state and pharmaceutical institutions and reasons they work to maintain the status quo of the current contraceptive market.

This project highlights not only the embodiment of birth control, but ways women assume roles as experts of their own reproductive bodies. While medicalized birth control is often individual in nature to determine the right hormonal match, there exists a larger desire to not only share information but also embrace collective experiences with contraception. Women persevere not only in obtaining information on sexual health and access to birth control, but also in maintaining contraceptive use in the face of inimical side effects. Decisions of major health institutions initiate a trickle-down effect on
individual decisions to navigate options for contraception. So what is to be said of agency and choice over pregnancy prevention in this context?

Some women decide to cease hormonal use, while other women endure its effects for the sake of pregnancy prevention. Outside feminist research urges us to avoid strict constructions of agency as either resistance or subordination (Mahmood 2001). In other words, “it is crucial to promote the conceptualization of freedom [and choice] as a contextual, rather than universal, practice” (Mahmood 2001: 845). Therefore, false dichotomization of women who desist or endure hormonal birth control “oversimplifies the complexity of contemplation and decision-making” here as well (Hernlund and Shell-Duncan 2007: 55). While some may argue this context stifles agency and choice over pregnancy prevention fully, I argue rather that women negotiate their needs in a context where agency is constrained, but not entirely absent. While policies certainly limit the possibilities for agency, the ways women demonstrate resolve over their pregnancy protection encourages a more nuanced analysis. Nonetheless, humanity persists behind this setting of technology and capitalism, and as such future research must complicate conceptions of agency, resistance and perseverance in this setting.

Pragmatic Implications

Beyond this, current pathways to abortion and the history of regulation of women’s reproduction expose more about the relationship between contraception and abortion. Essentially, there is a fundamental link between contraception and abortion. Research shows that rates of hormonal contraceptive use are one thing that can directly influence rates of abortions procured. Naturally, abortion rates decline when avenues to
comprehensive sex education and birth control are opened for women (Finer and Zolna 2016). Further, an examination of “the cost of government-subsidized contraception shows that expanding the use of subsidized birth control would produce substantial taxpayer savings by helping more women avoid unplanned births [and abortions]” (Haskins, Sawhill and McLanahan 2015: 2). Staunch opponents to abortion should seemingly support comprehensive sex education and contraceptive availability as both are statistically proven to lower abortion rates. However, the point is not about logic, but rather deeply held, often-religious beliefs on morality and reproduction. Nevertheless, treating contraception and abortion debates as mutually exclusive is not only inaccurate; it is also potentially harmful to women in society. Political deliberations and legal decisions that starkly contrast women’s real reproductive experiences not only alter women’s legal consciousness.

More, socio-legal scholars Zakiya Luna and Kristin Luker ask, “What are the limits of law for achieving justice? What nonlegal strategies do people use to overcome those limits? Can justice exist outside of law” (Luna and Luker 2013: 343)? Their analysis demonstrates that rights and their “nominal universalism” are critical to justice in society (Ibid.). However, scholars from various social sciences have warned against an overreliance on the state for social and legal reform. Luna and Luker advise that scholars and activists of Reproductive Justice (RJ) must expand their vision to be wary of legal rights that work to veil institutionalized racism, sexism, classism, homophobia, and ableism in the US (Luna and Luker 2013). Not only does state law work to perpetuate inequality, but legal rights are often “requisitioned by the state to advance its own larger interests” (Franke 2012: 46). However, in her study of domestic violence in Israel,
Madelaine Adelman positions my analysis to account for the “multivalent state with many moving parts that are sometimes in conflict with one another” (Adelman 2016: 232). It is this multidimensional quality that prompts deeper scrutiny on the “cultural politics of the state” that could offer a promising (and trepidatious) pursuit for social change (Ibid.). Robin West holds that current strategies should “urge a broader political argument for RJ in women’s lives that embraces, but does not center upon, rights-based claims” (West 2009: 1396-97).

