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The Politics of Reproductive Policy Restrictions:
Family Planning Policy in the United States

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in

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by

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DEDICATION

To everyone who has had to carve their own path and light their own way.

ABSTRACT OF THE DISSERTATION

The Politics of Reproductive Policy Restrictions:
Family Planning Policy in the United States

by

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Doctor of Philosophy, Graduate Program in Sociology
University of California, Riverside, December 2020
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Publicly funded family planning programs assist low-income women, many of whom are women of color, in realizing their reproductive, educational, and career goals. Conservative lawmakers have recently become increasingly active in passing laws that restrict the allocation and use of state-level funding for family planning programs, depriving low-income women of this critical resource. My dissertation research uses mixed-methods to better understand the politics and impacts of contemporary family planning policy restrictions from an intersectional feminist perspective. The first study (Chapter 2) is a quantitative, cross-sectional analysis of the social and political factors shaping state-level family planning funding policies in the U.S. Using regression techniques, I find that the strongest determinant of family planning policy restrictiveness is not public conservatism, states' fiscal health, or the strength of feminist interest groups, but rather, state government (i.e., policymakers') ideology. These findings underscore the significance of state actors and institutional power in reproductive health care policy making, as well as electoral politics. In addition, this chapter demonstrates that family

planning and reproductive health care has become increasingly subject to partisan policy making rather than public health care needs.

The qualitative chapters of my dissertation reveal the ways in which abortion-related restrictions to family planning in Texas compounded Latinx women's barriers to sexual and reproductive health care (SRHC) access along the border in the Rio Grande Valley (RGV) (Chapter 3) and the conditions under and ways in which these women mobilized against anti-abortion policies to protect and promote their reproductive health (Chapter 4). My analyses are based on 30 in-depth interviews with low-income Latinx women; twenty-five participants had used publicly funded family planning programs, while five were campus or community outreach advocates for family planning clinics.

Chapter 3 combines the social determinants of health perspective and intersectional feminist theory to gain a better understanding of, as well as elevate, Latinx women's lived experiences related to SRHC access and their health-seeking behaviors. Consistent with previous research on the social determinants of Latinx women's health care access, the SRHC challenges my respondents describe are largely related to socioeconomic status and financial hardship (structural barriers), and sociocultural barriers including familial and societal pressures of traditional religious beliefs and "sexual silence." The loss of funding as a result of Texas' cutbacks and restrictions to family planning programs (i.e., political barriers) disproportionately affected SRHC access in the RGV and further compounded the existing structural and sociocultural barriers, as it forced nearly a third of clinics to shut down in a region that was already recognized as medically underserved. The clinic closures

and increased costs of services made it increasingly difficult to schedule a timely appointment and access their preferred method of contraception.

I argue that this compounding convergence of structural, sociocultural, and political barriers among Latinx women in the RGV represent a distinct "matrix" of barriers that places low-income, uninsured Latinx women in this region within a multiply disadvantaged situation that I refer to as a *triple bind of reproductive oppression*. My concept of the *triple bind* builds on ideas advanced by intersectional feminist theory to situate the barriers to SRHC access within the interlocking systems of oppression and relations of power that ultimately structure and (re)produce the persistent SRHC disparities endemic to the RGV.

In Chapter 4, I draw from the social movements scholarship on mobilization to explore the conditions under and ways in which Latinx women in the RGV mobilize to promote and protect their reproductive health and rights. The findings in this study are based on the subset of interviewees who are current or former consumers of publicly funded family planning services (n=25). I find that material and ideological resource mobilization by social movement organizations are particularly important in first politicizing women around SRHC and then facilitating their political participation (e.g., from consciousness-raising efforts to education and advocacy outreach to protests). Respondents' personal connections to a broader network of activists and social movement activities (i.e., social movement communities) also significantly influence their participation. Finally, grievances (manifested as feelings of anger and a sense of injustice) and empowerment (i.e., pride and a sense of efficacy) are central to mobilizing – and often sustaining – political activity. For others, political non-participation is related to structural

barriers to participation and/or a calculated decision to avoid emotional strain – a cognitive process that others refer to as “emotion management” (Hochschild 1979; Norgaard 2006). As my research reveals, emotional strain caused by feelings of shame, social discomfort and anxieties, and activist burnout act as barriers to political participation. Emotional processes as inhibiting mobilization remain largely understudied in the social movement literature. Overall, my research reveals the necessity of publicly funded family planning programs for low-income women’s SRHC access as well as the importance of ideology and emotions for shaping political struggles over these programs.

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CHAPTER 1
SETTING THE STAGE: PUBLICLY FUNDED FAMILY PLANNING PROGRAMS AND POLICIES IN THE UNITED STATES

INTRODUCTION

Publicly funded family planning programs play a vital role in the status of women's reproductive health and in the U.S. health care safety net. They provide millions of low-income, uninsured women access to an array of subsidized contraceptive services and preventative reproductive health care. The ability to access birth control, in and of itself, has allowed women greater autonomy in planning and spacing their pregnancies, and has helped to prevent unintended, unwanted, and teen pregnancies (Kavanaugh and Anderson 2013; Sonfield et al. 2012). Moreover, publicly funded family planning programs have served as many women's initial – and for some, only – entry point into the U.S. health care system (Sonfield, Hasstedt, and Gold 2014). They have been an especially important resource for women who typically are confronted with the greatest social and economic barriers to realizing their educational, career, and/or childbearing goals (Cleland et al. 2006) – largely poor and low-income women of color.

Despite its demonstrable impact on women's health and well-being, funding for family planning has been under unprecedented attack nation-wide since 2010 (Marty and Pieklo 2013; Wilson 2016). Spurred by federal efforts in Congress to defund Planned Parenthood and eliminate the Title X program, several states have passed a series of anti-abortion legislation that has either reduced or placed eligibility restrictions on funding for family planning programs. For example, some states have implemented a tiered priority

system for the distribution of funds while others have denied public funding altogether to clinics that provide or are affiliated with abortion (Guttmacher 2020).

As previous research shows, targeting publicly funded family planning programs and clinics has had serious implications for women's reproductive health care access and reproductive health outcomes. For example, in Texas – a state notorious for its punitive reproductive policies and politics – the decision to drastically reduce state spending on publicly funded family planning and impose a series of abortion-related restrictions on the provision and allocation of funds immediately devastated the state's health care safety net (White et al. 2015, 2017); women's ability to access and clinics' ability to provide sexual and reproductive health care services (Center for Policy Priorities 2017; Stevenson et al. 2016); and exacerbated reproductive health disparities across the state (Lu and Slusky 2016; Fischer, Royer, and White 2018; Packham 2017). Disproportionately impacted by Texas' legislation were (and, indeed, continue to be) marginalized women living in remote, economically depressed, and medically under-resourced areas of the state (Hellerstein 2014; Nuestro Texas 2015; Woo, Alamgir, and Potter 2016).

The far-reaching implications of restricting and defunding family planning programs highlight the need for additional and in-depth research on the politics of family planning policies in the U.S. From an intersectional feminist perspective, my dissertation research uses mixed-methods to advance our understanding of the politics of contemporary family planning policy restrictions; document how they impact and are experienced by uninsured, working class women of color; explore the conditions under and ways in which these women mobilize to promote and protect their reproductive health and rights; and,

ultimately, underscore the importance of not only ensuring but expanding access to family planning and sexual and reproductive health care.

The aim of this chapter is to provide a full sketch of my dissertation research. I organize the chapter as follows. The first section provides a brief background on the structure of family planning policy in the U.S. Next, I situate family planning within a sociohistorical and political context and review the literature on the politics of family planning policy making. I then turn my focus to family planning policies in Texas and their broader impacts as a way to set the stage for the purpose of this dissertation.

The remainder of this chapter is devoted to the theoretical, methodological, and analytical components of my research. Before introducing and outlining the research questions and summaries for each of the three empirical chapters of my dissertation (Chapters 2, 3, and 4), I offer reflective comments on the motivation behind this project, my own positionality, and the standpoint from which I have conducted my research. I conclude this chapter with a succinct overview of the final dissertation chapter (Chapter 5), wherein I present the limitations, contributions, and implications of my dissertation research as well as propose directions for future studies on the politics of family planning policy restrictions.

BACKGROUND: WHAT IS PUBLICLY FUNDED FAMILY PLANNING?

Family planning programs are broadly defined by the U.S. Department of Health and Human Services (2000) as "those educational, comprehensive medical or social services or activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved."

Public funding for family planning programs, thus, serves as an important public health care resource that provides free or reduced cost preventive sexual and reproductive health care services to those who are: 1) of reproductive age (13-44 years); 2) sexually active and are not trying to become pregnant, and 3) living below 250 percent of the federal poverty level; *or* people younger than 20 years of age. Although men are eligible recipients, the majority of consumers (92 percent) are usually women (Besera 2016).

Access to free or reduced cost contraception is the primary service sought as family planning programs cover a range of FDA-approved contraceptive methods, including but not limited to condoms, oral contraceptives ("the pill"), injectables (e.g., Depo-Provera), subdermal implants, and intrauterine devices (Ranji, Bair, and Salganicoff 2016; Zolna and Frost 2015). Pregnancy testing is also provided. The services rendered via publicly supported family planning programs offer a wide range of sexual and reproductive health care services as well, such as testing for HIV, chlamydia, and gonorrhea; treatment for sexually transmitted infections (STIs); counseling and education on family planning and HIV/STI prevention; and HPV vaccinations (Zolna and Frost 2015). The administering of HPV vaccinations along with the provision of gynecological exams (Pap smears) and breast and cervical cancer screenings in particular provide women access to reproductive health care services that are both preventive and lifesaving.

The structure behind the appropriation of funds has been aptly described as an "intergovernmental labyrinth" of various federal, state, and joint federal-state statutes (McFarlane and Meier 2001:39). There are four sources through which family planning is funded: Medicaid, state appropriations, Title X, and federal block grants (Sonfield and

Gold 2012). Between 1937 and 1961, only seven states offered publicly funded family planning programs, all of which were in the south; it was not until the reproductive shift of 1960s – i.e., the rising birth rates, the introduction of the birth control pill and the intrauterine device, and the struggle for abortion access – did expanding family planning programs became of considerable national focus (McFarlane and Meier 2001). In 1965, Medicaid program was established and by 1967, forty-seven states were providing family planning services of their own. That same year, Congress mandated that Titles IV and V, the Social Services Program for Mothers and Children, of the Social Security Act include the provision of family planning services, with the federal government subsidizing 75 percent of the costs. By the end of 1970, Congress created the first and only fully federally funded family planning program under the Public Health Service Act, the Family Planning Services and Population Research Act (Title X).

To date, the single largest source of funding for family planning to date comes from the joint federal-state Medicaid insurance program, which accounts for 75 percent of public funds (Hasstedt, Sonfield, and Gold 2017). Through Medicaid, contraception and preventive reproductive health care services covered for all eligible enrollees, and states are reimbursed by the federal government for 90 percent of the costs of all services (Ranji, Bair, and Salganicoff 2016). Other sources funding family planning programs are state appropriations, which accounts for 13 percent of all funding, and Title X, which accounts for 10 percent. Additional sources of funding come from federal social service block grants such as the Maternal and Child Health block grant and block grants under Temporary Assistance to Needy Families (TANF).

Publicly funded family planning services are provided through the country's safety-net provider network (Guttmacher 2017). This network is made up of federally recognized state, county, local, and community health departments, community health centers, family planning clinics, and other centers such as hospitals and nonprofit clinics (Office of Population Affairs 2014). According to Zolna and Frost (2016), in 2015, subsidized family planning services were provided at 10,708 safety net health clinics; among these, 5,829 (54%) were federally qualified health centers, 2,242 (21%) were health departments, 1,108 (10%) were independent clinics, 853 (8%) were hospital outpatient facilities and 676 (6%) were Planned Parenthood clinics. Although Planned Parenthood represents a small percentage of the health care safety net, they serve approximately one-third of female family planning clients and over 40 percent of women seeking family planning services across 13 states (Ranji et al. 2019).

In fiscal year 2015, the public expenditures for family planning totaled $2.1 billion, down from the $2.37 billion in fiscal year 2010 (Hasstedt, Sonfield, and Gold 2017). The reduction in expenditures, however, was not due to a decrease in the demand for services. To be sure, the Medicaid expansions implemented under the 2010 Affordable Care Act did result in a decrease in the number of uninsured women in the U.S.; however, in 2014, roughly 20.2 million women in the U.S. were still in need of publicly funded family planning services – a five percent increase (one million) increase from the number of women who were in need in 2010. The largest percentage increases were among

"Hispanic" (Latinx[1]) women (nine percent) and Black women (six percent); white women experienced a two percent increase in need. According to the most recent estimates from 2017, there are now approximately 21 million in need of publicly funded family planning services (Frost et al. 2016; Ranji et al. 2017).

The sexual and reproductive health care services obtain via publicly funded family planning clinics are often many women's initial – and for some, only – entry point into the health care system (Sonfield, Hasstedt, and Gold 2014). As a public health care program that is intended for low-income women, many of whom are women of color, it is important to understand how family planning policy is sensitive to the politics and ideologies behind the appropriation of funds and the provision of services. As a social policy, it especially important to understand the ways in which family planning programs differentially – and simultaneously – enable and constrain women's reproductive autonomy. To make these connections, the following section will review the literature on the different ways in which family planning policy has been conceptualized, formulated, implemented, and interpreted in relation to race-ethnicity, class, and gender politics.

THE POLITICS OF REPRODUCTIVE POLICY: FAMILY PLANNING POLICIES IN THE U.S.

Publicly supported family planning is one among four common, interrelated types of reproductive policies. Reproductive policy in the U.S. typically involves reproductive

[1] The term "Latinx" is used throughout this dissertation out of respect for those who explicitly reject the gender binary and do not identify with feminine pronouns. Rooted in feminist praxis, these terms are part of conscious discourse that aims to challenge the patriarchal root of the term and its heteronormative connotations.

health care policies (i.e., family planning), fertility control policies, reproductive rights (or choice) policies, and anti-abortion (or anti-choice) policies. Coercive or compulsory contraceptive use (e.g., forced sterilization), 'family cap' policies, and abstinence-only-until-marriage education are types of *fertility control policies* intended to limit women's reproduction. *Reproductive rights policies* tend to focus on abortion care and contraception accessibility (and affordability) as well as comprehensive sex education and surrogacy. Meanwhile, *anti-choice policies* aim to regulate reproduction by restricting abortion access, clinics, and providers, and limiting the provision of contraception (usually out of religious objections to abortion, but also in large part out of conservative objections to women's non-marital sexuality).

As revealed in the literature on the politics of reproductive policy, each of these categories are interconnected and have been shaped by an interplay of various institutional and cultural factors that determine the distribution of resources, such as contraception and reproductive health care services, and whose reproduction is targeted for social regulation. Family planning policies in particular, however, have been informed by a unique, complex blend of clashing and complementary social and political forces that promote expanding access to services (specifically, contraceptive care) as a means to achieve fundamentally divergent ends. As Jaffee and Polgar (1968) discuss, the provision of family planning in the U.S. has been advanced largely through two channels of support – "accessibility" versus "cultural-motivational" approaches to program implementation. The accessibility approach to providing family planning services aims to ensure that low-income families have access, equal to all other families, to the means necessary to achieve their desired

family size and provide a better future for their children. Others have referred to this as an "altruistic" interpretation of the provision of family planning programs, as they reflect "policy makers' desires to help a largely disadvantaged minority" (Wright 1978:1086). The cultural-motivational approach, on the other hand, relies on a "culture of poverty"[2] framework that blames the poor for existing social problems as well as their quality of life (Jaffee and Polgar 1968). From this perspective, publicly supported family planning is promoted as a necessary means of preventing future generations from inheriting perceived "maladaptive" values and behaviors.

To an extent, much of the politics that drive support for family planning can be placed into one of these two approaches. However, welfare and reproductive scholars who focus on issues of fertility and social reproduction emphasize the importance of gendered and racialized discourses in shaping reproductive and social policies (Markens 2007). Like most social policies in the U.S., family planning policy is structured at the intersections of race-ethnicity, gender, sexuality, and class (among other social identities), and these identities are deeply, historically, and inseparably intertwined. Drawing from feminist, critical race scholarship on reproduction, I identify three dominant forces that influence the politics of family planning policies. First, there are f*orces promoting race- and class-based population control.* Second, there are *forces promoting accessibility of health care services and reproductive choices.* Finally, there are *religious and conservative forces opposing family planning.* Below, I thread together the complicated yet interconnected history of

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[2] The "culture of poverty" framework, coined by Oscar Lewis (1961), suggests that generationally inherited cultural and behavioral characteristics are what perpetuate poverty and poor life chances.

eugenicists and the "population control establishment" (Thomas 1985; Smyth 1996), feminists and women's health advocates (Morgan 2002), and religious conservatives (Wilson 2016), and their influence on family planning policy in the U.S. The literature on the religious conservative social forces shaping reproduction are especially salient for understanding the principle focus of my dissertation research on contemporary restrictions to family planning policies and their impact on women's reproductive health and lives.

Forces Promoting Race and Class-based Population Control

Historically, family planning in the U.S. has been immersed within a blend of racist, eugenicist, classist, and paternalistic rhetoric and controlling images around women's fertility and reproduction. The common racist, paternalistic assumptions underpinning the discourse on low-income women's reproduction, particularly low-income women of color, is that their "hyperfertility" is both a cause and consequence of poverty and crime (Bloch and Taylor 2014). Similar to the culture of poverty perspective, the concept of hyperfertility constructs women's reproduction as a social problem in and of itself. In discussing Latina reproduction within public and political discourse, Leo Chavez illustrates how hyperfertility is an ideological concept that is "racialized and class specific as well as gendered" (Chavez 2004:491) that predefines and prescribes normative fertility levels. Reproduction discourse, he argues, constructs non-Latino white women's fertility as normative, regulated, and restrained; meanwhile, women of color are regarded as hyperfertile (Chavez 2004:175). Thus, their reproduction is, at once, nonnormative and stratified.

The concept of stratified reproduction, or the notion that "some reproductive futures are valued while others are despised" (Ginsburg and Rapp 1995:3) is the driving force in the history of racialized reproductive policies and practices in the U.S. Black, Native, and Latinx women – especially immigrant women – have been the target of state-supported public health programs, starting with the eugenics movement at the turn of the 20th century (Carey 1998). The eugenics movement was the result of a number of social factors, most notably the continuous waves of immigration, growing wealth disparities, and expanding urbanization that were changing the social and economic landscape of the country (Shapiro 1985). This changing landscape prompted a perceived "racial" or "group threat" among whites and catalyzed many state-level reproductive policies. Conservative eugenicist pseudo-research was used to explain criminal behavior as well as poverty, cognitive disabilities, and sexual deviance as "hereditary mental deficiencies" that were viewed as inherent within immigrant and nonwhite populations (Carey 1998; Silliman et al. 2004). This research was then used to support explicitly racist, eugenicist family planning initiatives (i.e., fertility control programs) that promoted the sterilization of indigent women (and men) of color as a means of reducing the rising rate of the non-white populations (Thomas 1998; Roberts 1998; Silliman et al. 2004; Schoen 2005). Indeed, between 1907 and 1922, fifteen states had adopted sterilization laws that curbed women's fertility in order to preserve a white society that was "plagued by racial deterioration" (Carey 1998:78). State-supported sterilization of those deemed incapable of reproductive control and "unfit" to reproduce remained legal across 30 states until 1964 (Rodriguez-Trias 1978).

Efforts to expand access to voluntary sterilizations and contraceptive use were a major goal behind women's health advocacy efforts; however, the development of publicly funded family planning as a public health policy was still largely racialized during the 1960's. It was often promoted with the explicit intent of reducing the Black population in the deep South and the rising welfare costs (Schoen 2005). Southern lawmakers were reticent to the idea of publicly funding contraception and family planning programs when the pressure came from feminists, women's health, and reproductive rights advocates; however, support was more easily garnered when it was presented as a racially directed form of population control (Ross 2006). States like North and South Carolina were the first to implement a family planning budget in the 1950s, after it was presented to lawmakers as a way to control the Black population (Ward 1986).

As Schoen's (2005) case study shows, from 1929 until 1976, North Carolina's public health program disproportionately pressured Black women to accept sterilization, implantable devices like Norplant, or IUDs when applying for welfare benefits. At the federal level, President Nixon had directed Congress to develop a five-year federal family planning strategy; he used statistics that demonstrated a 25 percent growth in the Black population from the 1950s to the 1960s to promote curbing the population growth rate (Ross 2006). The solution to poverty and improving quality of life was through population control (Shapiro 1985:79).

The seemingly benevolent efforts by the Population Research Council at the time were also (and continue to be) complicated by underlying assumptions about gender, race, and class. In both the U.S. and within lesser developed countries, population control efforts

(what Smyth (1996) refers to as the "population control establishment") have promoted increased access to contraception and family planning services; however, they have often framed the need for family planning programs using Malthusian-inspired notions of overpopulation, poverty, and an impending fear of resource scarcity. The resource scarcity argument is used largely within a global economic context, suggesting that high fertility rates and population growth around the world will continue to strain already limited resources such as oil and land (Cleland et al. 2006). For some countries, resource scarcity is contextual and refers to food, water, and quality of life (Prata 2009). As some have critically argued, however, to consider fertility regulation as the solution to poverty and resource scarcity ignores the structural conditions under which poverty and poor life chances persist (Kuumba 1999).[3]

To be sure, the development of publicly funded family planning programs – especially the development of Title X in 1970 under the Nixon administration – was an important and proactive step towards improving women's life chances by expanding their ability to access contraception, as long as participation remained voluntary. The problematic nature of publicly funded family planning policies and practices, however, were the disproportionately high rates of involuntary, state-funded sterilizations among low-income Black women (Horsburg 1995; Roberts 1998; Schoen 2005), Native American women (Gurr 2011) and Latinx women (Gutierrez 2008; Rodriguez-Trias 1978) that had occurred throughout the century and well into the 1970s (Shapiro 1985). By 1970, Black

[3] Furthermore, as Kuumba (1999) contends, resource scarcity is not a result of overpopulation, but rather, is the consequence of "historically developed mechanisms of production and accumulation in the context of a world's racist, capitalist economy" (Kuumba 1999: 449).

women were being sterilized at twice the rate of white women (Nelson 2003). In Aiken County, South Carolina, over one-third of welfare recipients who gave birth during the first six months of 1973 were sterilized (Volscho 2010). Meanwhile. the U.S. Department of Health, Education, and Welfare was funding 90% of the nonconsensual sterilizations experienced by Native American women living on reservations (Gurr 2011). From 1973 to 1976, the federally funded Indian Health Service had sterilized approximately 3,406 Native women without gaining proper consent, providing adequate information on the permanence of the procedure, or suggesting alternative, reversible methods of contraception.

The most notable and egregious examples of sterilization abuse against immigrant women were brought to light in the *Madrigal v. Quilligan* case, a lawsuit filed by 10 Mexican immigrant women who, immediately post-childbirth, were forcibly sterilized by doctors at the Los Angeles County Medical Center during the 1970s. The "Madrigal 10" represent a few of the countless Latinx immigrant women who were being sterilized (via tubal ligation or hysterectomies) after giving birth without their knowledge or proper, informed consent (Gutierrez 2008; Hernandez 1976; Rodriguez-Trias 1978). Spanish-speaking Latinx immigrant women, it was revealed, were signing English-written documents unwittingly agreeing to undergo tubal ligations that they were told were "cleansing procedures" (Tajima-Peña 2015). Others signed out of fear over false threats of deportation and/or infant or maternal death (Gutierrez 2008; Rodriguez-Trias 1978; Schoen 2005). Undergirding the rampant sterilization abuse by medical professionals were explicitly gendered and racialized discourses regarding women's fertility, overpopulation,

as well as xenophobic ideologies – specifically, the popular, racist belief that poor, undocumented immigrant women were purposefully coming to the U.S. to give birth to acquire citizenship for their children and eventually themselves (Gutierrez 2008). These sentiments are captured by the derogatory, dehumanizing term, "anchor babies," that came to prominence in 2006 (Ignatow and Williams 2006) and continues to be referenced by several leading conservative, Republican lawmakers (Gamboa 2015).