Practically speaking, linking birth control and abortion on the reproductive continuum is imperative but may have important consequences with regard to organizing around reproductive rights and justice. While reflecting a more accurate comprehension of biology and reproductive experiences, linking the two may have grave implications for the over-regulation of both contraception and abortion. Liberal groups would be able to organize for birth control and abortion in tandem, yet linking the issues could also ignite more conservative attempts at total legal restriction on pregnancy prevention and termination. Insisting upon contraception and abortion as interconnected issues at the public and political level may unintentionally provoke conservative activists and politicians to ban everything associated with curtailing pregnancy. As scholars and activists aiming to open reproductive avenues, material and discursive consequences of this pragmatic reframing must be scrutinized. Ultimately, connecting birth control and abortion on the reproductive continuum would not only reconfigure public debate on reproduction but may inadvertently cause more harm than good for women in the US.

Ultimately, I argue that the concept of reproductive life histories is analytically salient for conceptualizing reproduction as a continuum of various experiences, and
bridging the gap between law and society, within both academic efforts and activism. This continuum can include sexual health education, contraceptive use, abortion, fertility and childbirth. Typically utilized in the natural sciences, reproductive life histories have also been invoked in studies of reproductive experiences among domestic workers in Rio de Janeiro, Brazil and also the Aymara peasant society of the Bolivian Altipano (Pitanguy and Mello e Souza 1997; Crognier, Villena, and Vargas 2002). Within these studies, researchers primarily have used the term to speak to the “database of social, cultural and biological information” on reproduction that is passed down and altered through generations (Crognier, Villena, and Vargas 2002: 5). The term was also used to explain sentiments over sterilization among domestic workers in Brazil as shaped by past reproductive experiences with negative side effects from the pill, male reluctance to use condoms, and limited knowledge of contraceptive alternatives (Pitanguy and Mello e Souza 1997).

This terminology offers way to uncover the linked nature between many stages of reproductive health care. Further investigation of the usefulness and practicality of this terminology is certainly required of our scholarship and organizing around reproduction. In other words, “historically, there have been—and will likely continue to be—a variety of interrelated reproductive issues that deserve fuller attention despite the pressure [to delink them]” (Luna and Luker 2013: 345). I argue it holds potential to shift isolated political conversations around birth control and abortion to deliberate them in ways that more accurately represent women’s lived experiences. However, as activists and scholars, we must also consider the detrimental impact of utilizing reproductive life histories within current political clashes, and therefore must be evaluated and tested further. Amid
contentious debates on birth control and abortion, advancing public and political
understanding of reproduction as a continuum holds potential for improving how we meet
current reproductive health needs and anticipate future ones.


205


Davis, Angela. Racism, Birth Control and Reproductive Rights. The Reproductive Rights Reader: Law, Medicine, and the Construction of Motherhood. Edited by Nancy


Galanter, Marc. Law and Society in Modern India. Edited by Rajeev Dhavan, Oxford:


210


APPENDIX A

LIST OF INTERVIEW QUESTIONS
1.) Demographic information:
   • Age
   • ethnic background
   • income level
   • educational background
   • marital status
   • religious affiliation
   • political affiliation
   • work status
   • insurance type, cost per month
   • number of children, ever pregnant?
   • how long have you been a resident of Arizona

2.) What is your most common mode of transportation?

3.) How many miles do you travel to get to the medical clinic to obtain contraception?

4.) What is your main/preferred method of contraception?

5.) How much money do you spend on contraceptive services per month?

6.) How many visits to the clinic have you needed to take this year?

7.) How much time is spent travelling to/from clinic each visit?

8.) How much time is spent waiting for medical services each visit?

9.) How did you come to learn about contraception and/or abortion options?

10.) Please explain any kind of sexual education you have received in the past.

11.) How involved is/are your partner(s) in deciding use of contraception in your relationship?