Reproductive scholars demonstrate the ways in which similar racial, class-based, and nativistic sentiments informed federal and state anti-welfare legislation since the 1960s have used racialized and class-based conceptions of women's fertility to promote fertility control policies as a means of reducing the welfare rolls (Placek and Hendershot 1974; Piven and Cloward 1971).[4] The passage of welfare reform legislation in 1996, known as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), however, enabled an unprecedented level of state effort to try to curb the fertility of poor women, most of whom were women of color (Reese 2005; Kelly 2010). As Thomas (1998) highlights, the anti-natalist policies of welfare reform were couched in economic terms of "reducing welfare dependency," "promoting responsibility," and "eliminating poverty"; however, underpinning reform were racialized stereotypes and controlling images about poor, single mothers trying to take advantage of the U.S. welfare, health, and educational systems (Romero 2011). Controlling images like the "welfare queen" continue to be used as a way to depict welfare mothers as hypersexual and hyperfertile women who lack work

[4] Public support for fertility control legislation was largely influenced by people like Daniel P. Moynihan (1968) who suggested welfare incentivized women to have more children as a means of increasing their benefits.

ethic and are trying to use their reproductive capacities to "scam the system." As critical race, intersectional feminist scholars poignantly argue, however, the socially constructed "hyperfertility problem" conveniently obscures the systemic and institutional effects of poverty, racism, and oppression that keep women and families trapped in the cycle of poverty (Kelly 2010; Gomez 2015).

Still, motivated by these stereotypes, conservative lawmakers implemented fertility control policies through benefit restrictions like the family cap and the "no new child' rule" (Reese 2005). The "family cap" was an attempt to promote self-sufficiency, reproductive 'responsibility,' marriage, and 'family values' (i.e., a heteropatriarchal family structure). As per the family cap (or 'child exclusion') law, single mothers receiving public assistance were denied an increase in cash benefits if they gave birth to additional children nine months after beginning to receive TANF (Reese 2005). The goal of the family cap not only was to dissuade but also to disincentivize out-of-wedlock births by placing a ceiling on the amount of welfare benefits unmarried mothers could receive. According to Thomas (1998:422), these restrictions essentially resurrected "old-fashioned eugenics" by "ensuring that…low-income [women of color] on welfare do not reproduce."

Research continues to demonstrate a relationship between race and family planning services, particularly racial and ethnic disparities in the sterilization rates among women. For example, studies show that, relative to white women, the odds of tubal ligation for Native women are 123% greater (Volscho 2010; Gurr 2011), and 75% greater for Black women (Volscho 2010). Volscho (2010) advances the concept of "sterilization racism" to provide a theoretical context to these findings. Sterilization racism, he writes, is "the

organization of racist controlling images, policies, and practices of delivering reproductive health care that operate to constrain, minimize, or completely eliminate the reproductive activities of women of color," (Volscho 2010:20). Volscho emphasizes the significance of this disparity, which reflects the influence of racialized controlling images that contribute to racial biases within the health care system.

Early research shows that the availability of family planning services tends to be concentrated in areas in which there are large Black populations (Kammeyer, Yetman, and McClendon's 1974). My own research findings suggest a similar trend – states with larger percentages of nonwhite populations are more generous with their funding for family planning. In 2014, I conducted a quantitative analysis of social factors that influence state-level appropriations for family planning funding. The findings demonstrated that every percentage increase in the nonwhite population increased the odds that a state spent more than the median on family planning in 2010 – even after controlling for other factors such as poverty, gross state product, teen birth rate, religiosity, and women's political representation. Although this study also does not suggest causality, it does demand further inquiry into deeper explanations behind the relationship between race and family planning that extends beyond consumer 'demand' (McCoy 2014). Indeed, in a previous study, I found that when controlling for partisan control, political and religious ideologies, and gross state product, there was a consistent and significant positive relationship between state spending on family planning and the percentage of the nonwhite population. Although there are competing theories within the welfare scholarship that can be used to explain this finding, it is conceivable that the history of racialized fertility control policies and practices

could be driving, at least in part, political support for contemporary funding of family planning programs as well as how these programs are implemented on the ground.

While the history of fertility control and family planning in the U.S. is inherently racialized and class-based, from the 1960s onward feminists and women's public health advocates started to play a bigger role and influence in the politics of family planning. Extending access to family planning services to those who would otherwise lack it was – and continues to be – one of several overarching frames they used to support the implementation of publicly funded family planning programs.

Forces Promoting Accessibility: Feminists and Women's Public Health Advocates

Family planning policies and practices were of considerable focus during the 1960s. The concern over the rise in the post-war birth rate, unemployment, and poverty influenced the expansion of federal and state family planning services. Meanwhile, the introduction of the birth control pill and plastic intrauterine devices (IUDs) along with the struggle over abortion rights and women-centered reproductive health care mobilized feminists and women's health advocates across the country. Influenced by the civil rights, welfare rights, and women's liberation movements, the women's health movement (WHM) and the reproductive rights movement of the 1970s is largely credited for the spread of feminist consciousness-raising around sexuality and reproductive health (Nelson 2015; Morgen 2002). Access to family planning and health care was framed around reproductive freedom, upward mobility, and women's ability to combat their subordination (Boston Women's Health Book Collective 1979; Freedman and Isaacs 1993; Ruzek 1978).

The WHM was a grassroots collaboration of feminist and reproductive health scholars, activists, medical experts, and organizations that emphasized the link between family planning services and women's self-determination, quality of life, and life chances (Morgen 2002; Cleland et al. 2006; Nelson 2015). The WHM was a critique of "sexism, and in some cases also racism and class, as structures implicated not only in the ways health care services were delivered, but in access to high-quality health care" (Morgen 2002:73). What emerged from this critique was a national uprising of women-centered and women-controlled community health clinics throughout the 1970s and 1980s that gave women the right to gather their own information and resources to make autonomous, informed decisions about their sexuality and reproductive health. Through education, self-training, provision of services, and political advocacy, the WHM challenged the explicit and implicit ways that heterosexism and patriarchy within medicine and science justified and maintained women's subordinated status.

The WHM and reproductive rights movements were advanced by feminists from a variety of intersecting social locations, as they mobilized around issues that they shared as women, largely the politics of reproductive health and women's empowerment. However, those experiences along with their perspectives and goals were not uniformly shared. As many reproductive justice scholars have pointed out, white, middle-class feminists comprised the bulk of the mainstream reproductive health and rights movement, and therefore often focused on gender as a singular form of oppression. Often missing was a systematic critique of the intersecting forms of racism, classism, and sexism practiced within medical institutions (Morgen 2002) – such as the rampant sterilization abuse against

Latinas, welfare recipients, and Native American women on reservations throughout the 1970s – and the ways in which this differentially shaped women's ability to exercise the same reproductive rights as white, middle-class feminists. Black women and Latinas were struggling over issues of access to reproductive services and care, but for them, reproductive freedom was largely freedom from coercive reproductive control (Gutierrez 2008; Rodriguez-Trias 1978).

The exclusion of the voices and experiences of feminists of color has often been the overarching critique of feminist activism around reproductive rights. Although literature from the feminist public health perspective also tends to leave out marginalized women's lived experiences, it has emphasized access to family planning as a necessary means for improving their life chances. Indeed, there is voluminous research on the impact and importance of contraception for individuals, families, and the broader society. For example, research abounds on how access to family planning allows women to control their own fertility, and to be able to time and space their pregnancies (Sonfield et al. 2013; Kavanaugh and Anderson 2013). Public health studies also demonstrate how access to contraception helps to prevent teen pregnancies, thereby increasing young women's chances of graduating from high school and enrolling in college (Sonfield 2013). Other research findings emphasized are the lower rates of teen pregnancy and fewer abortions, low-birth weight babies, births with late or no prenatal care, infant deaths, and neonatal deaths (McFarlane and Meier 2001; Klerman and Klerman 1994). Publicly funded family planning programs as a matter of public health, therefore, are touted – and rightfully so – for the positive impact they have had in helping low-income women realize their

reproductive, educational, and career goals (Frost, Zolna, and Frohwirth 2013; Frost, Finer, and Tapales 2008).

The liberal, feminist, and women's public health advocates promote benevolent or "altruistic" (Wright 1978) justifications to promote public family planning programs. While this stands in direct contradistinction to the racialized, conservative motives of the recent past which sought to slow the rising rate of the nonwhite population, feminist-liberals have often utilized the inherently problematic argument of 'fiscal responsibility' to garner lawmakers' and public support for funding family planning services. Family planning advocates popularize the cost-effectiveness of investing in family planning programs for its ability to not only avert unwanted pregnancies and abortions, but also reduce additional welfare and social support costs. For example, researchers have calculated that every $1 spent on contraception saves approximately $7 in other Medicaid expenses, including childbirth, maternal care, and abortions (Frost et al. 2014). In this vein, feminist-liberals and conservatives act as "strange bedfellows" (Markens 2007) in promoting fertility control as a means of reducing additional public welfare expenditures.

Religious Conservative Forces Opposing Family Planning

As previously stated, subsidized family planning in the U.S. is a contradictory social policy that is represented by oppositional forces – by explicitly and implicitly racially-motivated population control efforts and anti-welfare fertility control policies as well as by feminists and women's health advocates promoting access to contraception reproductive rights. Family planning policy, however, has also been significantly

influenced by religious organizations, particularly Catholicism and politicized Protestants known as the Religious or Christian Right.

The Catholic Church and other religious institutions have historically condemned the use of birth control, viewing it as a violation and interference of the purpose of marriage (i.e., procreation) (Shenker 2000). Catholicism (Wetstein and Albritton 1995; Berkman and O'Connor 1995) and Protestantism (Camobreco and Barnello 2008; Dennis, Medoff, and Stevens 2011), however, have both been shown to have an "interest group effect" on reproductive rights policies, particularly the rights to abortion and contraceptive use. Berry and Wilcox (2015) argue that whereas political parties seek to maximize votes, interest groups seek to maximize policy, particularly by attracting supporters to promote or bliock policy and policy agendas. The U.S. Catholic Church transformed itself into a full-fledged interest group (Fabrizio 2001) in response to rising Congressional and public support for and eventual implementation of the federal Title X program, and especially in opposition to the *Roe v. Wade* (1973) Supreme Court decision which constitutionally protected women's right to an abortion.

The Religious Right, a political coalition of pro-life, right-wing evangelicals and fundamentalists, gained political momentum in the post-*Roe v. Wade* years and most notably during the 1980s under the Reagan administration (McKeegan 1992). As di Mauro (2007:67) writes, the political formation of the Religious Right was primarily "a reaction to the women's liberation and gay rights movements of that era and the significant changes they ignited in sexual values, behaviors, relationships, and social policies." Their politicization around sexual conservatism and abortion allowed them to effectively shape

reproductive policy, particularly sexuality education, abortion access, and more recently, family planning funding.

In response to pressures from the Religious Right, federally funded abstinence-only programs were formed in 1981 in lieu of (and in direct opposition to) the growing support for family planning services, contraceptive use, and comprehensive sex education (Kantor et al. 2008). Although comprehensive sex education never received specific federal funds, according to the Sexuality Information and Education Council of the U.S., abstinence-only programs received federal funding via three separate streams: Adolescent Family Life Act (AFLA), created in 1981; the Title V abstinence-only-until-marriage program, created in 1996 under welfare reform; and the Community-Based Abstinence Education (CBAE), created in 2000.

According to McFarlane and Meier (2001:2), fertility policies such as abstinence-only programs can be viewed as part of a broader set of "morality policies" that seek to redistribute "values" rather than resources. Through their opposition to family planning, religious conservatives were able to secure funding for abstinence-only policies that promote "premarital chastity and traditional values" (McFarland and Meier 2001:7). Although evidence strongly suggests they are highly ineffective at reducing teen and unwanted pregnancy (Santelli et al. 2017; Sexuality Information and Education Council of the United States 2016), abstinence-only policies continue to regulate sexual and reproductive behavior by strictly prohibiting discussion of contraception and safe sex practices in public schools. They, instead, warn of the supposed physical, psychological, and social dangers of sexual activity outside of marriage (Santelli et al. 2017).

Wetstein and Albritton (1995) attribute the Catholic Church's ability to effectively lobby for its interests and directly influence policy to it's organized, hierarchical nature. For Wilson (2016), the strength and success of religious conservatives' ability to affect social policy is the result of the alliances formed across Catholic and Christian conservative organizations, leaders, lawyers, and lawmakers within the anti-abortion movement. Their ability to coordinate, mobilize, and influence policy so effectively, he argues, is the result of anti-abortion "street politics" and the development of institutional, legal, and funding resources, all of which have enabled an "organized and focused legal force working together for defined policy goals" (Wilson 2016:51).

Interestingly, while each of the political forces laid out above has individually and profoundly influenced the provision of family planning funding and services, there exists overlapping goals and motives among the three. That is, many of them share the same means to achieve different ends. For example, as previously mentioned, feminist and fiscal and racial conservative interests can appear as strange bedfellows, as they promote family planning as a means of avoiding future social spending, slowing population growth, and reducing welfare dependency. Meanwhile, neoliberal and neoconservative interests form an alliance in their shared opposition to subsidized family planning. Fiscal conservatives have argued for cuts to the family planning budget as a way to immediately reduce the federal deficit[5] (Kogen and Shapiro 2016) while social conservative lawmakers have imposed cutbacks and restrictions to publicly funded family planning as a way to regulate

[5] In 2011, the House of Representatives voted for the first time to completely defund Title X (National Family Planning & Reproductive Health Association, n.a.). The vote was promoted by fiscal conservatives as part of the budget sequestration.

abortion providers. Indeed, much of the family planning policy making over the last decade has been spurred by religious conservative forces and partisan politics (Medoff and Dennis 2011) that have successfully implemented various "TRAP" laws, or laws that "target the regulation of abortion providers," across the U.S. (Nash et al. 2013).

Contemporary Restrictions to Family Planning Policy

The new state-level policy trend to implement family planning program and clinic restrictions "TRAP" laws emerged in 2010 and continue to shape restrictive family planning policies at both the state and federal levels as conservative lawmakers attempt to regulate (i.e., penalize) abortion providers, most notably Planned Parenthood. In 2010, conservative Republicans made a sweeping political gain by taking a majority of federal and state legislative seats and making reproductive politics a policy priority. Nash et al. (2013) find that within two years, state lawmakers passed more restrictions to reproductive care and services than during the entire decade of 2001-2010 (Nash et. al 2013). Indeed, in 2011 alone, legislation targeting reproductive care reached a historical record as 36 state legislatures introduced 1,100 bills; 135 of these were successfully implemented (Nash et al. 2013). Putting these data into a larger historical context, they find that, ultimately, from 1993 to 2011, there was approximately a 183.3 percent increase in the number of anti-abortion and restrictive family planning bills introduced by state legislators.

The funding restrictions that have been implemented seek to reduce or deny funding to any entity that provides, contracts, or is affiliated with abortion care. These policies include: a priority system for the distribution of funds that disadvantages specialized family planning providers, placing them at the 'bottom of the list' of funding recipients;

prohibiting the use of state funds for abortion counseling and referral; barring specialized family planning clinics that offer or are affiliated with abortion care from receiving funding altogether; and, more recently, blocking federal funding (via Title X and Medicaid reimbursements) to Planned Parenthood and its affiliates (Guttmacher 2020).

To date, eighteen states have imposed abortion-related restrictions on the allocation of public funds; fifteen states specifically restrict the allocation of state funding; and three states (Iowa, Missouri, and Texas) have developed Medicaid "spin-off" programs (Guttmacher Institute 2020). Medicaid "spin-off" programs essentially opt out of Medicaid reimbursements and, instead, operate as an entirely state-funded program in order to circumvent the federal "free choice of provider" requirement (Ranji et al. 2017). The free choice of provider provision allows Medicaid recipients to seek and obtain sexual and reproductive health care at any federally qualified family planning facility of their choosing.

Not surprisingly, laws that target the regulation of abortion providers via family planning funding restrictions regenerated academic and public interest in family planning policy making in the U.S. Gender, reproductive, and public health scholars in addition to social groups and advocates of publicly funded family planning have criticized these policies as a draconian affront to women reproductive health and rights. Women's ability to choose whether and when to become pregnant, to determine the timing and spacing of their pregnancies, and to access affordable, quality sexual and reproductive health care services is effectively contingent on the particular state in which they live. This is especially true for those women who live in Texas – a state that stands at the center stage

of anti-abortion reproductive policy making. In 2011, Texas slashed its family planning budget by two-thirds, from $111 million to just under $38 million for the next two years (Texas Policy Evaluation Project 2020). That same year, lawmakers implemented a three-tiered funding distribution system that deprioritized Planned Parenthood, the state's largest family planning provider, from receiving public funds (Stevenson et al. 2016; White et al. 2014). Although federal law prohibits federal funding of abortions (per the Hyde Amendment) and although 97% the organization's services are unrelated to abortion (Planned Parenthood 2014), abortion opponents argue that subsidizing Planned Parenthood forces them to indirectly support abortion and the "abortion agenda."

In 2012, the state sought to disqualify family planning organizations and clinics affiliated with abortion (namely Planned Parenthood) from receiving funding from the state's joint federal-state Medicaid program, the Women's Health Program (WHP). The Women's Health Program served over 106,000 women aged 18 years and older with incomes 185% below the poverty line in 2010; for roughly half of those women, Planned Parenthood was the preferred family planning clinic for reproductive care (White et al. 2012). In 2013, after federal courts ruled that the state did not have legislative authority over federal money, the state overhauled the Women's Health Program and created their own Medicaid "spin-off" program. Lawmakers restructured family planning programs by replacing the joint federal-state family planning program, the Texas Women's Health Program (which received a 90% Medicaid reimbursement on family planning program expenditures), with a fully state-funded program (Healthy Texas Women) and succeeding in ensuring that Planned Parenthood would no longer receive public funding.

Conservative lawmakers' decision to target family planning programs and clinics set into motion a ripple effect of unintended (yet logically sequential) consequences on the health and livelihoods of women in Texas (MacDorman, Declercq, and Morton 2016). As previous research shows, the loss of funding in Texas resulted in clinic closures across the state, a massive downsizing of staff, increased service fees, longer travel distances to get to a clinic, and longer wait times to see a physician (Lu and Slusky 2016; Packham 2017; White et al. 2015). Studies documented a related decrease in contraceptive use among Texas women, fewer mammograms, and increases in the rates of teen and unintended pregnancies (Fischer, Royer, and White 2018; Packham 2017; White et al. 2018; Woo, Alamgir, and Potter 2016) as well as Medicaid-paid childbirth expenses (Stevenson et al. 2016); pregnancy-related deaths (MacDorman, Declercq, and Morton 2016). Moreover, despite lawmakers' policy intentions, researchers find that Texas' family planning restrictions did not reduce but rather increased the rates of medically performed abortion, particularly among teens (Packham 2017), as well as "DIY" abortions (Hellerstein 2014; Zelinksi 2020).

The studies cited above provide crucial insight on the extent to which Texas' abortion-related funding restrictions exacerbated reproductive health inequities across the state. However, when it comes to the politics of contemporary family planning policy restrictions, there are several avenues of research that remain vastly understudied. In the next section, I discuss how my dissertation fills those gaps. I present my research questions, data, methods, and analyses, and, in so doing, provide an overview of the layout of my dissertation research.

RESEARCH PROBLEMS

As previously mentioned, family planning policy making in the U.S. is complex, with multiple interests working together and in opposition to influence policy, including social conservative, fiscal conservative, religious, and feminist ideologies (McFarlane and Meier 2001; Nelson 2015; Shapiro 1985). The scholarship to date, however, has not fully considered the social and political determinants of present-day family planning policy making. Although the literature on the politics of reproductive policy has identified the salience of religious and anti-abortion ideology on abortion policy making, its role in the exponential rise in family planning funding restrictions since 2010 has not been given similar empirical attention. There is a need for additional research that extends beyond causal inference and provides a systematic empirical investigation of the social and political forces that contribute to contemporary family planning policy restrictions. As described more fully below, the first objective of this dissertation (Chapter 2) fills this research gap by providing a quantitative, cross-sectional analysis of the broader social and political forces shaping the politics of contemporary family planning restrictions in the U.S.

As feminist public health scholars would argue, the exclusion of subjective knowledge and lived experiences in the existing scholarship on contemporary family planning policy restrictions is largely because there is a general lack of intersectional theorizing and analyses in the broader literature on social inequities in health (Havinsky 2008; Lopez and Gadsden 2016; Lepalme et al. 2019).

As I discuss in greater depth in Chapter 3, intersectionality is defined here as both an intellectual and political project (Collins 2015) that takes a feminist, critical race, praxis-

oriented approach to understanding social inequalities. As a theoretical lens, intersectionality understands social categories and experiences such as gender, sexuality, social class, race-ethnicity, nativity, and other social identities as overlapping, interrelated, mutually reinforcing structures of inequality that produce varying degrees of power, privilege, and disadvantage (Collins 2000; Crenshaw 1991; Davis 1981). Moreover, intersectionality emphasizes the importance of employing methodologies that elevate the voices of those who are multiply marginalized (Cho, Crenshaw, and McCall 2013). Placing their lives "from the margin to the center" of analysis allows researchers to give voice to their experiences of oppression as well as their experiences with resistance and self-determination (Collins 2000). Finally, intersectionality's praxis-oriented approach is a commitment to social justice that promotes the application of empirical analyses and experiential knowledge in efforts to redress social and structural inequalities (Collins and Bilge 2020). My dissertation, especially Chapters 3 and 4, are guided by an intersectional feminist perspective and combines insights from multiple disciplines – including sociology, gender and ethnic studies, political science, and public health – to better understand the politics of, and lived experiences with, family planning policy.

Decades of welfare and social policy scholarship as well as anecdotal evidence tells us that defunding social support programs disproportionately impacts marginalized individuals, groups, and communities. Although existing research provides important and necessary evidence of the ways in which Texas' family planning policies have adversely affected women's health, most of these studies focus on documenting aggregate-level impacts. Very few studies examine how cutbacks and restrictions have been experienced

at the individual and community levels, especially by working class women of color and consumers of publicly funded family planning services in medically under-resourced and under-served regions of the state (Boom et al. 2019; Nuestro Texas 2013; Woo, Alamgir, and Potter 2016).[6] Along the borderlands of south Texas in a region known as the Rio Grande Valley (RGV), specialized, publicly funded family planning clinics have long been a primary source of health care for many low-income, uninsured Latinx women. Consequently, the loss of funding was particularly hard-hitting for local clinics and the women who rely on them in order to access sexual and reproductive health care services.

In order to address the inequities in Latinx women's reproductive health care access and outcomes, researchers, reproductive health and rights advocates, as well as policymakers must focus their attention on – as well as contextualize – Latinx women's lived experiences with accessing and utilizing sexual and reproductive health care. Currently, it is well understood in the literature on the social determinants of Latinx women's reproductive health that they face several barriers to health care access. For example, socioeconomic status (SES), a lack of health insurance, under-resourced health care infrastructures, in addition to other factors such as a lack of access to transportation, immigrant status, and language discordance are among the various *structural barriers* that prevent Latinx women from accessing and utilizing sexual and reproductive health care (SRHC) services. Latinx women often face additional *sociocultural* and *political barriers*

[6] Scholars have assessed the impacts of Texas' family planning policies as they were experienced and perceived by health organization program administrators (White et al. 2015) and as they affected primary care organizations (White et al. 2018).

as well. Sociocultural forces such as religiosity, the transmission of norms and expectations regarding traditional gender roles and sexuality, and parents' attitudes and beliefs about sex have also been shown to negatively impact women's health knowledge and thwart health-seeking behaviors (Rojas-Guyler et al. 2011). Meanwhile, abstinence-only curricula requirements and age- and citizenship-based eligibility restrictions (Hooton 2005; Hock-Long et al. 2003) pose additional political challenges for SRHC access.

The literature on the determinants of, or barriers to, Latinx women's access to SRHC is already extensive. Nevertheless, the "fragility of political and financial support for sexual and reproductive health services" (WHO 2010:8) represents new, insurmountable political barriers that have exacerbated existing structural and sociocultural barriers to SRHC. To date, only a few studies have examined the conditions under and ways in which Texas' policies compounded these existing barriers within specific social, political, and geographic contexts like the RGV (Cristancho, Garces, Peters, and Mueller 2008; Mann et al. 2016; Morales-Alemán, Ferreti, and Scarinci 2020; Smith, Sundstrom, and Delay 2020). Ultimately, it is not fully understood how Latinx women have experienced this convergence of barriers to SRHC while confronted with policies that specifically target SRHC by defunding and restricting publicly funded family planning programs. Chapter 3 of my dissertation aims to fill that research gap using qualitative methods, specifically in-depth, semi-structured interviews, to advance the second objective of my research: revealing the ways in which Texas' abortion-related restrictions to family planning compounded Latinx women's barriers sexual and reproductive health care access

along the border in the RGV, particularly among current and former consumers of publicly funded family planning programs.

Feminists and advocates of family planning criticize Texas' punitive family planning funding policies as an attack on women's reproductive health and rights. At the height of Texas' anti-abortion policy making, national organizations like the Center for Reproductive Rights and the National Latina Institute for Reproductive Health came together in an effort to organize and mobilize RGV women in defense of their reproductive health and rights (Nuestro Texas 2013, 2015). However, scholarship on the conditions under which low-income women and women of color mobilize to defend their reproductive health care access has been notably absent across reproductive, welfare, and social movement research. Chapter 4 of my dissertation completes the third objective of my dissertation by examining, through qualitative methods, the mechanisms and processes that enable or constrain the political mobilization of low-income Latinx women in the RGV. Understanding women's reproductive health care mobilization fundamental to studying the politics of family planning policy restrictions, as it sheds light on the challenges that limit their voice and influence within reproductive policy debates, as well as how those challenges are sometimes overcome.