12.) Who else has been influential in deciding what contraception to use? Ways to obtain it?

13.) How do you usually go about obtaining your birth control? How do you pay for it?

14.) Which clinics or doctor’s office do you frequently visit?

15.) What kinds of things have made this process easier or more efficient?

16.) Has new healthcare under the Affordable Care Act impacted how you obtain your contraception?

17.) Overall, do you feel your contraceptive needs are being met?

18.) What have been the best and worst parts of your experience(s) seeking contraception?

If you have gotten pregnant and sought an abortion:

1.) At what age was your first pregnancy? Age at most recent pregnancy?

2.) What was the first thing you did when you found out you were pregnant?

3.) Where/how did you seek out abortion services? Please describe, in as much or little detail as comfortable with, what that experience was like.

4.) How many miles did you have to travel to the abortion clinic?

5.) What was your first visit to this clinic like?

6.) What kinds of information were you given during this initial appointment? What kind of information was asked of you?

7.) How many trips did you have to take for the procedure to be completed?
8.) Approximately, how much did you spend out-of-pocket for these abortion services?
9.) What was your most common form of transportation for these visits?
10.) Overall, how would you describe your experience with abortion services in Phoenix, AZ?
11.) What other steps/visits were required for you to actually obtain an abortion (by pill or surgically)?
12.) Take me through the abortion procedure (in as much or as little detail as you feel comfortable with).
13.) What did you find most difficult and burdensome about the process? What was most helpful to you during the process? What were the best and worst parts of the experience?
APPENDIX B

SAMPLE RECRUITMENT MATERIALS
Recruitment Script:

Hello, my name is Melissa Martinez and I am a graduate student under the direction of Dr. Madelaine Adelman in the Department of Justice and Social Inquiry at Arizona State University. I am conducting a research study to understand more about the ways women obtain contraception and/or abortion in the Phoenix area.

I am recruiting individuals to be interviewed about their different experiences and results with seeking contraception and/or abortion over the last three years, which will take approximately 1-2 hours total. This interview can be done in-person or over telephone/Skype. All participants must be between 18-45 years of age during the time of the interview. I would like to audio record the interview to look at the data more closely. The recordings will be de-identified and deleted upon transcription. De-identified interview transcriptions will be retained for possible future research.

Your participation in this study is completely voluntary. If you have any questions concerning the research study or would like to see a list of specific interview questions, please call me at (714) 552-6777 or email at mjmart22@asu.edu.

Resource List:

If you feel any emotional, psychological or mental discomfort, here are resources to for you:
- Maricopa Crisis Line  - Available 24 hours/7 days a week (602) 222-9444 or (800) 631-1314
- EMPACT 24-Hour Crisis Line (480) 921-1006
- National Sexual Assault Hotline (800) 656-HOPE (4673)
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Work Status</th>
<th>Insurance</th>
<th>Religion</th>
<th>Politics</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally</td>
<td>22</td>
<td>White</td>
<td>Some college</td>
<td>FTW</td>
<td>Parental</td>
<td>NA</td>
<td>Con</td>
<td>LTR</td>
</tr>
<tr>
<td>Alicia</td>
<td>28</td>
<td>White</td>
<td>Graduate work</td>
<td>PTW/FTS</td>
<td>Student</td>
<td>Atheist</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Ashley</td>
<td>26</td>
<td>As Am</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Obamacare</td>
<td>Christian</td>
<td>Con</td>
<td>LTR</td>
</tr>
<tr>
<td>Laney</td>
<td>20</td>
<td>Latina</td>
<td>HS</td>
<td>FTW</td>
<td>Parental</td>
<td>NA</td>
<td>Ind</td>
<td>Single</td>
</tr>
<tr>
<td>Helena</td>
<td>23</td>
<td>White</td>
<td>Some college</td>
<td>FTW</td>
<td>None</td>
<td>NA</td>
<td>Con</td>
<td>Single</td>
</tr>
<tr>
<td>Karlie</td>
<td>25</td>
<td>White</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>NA</td>
<td>Lib</td>
<td>Single</td>
</tr>
<tr>
<td>Lucille</td>
<td>24</td>
<td>White</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Parental</td>
<td>Christian</td>
<td>Con</td>
<td>LTR</td>
</tr>
<tr>
<td>Evelyn</td>
<td>23</td>
<td>Latina</td>
<td>HS</td>
<td>FTW</td>
<td>None</td>
<td>NA</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Bonnie</td>
<td>18</td>
<td>Black</td>
<td>HS</td>
<td>Unemployed</td>
<td>Parental</td>
<td>Christian</td>
<td>Ind</td>
<td>Single</td>
</tr>
<tr>
<td>Carissa</td>
<td>21</td>
<td>White</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Parental</td>
<td>Catholic</td>
<td>Ind</td>
<td>Single</td>
</tr>
<tr>
<td>Korinne</td>
<td>19</td>
<td>As Am</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Parental</td>
<td>Christian</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Raquel</td>
<td>24</td>
<td>Latina</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>Catholic</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Jane</td>
<td>29</td>
<td>Latina</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>Atheist</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Karla</td>
<td>23</td>
<td>White</td>
<td>HS</td>
<td>FTW</td>
<td>Parental</td>
<td>NA</td>
<td>Ind</td>
<td>Married</td>
</tr>
<tr>
<td>Alex</td>
<td>25</td>
<td>White</td>
<td>HS</td>
<td>FTW</td>
<td>Obamacare</td>
<td>Christian</td>
<td>Con</td>
<td>LTR</td>
</tr>
<tr>
<td>Kassie</td>
<td>24</td>
<td>White</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Obamacare</td>
<td>Catholic</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Desiree</td>
<td>22</td>
<td>Latina</td>
<td>Some college</td>
<td>Unemployed</td>
<td>Parental</td>
<td>Catholic</td>
<td>Con</td>
<td>Single</td>
</tr>
<tr>
<td>Jocelyn</td>
<td>26</td>
<td>As Am</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>Atheist</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Melanie</td>
<td>19</td>
<td>White</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Parents</td>
<td>Christian</td>
<td>Ind</td>
<td>Single</td>
</tr>
<tr>
<td>Haylee</td>
<td>18</td>
<td>White</td>
<td>HS</td>
<td>PTW/FTS</td>
<td>Parental</td>
<td>Christian</td>
<td>Ind</td>
<td>Single</td>
</tr>
<tr>
<td>Noelle</td>
<td>25</td>
<td>As Am</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>NA</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Natasha</td>
<td>25</td>
<td>As Am</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Obamacare</td>
<td>Atheist</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Tiffany</td>
<td>27</td>
<td>White</td>
<td>Graduate work</td>
<td>FTW</td>
<td>Employer</td>
<td>NA</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Lacy</td>
<td>30</td>
<td>Black</td>
<td>Graduate work</td>
<td>FTW</td>
<td>Employer</td>
<td>Christian</td>
<td>Lib</td>
<td>Single</td>
</tr>
<tr>
<td>Rhonda</td>
<td>21</td>
<td>White</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Obamacare</td>
<td>Christian</td>
<td>Lib</td>
<td>LTR</td>
</tr>
<tr>
<td>Julie</td>
<td>24</td>
<td>Middle Eastern</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Parental</td>
<td>NA</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Bethany</td>
<td>25</td>
<td>White</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Parental</td>
<td>Christian</td>
<td>Ind</td>
<td>LTR</td>
</tr>
<tr>
<td>Katelyn</td>
<td>22</td>
<td>White</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Parental</td>
<td>NA</td>
<td>Ind</td>
<td>LTR</td>
</tr>
</tbody>
</table>
Abortion Sample:

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Work Status</th>
<th>Ins. Type</th>
<th>Religion</th>
<th>Politics</th>
<th>Marital Status</th>
<th>Abortion type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicia</td>
<td>28</td>
<td>White</td>
<td>Bachelor’s</td>
<td>FTW</td>
<td>Employer</td>
<td>Catholic</td>
<td>Con</td>
<td>Single</td>
<td>Pill</td>
</tr>
<tr>
<td>Kathy</td>
<td>37</td>
<td>Latina</td>
<td>Graduate work</td>
<td>FTW</td>
<td>Obamacare</td>
<td>NA</td>
<td>Lib</td>
<td>LTR</td>
<td>Pill</td>
</tr>
<tr>
<td>Rosaline</td>
<td>21</td>
<td>Latina</td>
<td>Some college</td>
<td>PTW/FTS</td>
<td>Student Health</td>
<td>Catholic</td>
<td>Ind</td>
<td>Single</td>
<td>Surgery</td>
</tr>
<tr>
<td>Maria</td>
<td>26</td>
<td>Latina</td>
<td>HS</td>
<td>FTW</td>
<td>None</td>
<td>NA</td>
<td>Lib</td>
<td>LTR</td>
<td></td>
</tr>
</tbody>
</table>

Key:
AsAm – Asian American
HS – High school completion
FTW – Full time work
PTW/FTS – Part time work/full time student
NA – No religious affiliation
Lib – Liberal political orientation
Con – Conservative political orientation
Ind – Independent political orientation
LTR – Long-term relationship
APPENDIX D

IRB APPROVAL DOCUMENTS
**APPROVAL: EXPEDITED REVIEW**

**Madelaine Adelman**  
Social Transformation, School of  
480/965-4886  
mad@asu.edu

Dear Madelaine Adelman:

On 7/13/2015 the ASU IRB reviewed the following protocol:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Encounters with the State: A Study of Pathways to Pregnancy Prevention and Termination in Phoenix, Arizona</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Madelaine Adelman</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00002835</td>
</tr>
<tr>
<td>Category of review:</td>
<td>(6) Voice, video, digital, or image recordings, (7)(b) Social science methods, (7)(a) Behavioral research</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Grant Title:</td>
<td>None</td>
</tr>
<tr>
<td>Grant ID:</td>
<td>None</td>
</tr>
</tbody>
</table>
| Documents Reviewed: | • Adelman, Martinez, IRB Application, Category: IRB Protocol;  
• Adelman, Martinez, Consent Document, Category: Consent Form;  
• Martinez, CITI Refresher Completion Cert, Category: Other (to reflect anything not captured above);  
• Adelman, Martinez, Resource List, Category: Resource list;  
• Martinez, CITI Basic Course Completion Cert, Category: Other (to reflect anything not captured above);  
• Adelman, Martinez, Recruitment Script, Category: Recruitment Materials;  
• Adelman, Martinez, Interview Questions, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); |
The IRB approved the protocol from 7/13/2015 to 7/12/2016 inclusive. Three weeks before 7/12/2016 you are to submit a completed Continuing Review application and required attachments to request continuing approval or closure.

If continuing review approval is not granted before the expiration date of 7/12/2016 approval of this protocol expires on that date. When consent is appropriate, you must use final, watermarked versions available under the “Documents” tab in ERA-IRB.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Melissa Martinez
Melissa Martinez
Madelaine Adelman  
Social Transformation, School of (SST)  
480/965-4886  
mad@asu.edu

Dear Madelaine Adelman:

On 6/14/2016 the ASU IRB reviewed the following protocol:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Continuing Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Encounters with the State: A Study of Pathways to Pregnancy Prevention and Termination in Phoenix, Arizona</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Madelaine Adelman</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00002835</td>
</tr>
<tr>
<td>Category of review:</td>
<td>(6) Voice, video, digital, or image recordings, (7)(b) Social science methods, (7)(a) Behavioral research</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Grant Title:</td>
<td>None</td>
</tr>
<tr>
<td>Grant ID:</td>
<td>None</td>
</tr>
</tbody>
</table>

Documents Reviewed:  
- Adelman, Martinez, Resource List, Category: Resource list;  
- Adelman, Martinez, Recruitment Script, Category: Recruitment Materials;  
- Martinez, CITI Refresher Completion Cert, Category: Other (to reflect anything not captured above);  
- Adelman, Martinez, IRB Application, Category: IRB Protocol;  
- Adelman, Martinez, Interview Questions, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions);  
- Martinez, CITI Basic Course Completion Cert, Category: Other (to reflect anything not captured above);  
- Adelman, Martinez, Consent Document, Category: Consent Form;
The IRB approved the protocol from 6/14/2016 to 7/11/2017 inclusive. Three weeks before 7/11/2017 you are to submit a completed Continuing Review application and required attachments to request continuing approval or closure.

If continuing review approval is not granted before the expiration date of 7/11/2017 approval of this protocol expires on that date. When consent is appropriate, you must use final, watermarked versions available under the “Documents” tab in ERA-IRB.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Melissa Martinez
    Melissa Martinez
APPENDIX E

<table>
<thead>
<tr>
<th></th>
<th>Total (1,000)</th>
<th>Rate per 1,000 women&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Ratio per 1,000 live births&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>363.1</td>
<td>374.4</td>
<td>240.8</td>
</tr>
<tr>
<td>Mountain</td>
<td>68.2</td>
<td>63.6</td>
<td>33.6</td>
</tr>
<tr>
<td>Montana</td>
<td>3.7</td>
<td>3.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Idaho</td>
<td>2.7</td>
<td>2.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1.1</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>23.1</td>
<td>22.4</td>
<td>13.6</td>
</tr>
<tr>
<td>New Mexico</td>
<td>8.4</td>
<td>8.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Arizona</td>
<td>15.8</td>
<td>14.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Utah</td>
<td>4.2</td>
<td>3.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Nevadas</td>
<td>9.2</td>
<td>8.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Pacific</td>
<td>314.9</td>
<td>310.8</td>
<td>207.3</td>
</tr>
<tr>
<td>Washington</td>
<td>37.0</td>
<td>35.6</td>
<td>20.9</td>
</tr>
<tr>
<td>Oregon</td>
<td>17.7</td>
<td>17.7</td>
<td>13.3</td>
</tr>
<tr>
<td>California</td>
<td>250.4</td>
<td>248.1</td>
<td>165.5</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.9</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Hawaii</td>
<td>8.0</td>
<td>7.6</td>
<td>5.9</td>
</tr>
</tbody>
</table>

APPENDIX F

PLANNED PARENTHOOD ARIZONA IN-CLINIC ABORTION PRICING
IN CLINIC ABORTION PRICING

Planned Parenthood Arizona, Inc.
Phoenix (602) 277-PLAN (7526), Tucson (520) 408-7526, Toll Free (855) 207-7526

In Clinic Abortion Pricing Information

<table>
<thead>
<tr>
<th>In-Clinic Abortion</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0 – 11.6 Weeks</td>
<td>$515</td>
</tr>
<tr>
<td>12.0 – 13.6 Weeks</td>
<td>$800</td>
</tr>
<tr>
<td>14.0 – 15.6 Weeks</td>
<td>$950</td>
</tr>
<tr>
<td>16.0 – 17.6 Weeks</td>
<td>$1225</td>
</tr>
</tbody>
</table>

Payment is due in full on the day of your appointment. Be advised that Planned Parenthood offers financial assistance for those who qualify.

There may be additional fees if you have an RH negative blood type or if you request certain types of birth control.

Planned Parenthood accepts most major insurance. We are happy to contact your insurance company to verify coverage and benefits. Please bring your insurance card with you.

We accept cash, major credit cards, and money orders. We do not accept personal checks.