Using an intersectional feminist perspective as well mixed-methods research, my dissertation aims to fill the above gaps in the existing literature and provide a more comprehensive study on the politics of contemporary family planning policy restrictions. My research design for Chapter 2 is discussed more fully in that chapter. Below, I discuss

the methodological and analytical tools used for the qualitative portions of my dissertation, Chapters 3 and 4).

Qualitative Research Design

Before presenting the research questions and findings of each qualitative chapter, it is necessary to first provide an explanation and justification for my approach. In this section, I detail my case selection, interview sampling procedures as well as my research and analytical methods for my community case study.

Case Selection

The RGV, the persistent disparities in reproductive health care access and outcomes, and the women whose lives that have been affected by lawmakers' decision to target family planning and preventive reproductive health care access are motivations for this dissertation research. The "Valley," as it is affectionately referred to by locals, is a relatively large region of south Texas that is comprised of four counties – Cameron, Hidalgo, Starr, and Willacy. More than one in three people among the 1.3 million residents (over 90% of whom are Latinx, specifically Mexican, descent) live below the poverty line (Ura 2016). Women are especially economically marginalized. In the metropolitan areas of the RGV, forty-five percent of households living in poverty are female-headed households, yet only less than 30 percent of households are female-headed (Center for Public Policy Priorities 2017).[7]

[7] Across the four counties, there are nine metropolitan areas (two in Cameron, six in Hidalgo, and one in Starr), all of which are surrounded by predominantly rural communities and *colonias*. *Colonias* are unincorporated communities that are marked by extreme poverty and lack basic living necessities such as electricity, sewage systems, potable water, and paved roads.

Health care access is also a persistent, pervasive, and systemic problem in the RGV. Each of its four counties is designated as a "Medically Underserved Area and Health Professional Shortage Area" (United States-Mexico Border Health Commission, 2014). The health care infrastructure along the border is severely under-resourced and, as such, is unable to meet the needs of the community (Boom et al. 2019). Meanwhile, thirty-eight percent of the population lacks health insurance, and nearly half of women of reproductive age (15-44) are likely to be uninsured – compared to just one out of four across the state (Tingle, Haynes, and Li 2017). Thus, it is no surprise that there are disproportionately high rates of unintended, teen, and repeat teen births as well as significantly higher rates of gonorrhea, chlamydia, and cervical cancer diagnoses relative to the rates at both the national and state levels (County Health Rankings and Roadmaps 2016). Indeed, women living in counties along the south Texas-Mexico border are 31 percent more likely to die of cervical mortality relative to women who live in non-border communities (Nuestro Texas 2013).

Although many of these reproductive health inequities can be found elsewhere, this particular region along the border reflects the severity of the impact that punitive anti-abortion family planning policies have on low-income, uninsured Latinx women, and their communities. Within two years (between 2010 and 2012) of Texas' decision slashed its budget for family planning by two-thirds and implemented funding eligibility restrictions, almost a third of the RGV's state-funded, specialized family planning clinics were forced to shut down. As I elaborate in Chapter 3, the clinic shutdowns had disastrous effects on women's ability to access health care, clinics' ability to provide services, and RGV

women's overall reproductive health. Fewer clinics, fewer staff, and longer wait times made it more difficult for women to access basic, necessary, lifesaving preventive health services and care.

The extent of women in need of publicly funded family planning services and the impact that anti-abortion reproductive policies have had in this region make the RGV an important site of research. To date, there are only six publicly funded clinics specializing in family planning that are still operating across the entire four-county region (as opposed to the 10 that existed prior to 2013). Four of the six are located in the McAllen metropolitan statistical area (MSA) – thus making McAllen the specific site of my research.

My interest in the RGV (indeed, my motivation for this research) stems from my background and upbringing as an RGV native, a passionate advocate of reproductive justice, and a former consumer of publicly funded family planning. Growing up, the only access to health insurance I had was through the Texas Children's Health Insurance Program (i.e., "CHIP") and Medicaid.[8] While in college, I did not have access to health insurance. I could barely afford to cover my costs of living let alone set extra money aside to pay for health-related expenses. Through word of mouth, I learned that I could "get a check-up" (i.e., receive preventive health screenings) at the local Planned Parenthood at little to no cost. One year later, Texas proposed to and successfully cut state funding for family planning programs. I along with thousands of other women across the state could

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[8] Like Medicaid, CHIP provides health insurance to children 18 years and younger in low-income families (for more detailed information, see Texas Health and Human Services 2020).

no longer access reduced cost contraception and other indispensable reproductive health services. The feminist adage “the personal is political” became a lived reality.

During my last two years as an undergraduate at the University of Texas Pan American (now University of Texas RGV), I was further galvanized as I began to participate in discussions, demonstrations, and other reproductive health and rights-related events. Inspired and aggrieved, I signed up for a leadership position in the student organization, *VOX: Voices for Planned Parenthood*, in order to promote reproductive health and education on campus, inform students on how and where to access services, and advocate for reproductive rights. Through my participation, I established and maintained friendships as well as both formal and informal connections with other women involved in reproductive politics. As I describe in the section below, these women played a large role in my efforts to recruit interviewees for my research.

Sampling

I attempted to gather a sample that could provide an intimate, more humanized illustration of the importance and necessity of family planning access. As previously discussed, family planning clinics have been a crucial source of health care access for many women in the economically disadvantaged RGV. In order to best understand how family planning policy restrictions have been experienced in the borderlands of south Texas, I sought to interview Latinx women who are current or former consumers of public family planning in the McAllen MSA. It is additionally important to appreciate if and how consumers of publicly funded family planning services come to view themselves as political subjects and agents of social change (i.e., how they become politicized). Finally,

I specifically chose Latinx women as the sample for this study as a way to include and expand the voices of Latinx women in the literature on women's reproductive and political experiences. A common critique in critical, feminist reproductive scholarship is that mainstream research on and advocacy for reproductive rights often excludes discussions on the ways in which women of color experience, perceive, and mobilize against anti-abortion policies (Garcia 2016; Mann et al. 2016; Ross 2006).

In-depth, semi-structured interviews were conducted with 30 working class Latinx women who live in the McAllen MSA of the RGV; twenty-five are current or former consumers of publicly funded family planning programs; five are or were affiliated with the local family planning clinics as campus or community outreach advocates. My respondents' ages ranged from 23 to 39 years of age, with a median age of 31. Table 1 below describes additional demographic characteristics of my sample.

Table 1: Participant Characteristics

Publicly Funded Family Planning Services	**N=30**
Never used	5
Current Consumer	4
Former Consumer	21
Gender Identity	
Cisgender	27
Gender Queer	3
Sexual Orientation	
Heterosexual	24
LGBTQA	7
Educational Attainment	
Some college	6
Currently enrolled	6
Bachelor's degree	14
Advanced degree	4
Citizenship	
U.S. Born citizen	26
Naturalized citizen	4
Employment	
Currently employed	27
Unemployed	3
Insurance Status	
Employer-provided	15
Family insurance plan	5
Public health insurance	4
Uninsured	6
Household Income	
Less than 10,000	1
10,000-29,000	10
30,000-49,000	15
60,000+	3
Don't know	1
Children	
Yes, 17 years of age or younger	5
Yes, 5 years of age or younger	1
No children	25
Marital Status	
Single	12
Married	3
Divorced	2
In a committed relationship and living together	6
In a committed relationship and not living together	7
Public Assistance (TANF, SNAP, Unemployment, CHIP, WIC)	
Currently Receive	3
Received in the last 5 years	4

Twenty-seven of my respondents identify as female, or cisgender, two identify as gender queer, six as bisexual, and one as asexual. While most respondents were born in the U.S., four are naturalized citizens. All but two interviewees had at least "some college" experience: six had some college experience but are no longer enrolled; five are currently enrolled in college; and seventeen hold a bachelor's degree – four of whom hold an advanced degree. Most respondents, like other local residents, have modest incomes (median household income in the RGV is $34,009) and most now have health insurance. Two-thirds of women have either employer-provided insurance (n=15) or are enrolled through their family's health care plan (n=5), while the remaining third have public health insurance (n=4) or are uninsured (n=6).

Snowball sampling was the preferred method of recruiting respondents in this context, as it allowed for a greater ease of access to consumers of publicly funded family planning via personal connections. The use of a snowball sampling method also allowed me to eschew any potential issues that might have surfaced if, for example, I would have attempted to directly approach family planning clients at a clinic (convenience sampling).

Through my participation in political advocacy and outreach efforts as an undergraduate, I was introduced to various (in)formal networks in the broader social movement community and developed friendships with some of the other, more seasoned community activists. The connections I've maintained, specifically the points of contact I have with two clinic (nonmedical) staff members, two former consumers of publicly funded family planning services, as well as several family planning advocates, afforded me the "snowball momentum" that was needed to facilitate the recruitment process by

providing an initial set of names of and contact information for potential interviewees and personally "vouching" for my credibility as an advocate, scholar, and friend.

Every potential participant was first contacted via email using a recruitment script. Those who expressed interest in participating were given a consent form prior to receiving the screening questionnaire. The consent form detailed the aims of the study; the protocols for participation; participants' rights to privacy and confidentiality; the voluntary nature of their participation; the benefits and potential risks; their ability to terminate the interview or withdraw from the study at any time; and contact information for myself, my faculty sponsor, and the UCR Office of Research Integrity. The screening questionnaire determined their eligibility for the study; it was also used as a collect demographic and background data. (See Appendix A for more details on the recruitment process, including the examples of the recruitment script, screening questionnaire, consent form.)

Research & Analytical Methods

Conducting semi-structured interviews, as opposed to structured interviews or using survey methods, was the most effective way – especially from an intersectional feminist perspective – to allow women to narrate their own experiences with family planning freely and openly. As Judith Stacey (1988:21) writes, "[M]ost feminist scholars advocate an integrative, trans-disciplinary approach to knowledge which grounds theory contextually in the concrete realm of women's everyday lives." Interview methods allows the researcher a greater depth of qualitative data, as well as a much more comprehensive understanding of their respondents' perspectives and "interpretation of reality" (Blee and Taylor 2002) than what can be gathered using a strict question-answer format or other,

alternative methods. Moreover, the flexibility and adaptability of semi-structured interview questions enables researchers to extemporaneously modify the interview to explore in more depth any topics and themes that organically.

The interview questions focused on participants experiences with family planning services and/or other sexual and reproductive health care resources; the ease or difficulty with which they were able to access services in their community; whether respondents were aware of Texas' cutbacks and restrictions to publicly funded family planning programs; and how they experienced, navigated, and/or challenged those policies.[9] (The interview questionnaire can be found in Appendix B.) Three of the interviews were conducted in-person in a public setting (e.g., restaurants and a coffee shop) while the rest were conducted either via video call (n=4) or phone call (n=23). The interviews ranged from 35 to 120 minutes and were audio-recorded using a digital recorder with participants' written and verbal consent. Three undergraduate research assistants aided in transcribing the interview data.[10] The transcriptions were uploaded into a password protected Google Drive folder that was accessible to only myself and my research assistants. To verify the accuracy of the transcriptions, I listened to the audio-recordings while following along with the transcribed text in Microsoft Word.

[9] Although the interview questions inquired about use of sexual and reproductive health services, respondents were not asked to disclose any medical records or information.

[10] While it could be argued that this might have distanced myself from part of the data collection and analyses, I firmly believe that it is important that we introduce, mentor, and integrate undergraduate students in the research process in order to help them further develop professional research skills that they then can apply in future projects of their own.

Atlas.ti, a computer-assisted qualitative data analysis software tool, was initially used in the data management process; however, subsequent data management and analyses were performed manually. In order to construct analytic categories around Latinx women's perceptions and lived experiences, I conducted thematic content analysis of the transcribed interview data (specifically during the transcription verification process) by identifying, annotating, and coding reoccurring themes using Microsoft Word. For both Chapters 3 and 4, I analyzed the conceptual categories created using a descriptive and an interpretive approach as well as grounded theory (Charmaz 2004) to make sense of the interview data. The descriptive analysis represents interviewees' literal responses so that my research, in large part, directly reflects consumers' experiences regarding the ways in which policies have impacted their ability to seek and obtain family planning services as well as whether and how they have mobilized and challenged anti-abortion policy making. The interpretive analysis uses a sociological perspective to organize those experiences around the themes and sub-themes that emerge in order to "explain and understand" (Charmaz 2004:499) those experiences from their standpoint. As Charmaz (2004:499) writes grounded theory methods "bridge interpretative analyses with traditional positivist assumptions because they are used to discover research participants' meanings; they assume an empirical enterprise, and they provide a set of procedures to follow." All respondents were assigned pseudonyms in the reporting of my findings.

DISSERTATION OVERVIEW

In Chapter 2, "The Politics of Family Planning Funding Restrictions in the U.S.," I explore the extent to which institutional and ideological forces – including legislative

ideology and religious conservatism, in addition to feminist interest group effects and racial-ethnic contexts – influence state-level family planning policy restrictiveness. My research question asks: *To what extent does religious-conservative politics explain the relative restrictiveness or leniency in states' family planning policy making?* Using a proprietary dataset and regression techniques, I gauge the relative impact of various social and political factors –including government ideology, religious-conservative ideology, feminist influence, and states' racial-ethnic composition – on variation in states' family planning restrictiveness. I find that religious-conservative ideology among state lawmakers to be the strongest predictor of such restrictiveness, as measured by the cumulative count of six popular restrictions either introduced or implemented by the end of January 2018.

In Chapter 3, "Caught in a Triple Bind: Latinx Women's Barriers to Sexual and Reproductive Health care in the Rio Grande Valley," I apply the "power conscious lens" of intersectionality to 1) examine the structural, sociocultural, and political barriers to SRHC access as they are experienced by Latinx women in the RGV; and 2) explore the ways in which women make sense of and navigate these barriers in an effort to meet their SRHC needs. I analyze these three sets of barriers within the multiple, interconnected systems of inequality and relations of power that create and sustain these and other social inequalities (Collins and Bilge 2020) within the particular sociogeopolitical context of the RGV within the state of Texas. Using an intersectional framework also allows me to bring to the forefront women's lived experiences as reproductive agents (Carvajal and Zambrana 2020).

Throughout Chapter 3, I argue that the convergence of structural, sociocultural, and political barriers as they are experienced by and impact Latinx women in the RGV represent a distinct "matrix" of barriers that places low-income, uninsured Latinx women in this region within a multiply disadvantaged situation that I refer to as a "triple bind" of reproductive oppression. This triple bind results from the intersecting, mutually reinforcing systems of oppression and relations of power (i.e., patriarchy, heterosexism, neoliberal capitalism, and neoconservative governance) that structure and (re)produce the persistent SRHC inequities within this region. Each barrier is enacted and experienced via multiple "domains of power" (Collins 2009, 2017) and impacts various dimensions of access (Price and Hawkins 2007). These power domains, along with SRHC and other inequities, however, can also engender resistance.

Consistent with previous research, the challenges in accessing SRHC that my Latinx respondents describe are largely related to socioeconomic status and financial hardship (structural barriers), and sociocultural barriers including familial and societal pressures of traditional religious beliefs and "sexual silence" (Davila 2005). Of particular importance to this study are the political barriers to SRHC that emerged as a result of Texas' family planning policies. The loss of funding disproportionately affected access in the RGV and further compounded the existing structural and sociocultural barriers, as it forced nearly a third of clinics to shut down in a region that was already recognized as a medically underserved area. The clinic closures and increased costs of services made it increasingly difficult to schedule a timely appointment and access their preferred method of contraception.

Women's accounts document the ways in which they exercise reproductive agency and autonomy and are able to do so with the help of publicly funded family planning programs. According to my respondents, local family planning clinics are a primary source for many working class Latinx women's access to preventive health care. For most women, publicly funded family planning programs are their first and often only access to any type of health care program. Interestingly (albeit unsurprisingly), some respondents disclosed that they have utilized publicly funded family planning services as a strategic act of resistance to the conservative political climate that they perceive as a threat to their physical health and reproductive rights.

Chapter 4, "Reproductive Rights on the Margins: Latinx Women's Mobilization around Reproductive Health care Politics in the Rio Grande Valley," builds on the momentum of political resistance by exploring the ways in which Texas policies have been perceived and challenged by current and former recipients of publicly funded family planning programs. The central question guiding my research asks: *What mobilizing factors influence whether low-income Latinx women in the RGV mobilize in response to punitive reproductive policy making and engage in political activities that defend and promote reproductive health, rights, and justice?* The emphasis here is not on mass mobilization or the *types* of political activities, but rather, individuals' micro-mobilization processes – or their "pathways to mobilization" (Viterna 2006).

In addition to the conventional structural and personal barriers to political participation, attention is paid to the mobilizing processes of social movement organizations (SMOs), networks (social movement communities, or SMCs, and social

ties), and emotions (particularly grievances and empowerment). My analysis highlights the emotional processes that inhibit mobilization which has been understudied in the social movement literature. Previous literature on the role of emotions for political participation instead tends to focus on how emotions motivate political participation.

Consistent with previous social movement scholarship, I find that material and ideological resource mobilization by SMOs, access to personal and organizational movement networks (social movement communities), and emotional resonance (particularly with grievances and feelings of empowerment) help to galvanize some women's political engagement with reproductive health care politics. For others, political non-participation is related to structural barriers to participation and/or a calculated decision to avoid emotional strain. SMOs are especially important for politicizing (Frease 1975; Levitsky 2014) women around sexual and reproductive health and politics, and for providing the necessary material resources that facilitate participation.

Women's personal connections to a broader network of activists and social movement activities (SMCs) also significantly influences their political participation in reproductive health care politics. Finally, grievances (manifested as feelings of anger and a sense of injustice) and empowerment (i.e., pride and a sense of efficacy) are central to mobilizing – and often sustaining – political activity. Many women express grievances over both the structural and cultural constraints shaping their physical and informational access to reproductive health care as motivations for "getting involved" (e.g., anti-abortion reproductive policies, patriarchal gender ideology, Catholicism, and sexual conservatism).

Unlike previous research, my research highlights the emotional dynamics that not only encourage but also discourage individuals from political engagement. Interviews reveal that emotions (e.g., feelings of shame, social discomfort and anxieties, and activist burnout) act as barriers to political participation. Nonparticipation, thus, is based on a rational, calculated decision to avoid emotional strain – a cognitive process that is referred to as "emotion management" (Hochschild 1979; Norgaard 2006). Still, for some, political participation is inevitably limited by personal constraints such as discretionary time, employment, childcare, transportation – i.e., their biographical availability (McAdam 1986) – as well as their structural availability, or their access to informational networks that tend to provide the necessary details for event participation (Schussman and Soule 2005).

Finally, I situate my respondents' mobilization within the political and sociocultural contexts that shape sexual and reproductive health care politics for women in the RGV. I argue that their activist experiences in the RGV reflect a culturally- and geographically-distinct "border feminism" (Anzaldua 1987; Pardo 1995, 2017; Saldivar-Hull 1991); their resistance and advocacy are part of a longstanding battle to secure sexual and reproductive agency in the face of political, institutional, and cultural constraints. Women, ultimately, are seeking to challenge both policy and cultural stigmas associated with female sexuality by promoting sexual and reproductive health education and awareness.

CONCLUSION

The three objectives of my dissertation and their corresponding chapters are laid out in a deliberately sequential order as a way to develop a larger argument about the consequences of anti-abortion reproductive policies and their real-life impacts on marginalized women's access to reproductive health care. The underlying argument is that policies that reduce or restrict public funding for family planning programs and reproductive health care do not promote or enhance, but rather, constrain and even threaten the reproductive health, autonomy, and livelihoods of the women who rely on them. Without health insurance and the ability to enter the health care system, poor and low-income Latinx women are far less likely to be able to access contraception, life-saving cancer screenings, and other preventive sexual and reproductive health care services that would help significantly reduce the incidents of negative – and often fatal – reproductive health outcomes. Nevertheless, it is important to not view low-income Latinx women simply as passive victims of restrictive family planning policy and other barriers to SRHC. Instead, they actively respond to the various challenges they face in accessing SRHC. Some cross the U.S.-Mexican border in order to obtain the reproductive health care services they need. Some also mobilize politically in an effort to shape reproductive health care policies. Even those who do not mobilize politically around these issues often do so as a rational and calculated effort to avoid emotional strain.

Understanding the social and political forces behind punitive family planning funding restrictions as well as their public health and political impacts make this dissertation research a timely and crucial endeavor. Because publicly supported family

planning plays a considerable role in shaping women's health, social mobility, and life-chances, my dissertation was motivated by academic, public health, and reproductive justice pursuits. I emphasized throughout my dissertation the importance of using intersectional feminist theory in combination with other perspectives in order to provide a critical and comprehensive study on the politics of reproductive policy and family planning policy restrictions. Lived experiences and personal narratives reveal the extent to which restrictive family planning and reproductive policies not only threatens women's health care access and health outcomes; they also signal the importance of expanding funding and support for publicly funded SRHC. In Chapter 5 of this dissertation, I review these and other implications of my research findings, including insights gained from my analyses that can be used to promote reproductive health care access, education and outreach, and policy.

In Chapter 5, I also discuss the conceptual, methodological, and analytical limitations to my research that future studies would do well to address. For example, although several states have sought to defund and restrict family planning programs and clinics, there are many other states that have expanded access to publicly funded health care services via Medicaid expansions and increases in state appropriations for family planning programs, clinics, and services. In addition, my interview data is neither a random nor representative sample and I focus on one specific region within the United States. Latinx women are also not monolithic and my interview sample. In particular, Latinx women without any college education are not well represented in my interview sample. In addition, I did not include in my interview questionnaire questions related to LGBTQ

experiences with SRHC and political mobilization, although some participants did discuss those experiences in the course of my interviews. Including more questions regarding LGBTQ experiences and perspectives would have further enriched my research findings, especially since nearly one-third of my interview sample identified as part of the LGBTQ community. I hope that my dissertation helps to inspire additional research on this topic to help address these and other various limits in my dissertation.

Lastly, I close the dissertation with a discussion on how my research can inform ways in which to address the challenges constraining Latinx women's reproductive health care access in the RGV. The implications of my respondents' narratives and lived experiences offer insights that lawmakers, public health professionals, and reproductive health and rights advocates can use when designing interventions that seek to minimize disparities, expand health care access and utilization, promote reproductive agency, and uplift women by recognizing access to SRHC as a basic human right.

CHAPTER 2
THE POLITICS OF FAMILY PLANNING POLICY RESTRICTIONS IN THE U.S.

"*Never in its history has the nation's family planning safety net faced as significant a threat as it does today*" (Hasstedt 2016:67).

INTRODUCTION

Under what conditions have U.S. states restricted publicly funded family planning programs? This chapter seeks to address this question using quantitative methods. Currently, much of the existing scholarship on family planning policy has been written from an epidemiological perspective, focusing on program implementation, use, impact, and effectiveness (Freedman 1987; Ricketts, Klingler, and Schwalberg 2014), and often within a global context (Bongaarts 2014; Kuumba 1999). Research that has previously examined the politics of publicly funded family planning in the United States is not only dated, it also has occurred largely within the field of political science and public health, rendering it noticeably absent within the sociological literature on reproductive policy, welfare policy, and gender studies. The goal for this chapter, thus, is to contribute to the research on the politics of family planning policy, using a sociological perspective to examine the social and political forces shaping state-level restrictions to family planning programs.

To state the guiding question succinctly: *To what extent does religious-conservative politics explain the relative restrictiveness or leniency in states' family planning policy making?* To address this question, I first provide an overview of previous research on family planning politics in the U.S., including the recent conservative, anti-abortion legislation that has targeted funding. Next, I examine social and political factors often

presumed to influence family planning policy making. Through regression analyses, I gauge the relative impact of various independent variables –government ideology, religious-conservative ideology, feminist influence, and states' racial-ethnic composition – on variation in states' family planning restrictiveness. I find that religious-conservative ideology among state lawmakers to be the strongest predictor of such restrictiveness, as measured by the cumulative count of six popular restrictions either introduced or implemented by the end of January 2018.

The findings in this study underscore the significance of state actors and institutional power in social policy making, as well as electoral politics, especially on ideologically salient issues (or "morality policies") like reproductive politics. This study demonstrates that family planning and reproductive health care policies have become increasingly subject to ideological, partisan policy making rather than public health care needs. As welfare scholars contend, states "may be sites of autonomous official action" by self-interested officials and bureaucrats whose goals are "not reducible to the demands or preferences of any social group(s)" (Orloff and Skocpol 1984:730). Nevertheless, legislators' personal interests and ideologies offer only a partial explanation for the prevalence of restrictive family planning (and reproductive) policy making. Government ideology functions an institutional force shaping reproductive health care policy and outcomes precisely because of the electoral process whereby political "allies" are elected into office. In other words, institutional conditions matter, but it is also by shaping electoral outcomes that conservative, anti-abortion interest groups (the organized and politicized "Religious Right") influence policy the most.

REVISTING THE LITERATURE: THE POLITICS OF FAMILY PLANNING POLICY

Voluminous research on the politics of reproductive policy has long discussed the relationship between socially conservative politics and reproductive policy making. The reproductive politics of the 1960s leading up to the legalization of abortion in the 1973 landmark *Roe v. Wade* case spurred a political backlash that effectively mobilized the Religious Right – a political coalition of "pro-life," right-wing evangelicals and fundamentalists. As di Mauro (2007:67) suggests, the political formation of the Religious Right was primarily "a reaction to the women's liberation and gay rights movements of that era and the significant changes they ignited in sexual values, behaviors, relationships, and social policies."

The Religious Right's politicization around sexual conservatism and abortion allowed them to effectively shape reproductive policy, particularly sexuality education, abortion access, and family planning funding. For example, in 1976, in response *to Roe v. Wade* and pressures from the Religious Right, Congress authorized the Hyde Amendment, which ruled that no federal money could be used to fund abortion, except in cases of rape, incest, or life endangerment (Swers 1998). During the 1980s, under the Reagan administration and in response to the growing demand for family planning, contraceptive use, and comprehensive sex education (McKeegan 1992), religious conservatives were able to ensure that federal funding for family planning services included resources for abstinence-only programs promoting "premarital chastity and traditional values" (McFarland and Meier 2001:7). Under Reagan's "restructured federalism" in 1981-1982,

federal family planning expenditures were reduced, severely impacting state-level programs that had to then compete over fewer available resources. As McFarlane and Meier (1993:839) note, "The likelihood that a low-income woman would receive family planning services became more dependent on her state of residence than ever before." The retrenchment of family planning programs, they argue, was a politically motivated attack intended to placate the Religious Right of the Republican party.

During the 1990s, a few states began to impose abortion-related restrictions on state funding that barred the use of funds not only for abortion but for abortion referrals and counseling as well (Guttmacher Institute 2017). Since 2010, however, policy makers have re-focused their efforts to challenge abortion policy via family planning funding regulations.[11] In fact, as Nash et al. (2013) show, there were more restrictions to reproductive health care and services (including abortion and family planning services and funding) passed between 2010-2013 than during the entire decade of 2001-2010. Over the last 10 years, several states have made significant cuts to their own family planning budgets (Guttmacher 2017) and have stringently regulated the allocation and distribution of funds to federally qualified family planning clinics (Marty and Pieklo 2013; Wilson 2016). Many states have imposed various abortion-related sanctions on the provision and use of public funding (Guttmacher 2017). Some of the restrictions on publicly supported family planning include prohibiting the use of state funds for abortion counseling and referral; a priority system for the distribution of funds that disadvantages family planning providers; blocking

[11] In 2010, self-identified Tea Party Republicans who campaigned on firm, anti-abortion politics made a sweeping gain and took a majority of federal and state legislative seats. Following their political win was an unprecedented wave of restrictive reproductive policy making.

specialized family planning clinics that offer, counsel on, or are affiliated with abortion services from receiving state funding altogether; and, more recently, blocking federal Title X and Medicaid reimbursements to Planned Parenthood and its affiliates (Guttmacher Institute 2017; Ranji et al. 2017).

By 2015, 24 states had attempted and 17 had succeeded in enacting one or more of these funding restrictions (Hasstedt 2016). Two states in particular (Texas in 2011 and Missouri in 2017) have taken some of the most extreme measures to regulate public funding for family planning by forgoing the federal financial support provided by the Medicaid family planning expansion program – which covers 90 percent of the costs of family planning services and care – to ensure full latitude over the appropriation and distribution of funds. And with the ideological and institutional support from the 45th president of the U.S. and his administration, state legislatures and Congress are continuing to improvise ways to sustain and intensify the legislative campaign targeting publicly funded family planning programs.

Religious conservatives' "interest group effect" on federal and state policies has allowed them to have a significant and lasting impact on reproductive policy making for roughly forty years (Berkman and O'Connor 1995; Camobreco and Barnello 2008; Dennis, Medoff, Stevens 2011; Medoff 2002). Their political "interest" in reproductive policies like abortion and family planning programs explicitly reflect deeply held convictions regarding what is right and wrong under "moral and religious law." According to McFarlane and Meier (2001), such convictions behind reproductive politics make family planning programs a redistributive "morality" policy: they involve state and bureaucratic

authority over the "legitimacy of values" that are greatly influenced by organized religion. While the moralization of the matter in public discourse is obvious – rendering reproductive politics and abortion especially contentious – publicly supported family planning can certainly be understood in broader terms than "redistributive morality politics."

To be sure, much of contemporary family planning policy making has been influenced by religious conservative ideology, but the politics of family planning policy is hardly as contentious and divisive as *abortion* politics. Unlike abortion, publicly supported family planning policy is not a "bimodal" issue, as Medoff, Dennis and Bishin (1995:294) put it, with two and only two "intense, inflexible, and uncompromising" positions. Moreover, the politics of family planning is uniquely situated at the intersection of reproductive and welfare politics. It entails, at once, both public assistance and reproductive health care programs. As such, the dynamics of family planning policy in the U.S. are deeply entrenched within a complex network of gender, race, class, and religious politics – a contentious terrain of support for and opposition to publicly supported family planning.

Other social and political forces impacting family planning policy making have included racist, class-based population control agendas (Silliman et al. 2004); feminist, reproductive health and rights advocacy (Morgan 2002); and neoliberal, fiscal conservatism (Meier and McFarlane 1993). For example, family planning initiatives in the U.S. at the start of the 20th century were largely racist, eugenicist fertility control programs that promoted the sterilization of indigent women (and men) of color as a means of

reducing the rising rate of the nonwhite (particularly Black and Latino) populations (Roberts 1998; Schoen 2005; Thomas 1998).

The women's health movement of the 1970's was also an exceptionally noticeable force in family planning policy making, as advocates actively promoted access to contraception as the means necessary for women's reproductive autonomy and self-determination (Morgan 2002; Nelson 2015). Today, feminists and women's health and reproductive rights advocates continue to emphasize the importance of access to contraception and preventive reproductive health care services for all women, especially those with the greatest social and economic barriers to reproductive freedom (Freedman and Isaacs 1993).

Nevertheless, like other social programs, publicly funded family planning has also been shaped by a fiscal conservative interest in minimizing public costs (Meier and McFarlane 1993). Cost-cutting interests certainly contribute to support for reducing family planning spending. Meanwhile, fiscal conservatism can also lend support to expanding access to family planning services when these services are seen as a means of reducing welfare costs, poverty, and overpopulation (for population control politics, see Shapiro 1985). Fiscal interests are also rarely neutral in terms of which social beneficiaries are targeted for cutbacks; implicit and sometimes explicit targets of family planning cutbacks have often been low-income women of color – Latina, black and indigenous women in particular (Ross 2006; Schoen 2005; Volscho 2010).

Although public family planning programs have been supported and opposed by a variety of complementary and conflicting factors for roughly a century, the politics of

family planning programs continues to receive scarce attention, especially when compared to the extensive research on abortion policies. The most notable studies on the politics of family planning have been conducted by McFarlane and Meier (1989; 1993; 1995; 2001). Throughout their research, they highlight the importance of accessing family planning services and care, largely by assessing the determinants and impacts of publicly funded family planning. They have applied the theory of statutory coherence[12] to Title X funding and found that every dollar spent per capita through Title X in each state had a significant impact on birth rates, abortion rates, late prenatal care, and infant and neonatal mortality (Meier and McFarlane 1996). In other work, they found that from 1982 to 1988, state-level funding was associated with fewer low birthweight babies, births with late or no prenatal care, infant deaths, and neonatal deaths (Meier and McFarlane 1994).

Finally, in another study, McFarlane and Meier (2001) examined state-level discretionary funding for family planning. They found that states with greater party competition and more Democrats were positively associated with the use of more discretionary funding sources for family planning. Interestingly, contrary to their hypothesis, they also found that the strength of conservative advocacy groups (measured as the percentage of the state population that is Catholic and the percentage of the state population that belongs to Christian fundamentalist churches) was positively associated with more sources of family planning funds.

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[12] Meier and McFarlane build off of the work provided by Mazmanian and Sabatier (1989) who argue that policies with statutory coherence – that is, policies "with precise, clear goals, supported by an adequate causal theory, with clear administrative responsibilities, clear implementation rules, and assigned to committed agencies" – are likely to be the most effective in their intended impact.

While they have made wide-ranging and important contributions to family planning research, these now dated studies suggest the need for current reexamination. The social and political forces shaping the new wave of restrictions to public funding and the extent of their influence have yet to be systematically considered by scholars of family planning, reproductive politics, and social welfare. Timely research is needed to address the structure and implications of contemporary family planning policy making in the U.S. Below, I consider the degree to which religious conservatism, along with feminist influence and states' racial-ethnic contexts, shape family planning policy implementation, specifically state-level restrictions on family planning programs and funding.

DATA AND METHODS

States display considerable differences in their policy making efforts around health and spending on public services, so it is not surprising that there is considerable variation in public family planning programs (Miller 2005). In order to best predict states' relative restrictiveness or leniency in its family planning policy making, I use regression techniques and an original data set that combines secondary state-level data from multiple sources. The overarching goal is to understand the impact that religious conservative ideology has on the availability and accessibility of family planning services across states.

Dependent Variable: Family Planning Funding Restrictiveness

Most of the increases in state-level restrictions and cuts to family planning funding began after the Republican take-over of federal and state legislatures in 2010; as such, the dependent variable is an index of policy restrictiveness ranked by the cumulative count of restrictive family planning policies in existence as of (January) 2018. Data for the

dependent variable were obtained from the Alan Guttmacher Institute's Data Center (Guttmacher Institute 2017).

The index includes states that either successfully implemented or attempted to implement one of the following restrictions to family planning funds: (1) prohibiting the use of federal funds for abortion except in cases of rape, incest, or life endangerment; (2) prohibiting the use of *state* funds for abortion, abortion counseling, and abortion referrals; (3) prohibiting certain entities (e.g., clinics that provide or are affiliated with abortion services) from receiving state funds; (4) a priority system for the distribution of state funds, and (5) blocking or interfering with federal reimbursements (predominantly Title X grant funding and Medicaid); and (6) foregoing the joint federal-state Medicaid family planning expansion program in favor of a fully state-funded program. The index ranges from 0 (no restrictions on funding) to 6 (all six restrictions to funding). No state had all six; however, sixteen states had zero restrictions and 14 states had at least one. Eight states had at least two funding restrictions placed on family planning programs, and four states adopted three types of restrictive policies. Seven states had four restrictions placed on their family planning funds, and one state (Texas) had five. This comes as no surprise, as Texas is notorious for its aggressive anti-abortion policies.

Independent Variables and Hypotheses

Religious and Conservative Political Ideology

Political party ideology and institutional control of legislative and executive branches of government have a significant impact on a range of social policies, especially reproductive policies (Medoff, Dennis, and Stevenson 2011). Indeed, institutional theories

on social policy making hold that the structure of the state, political parties, and state actors are among the most important predictors (Amenta and Poulsen 1996; Orloff and Skocpol 1984). To examine the institutional politics of religious and conservative ideology and the extent to which they influence restrictive family planning policy making, the analysis includes Berry and colleagues' measure of government (i.e., policymakers') ideology. Government ideology is a measure based on "interest group ratings of members of Congress, election returns for congressional races, and data on the party composition of state legislatures and party affiliation of governors" (Berry et al. 2014 [1998]:329). This particular measure of government ideology has been used to examine political ideology as it relates to a variety fiscal and social policies, including state higher education policy priorities and expenditures (Dar and Lee 2014), health outcomes in the U.S. (Herian et al. 2014), and restrictive voter identification laws (Hicks et al. 2015).

Political theories of social policy making emphasize the influence of non-state actors, opinions, and organizations (Amenta, Bonastia, and Caren 2001). Public, or citizen, ideology can account for notable differences among states in terms of policy making and implementation (Brace et al. 2004; Erikson, Wright, and McIver 1985). Public ideologies may also give strength to, and reflect the influence of, interest groups in politics. Studies show that conservative religious groups, and the Religious Right in particular, have an interest group effect on reproductive policies because of their explicit and firm stance on abortion (and, often, contraceptive use) (Berkman and O'Connor 1995; Camobreco and Barnello 2008; Dennis, Medoff, Stevens 2011; Medoff 2002). Further, according to Jones and Cox (2016:9), "White evangelical Protestants remain the dominant religious force in

the GOP." More than one-third (35%) of all Republicans identify as white evangelical Protestant, a proportion that has remained roughly stable over the past decade. And although White Christians now account for fewer than half of all adults living in the U.S., about three-quarters (73%) of Republicans belong to a white Christian religious group. Thus, it is hypothesized (H1) that: *States with a stronger conservative religious and political conservative influence will have more restrictive family planning policies.*

To assess the influence of public ideologies and interest groups effects on family planning policy in each state, I used an index based on three indicators of conservatism. The first measure, designed to capture the interest group effects of the Religious Right, is the rate of evangelical Protestant adherents per 1,000 population in each state, obtained from the U.S. Religion Census: Religious Congregations and Membership Study, 2010 (Grammich et al. 2012). Religious conservatives' interest group effects on family planning policy are also captured using anti-abortion attitudinal data from the 2016 Cooperative Congressional Election Survey (Ansolabehere and Schaffner 2017).

The second measure gauges the strength of anti-abortion attitudes. In the 2016 Cooperative Congressional Election Survey, respondents were asked to respond with "support" or "oppose" to the statement*: Always allow a woman to obtain an abortion as a matter of choice.*

The data was disaggregated and transformed into state-level data by calculating the mean for each state.

Public ideology measured using Berry and colleagues' (2014 [1998]) citizen ideology, is the third measure of political conservatives' interest group strength. Citizen

ideology is based on the ideological position of each member of Congress in a Congressional district using interest ratings, the ideology score of the incumbent and challenger, and the electoral results that reflect the ideological divide. The scores for each district are then calculated into an unweighted state average with higher scores indicating a more liberal ideology. Like abortion attitudes, across-state variation in public ideology has displayed relative stability over time (Brace et al. 2004).

As expected, according to the factor analysis, there were strong correlations among the three proxy variables for religious conservatives' interest group effects (evangelical Protestants: 0.699; abortion attitudes: 0.866; citizen ideology: -0.803). One way to handle issues around multicollinearity is to combine the variables into a composite measure, like a standardized scale. A standardized scale of religious conservatism, therefore, was created. Combining the variables into the scale addresses collinearity and provides a multifaceted measure of religious conservatism that might not be adequately captured with one variable. For example, although the strength of anti-abortion attitudes might adequately measure religious conservatism on its own, conservatism is more than public opinion on abortion. This is especially the case for swing states, like New Mexico, where the population can hold relatively strong anti-abortion beliefs, but have relatively liberal (i.e., less punitive and restrictive) reproductive policies. Creating a scale with multiple indicators, therefore, allows for a fuller, more comprehensive measure of religious conservatism than that of individual measures alone.

Feminist Influence

Feminists' and reproductive health and rights advocates' interest group effects may also have an impact on the restrictiveness or leniency of states' family planning policies. Advocates have encouraged and promoted the adoption of publicly supported family planning programs as a means to improve women's health and life chances and foster reproductive autonomy (Correa and Petchesky 1994; Gilliam and Gordon 2009; Gold 2013). It is hypothesized (H2) that: *States with a stronger feminist influence will have less restrictive family planning policies.*

One would expect feminists to have more influence where women, as an interest group, hold greater political, institutional, and economic power relative to men. For example, female lawmakers, relative to their male colleague counterparts, are more likely to consider women their own interest group with distinct political concerns (Reingold 2006). Further, they are more likely to support, as well as introduce and pass, legislation of particular concern to women, including reproductive health policies (Berkman and O'Connor 1993; Reingold 2006; Swers 1998; Thomas and Welch 1991). It is also argued that career women, as a constituency group, are more likely to "be supportive of pro-choice policies and better able to mobilize on their behalf than women who are home-makers" (Medoff 2002).

Feminist influence, or interest group effects, were measured using three proxy variables: the percent of women across both chambers (House of Representatives and Senate combined) in state legislatures in 2017, the gender pay gap, and the percentage of women in high status occupations. Taken from the American Association of University

Women (2016), the gender pay gap is calculated as the state earnings ratio using median annual earnings among full-time workers 16 years and older, based on the Census Bureau's American Community Survey. On average, women in the U.S. make 80 percent (a 20% gap) of what men make. The percent of women in high status occupations includes women 16 years and older in Management, Business, & Financial; Professional & related fields, in 2013 – the most recent data collected in an analysis of American Community Survey data by the Institute for Women's Policy Research (Status of Women in the States 2018)

Similar to the individual predictors of religious conservatism, the factor loadings for the three indicators of feminist interest group effects displayed relatively high values, suggesting the data suffered from multicollinearity (female legislators: 0.630; gender pay gap: -0.70; women in high status occupations: 0.491). It was determined that the extent of feminist influence on family planning policy restrictiveness would also be better measured using a multidimensional, composite measure. A standardized scale of feminist influence was created in the same fashion as the scale for religious conservatism – by standardizing and combining the values for each of the three predictors and changing the direction of the values where necessary so that a higher score indicates greater strength of feminist influence. The scale of feminist influence provides a more substantive snapshot of the relative strength or weakness of feminists' and reproductive health and rights advocates' interest group effects on state-level family planning policy.

Racial-Ethnic Context

There are competing perspectives regarding the effects of the racial and ethnic composition of a population on policy outcomes. Some scholars suggest that, under certain

conditions, increased proximity to nonwhite populations – i.e., the "contact hypothesis" (Allport 1954; Fox 2004) – reduces prejudice, increases tolerance, and leads to more supportive and generous welfare policies. Others emphasize the "power of numbers," and how larger populations of racial and ethnic minorities are able to mobilize more easily both inside and outside of the ballot box, which helps to hold politicians more accountable to their policy demands (e.g., see Reese et al. 2013). Other scholars take a critical race perspective and emphasize the effects of the "group threat hypothesis" (Johnson 2003). Contrary to the contact hypothesis, which largely neglects power dynamics, this hypothesis suggests that increases in the nonwhite population leads the majority, white population to feel economically and politically threatened, creating political pressure on policymakers to adopt legislation that reduces the size, influence, and resources of nonwhites.

Even with these conflicting perspectives aside, the tangled politics of race and reproduction in the U.S. in an of itself necessitate the inclusion of states' racial-ethnic context as a possible determinant of contemporary family planning policy. While publicly supported family planning programs significantly benefit millions of marginalized women in the U.S., unlike other social programs benefiting minority populations, the history and development of public family planning programs were originally supported as a means of explicitly targeted population control, using gendered, racialized, classist stereotypes about fertility and sexuality (Thomas 1985; Smyth 1996). Further, the motives and outcomes of present-day fertility control policies continue to significantly differ by race (Borrero et al. 2009). For example, current research shows that Black and Native women, relative to white

women, continue to have disproportionately high rates of sterilization (Gurr 2011; Volscho 2010).

Including states' racial-ethnic context allows for the ability to examine the impact of race and ethnicity as a structural force shaping reproductive health care policy making and implementation. The percentage of the population that is nonwhite as provided by the U.S. Census Bureau for 2016 is one measure used. The nonwhite population includes people who are Hispanic/Latina/o, Black, Asian, American Indian or Alaskan native, Native Hawaiian or Pacific Islander, or mixed race. It is hypothesized (H3) that: *States with larger nonwhite populations will have less restrictive family planning policies.* It is possible that family planning policies are informed by 1) favorable support for redistributive policies like publicly funded family planning that benefit working class women of color; 2) implicitly racist and class-based fertility/population control efforts; or 3) a combination of the two.

The study also included social survey data on racial resentment from the 2012 Cooperative Congressional Election Survey (CCES) (N = 54,535) to test the possibility that racist attitudes continue to shape family planning policy making.[13] Many prominent

[13] The Cooperative Congressional Election Survey's (2012) measure of racial resentment are two Likert scales intended to capture racist attitudes among the public. The two survey questions ask respondents to answer if they strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree (coded 1 to 5) with the following statements:
The Irish, Italians, Jews and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favors.
Generations of slavery and discrimination have created conditions that make it difficult for Blacks to work their way out of the lower class.
The first scale ("Blacks should do the same without any special favors.") was reverse coded from 1 to 5 to 5 to 1 so that a high value (4 or 5) would be consistent and indicate the same type of response across the two scales. The two were combined into an aggregate scale and transformed into state-level units of analysis by calculating the mean by state. Because whites wield a

critical race scholars (Bonilla-Silva and Forman 2000; Omi and Winant 1994; Winant 2000) suggest, however, that the political and social influence of explicit racism has waned though in favor of coded or symbolic racism that might be best captured through the first measure. (See Lopez 2013 on the use of "dog-whistling" in American politics.)

Control Variables: Fiscal Health, and Service Needs

To determine the extent to which the three primary social and political forces shape family planning programs in each state, net of other economic, institutional and political factors, this study controls for government ideology, the fiscal health of a state, and the percentage of women that are eligible for services (which shapes the relative demand or need for publicly funded family planning services).The (log transformation of) gross state product per capita (U.S. Bureau of Economic Analysis 2016) is included as a way to control for the possibility that more restrictive policies may be enacted in states with fewer fiscal resources due to lower tax bases.

Some scholars argue that increased demand for services could actually incite restrictive social policy making (specifically regarding welfare) if states are unable or unwilling to meet the demand (Zylan and Soule 2000). Consistent with this, Reese et al. (2013) find that states had more restrictive policies regarding immigrants' welfare rights in states where the demand for welfare (i.e., the poverty rate) was higher. On the other hand, scholarship on restrictive family planning policies suggests that they are mainly introduced and implemented for political reasons rather than to address women's actual

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disproportionate amount of political and institutional power, a subset variable that contained only white survey respondents was created. Higher scores indicate more racist attitudes.

reproductive health care needs, or a desire to curb the costs associated with rising demands for services. It is anticipated that controlling for the percentage of women eligible for family planning services will demonstrate that restrictive family planning policies are not significantly related to the extent to which services are needed in each state.

In order to measure the relative demand for services, the study includes the percent of women in each state who meet the criteria of being defined as "in need of publicly funded family planning services" (Frost, Frohwirth, and Zolna 2016). These are women who are 1) either younger than 20 years old or are of reproductive ages (13-44), 2) sexually active, able to conceive, not trying to become pregnant, and 3) have a family income below 250 percent of the federal poverty level (Frost, Frohwirth, and Zolna 2016). The most recent data available are from 2014 and were obtained from the Guttmacher Institute's Data Center.

Statistical Estimation

Family planning policy restrictiveness was estimated using Poisson regression with the statistical package, Stata version 14. Poisson regression is ideal for modeling count variables, with the assumption, however, that the data are not over-dispersed (Hoffman 2004). Data are overdispersed when the mean and variance of the count data for the dependent variable are not equal as they should be in a pure Poisson distribution (Long and Freese 2006).

Although the mean of the dependent variable, family planning policy restrictiveness, is nearly equal to its variance, a likelihood ratio test was performed to ensure Poisson was the most appropriate regression for the study. The likelihood ratio test

is a diagnostic to help determine if a negative binomial model would be an improvement over a Poisson model. According to Long and Freese (2006), the likelihood ratio test gives a chi-square value testing if alpha=0; alpha is the overdispersion coefficient in a negative binomial model, which essentially acts as a "correction factor" for any overdispersion that might exist. In a Poisson model, alpha=0 because Poisson models assume the dependent variable is *not* overdispersed, thus the likelihood ratio test helps determine whether the model's dispersion is significantly different from 0. If the likelihood ratio test of alpha=0 is statistically significant, negative binomial regression should be used rather than Poisson. The likelihood ratio test of alpha=0 performed for this study was not significant, making Poisson regression an appropriate fit.

FINDINGS

The descriptive statistics for the variables used in this analysis are listed in Table 2 below.

Table 2: Descriptive Statistics

	Mean	Std. Dev.	Minimum	Maximum
Family Planning Restrictions	1.5	1.474	0 (16 states)	5 Texas
Government Ideology	42.653	32.543	6.375 Idaho	96.5 Vermont
Evangelical Protestants (per 1,000)	160.134	108.673	22.809 Utah	420.41 Alabama
Abortion Attitudes	1.002	0.214	0.459 Delaware	1.353 Kentucky
Citizen Ideology	49.874	15.644	20.979 Utah	91.852 Connecticu t
Religious Conservative Influence (scale with the 3 variables above)	-3.37e-09	0.878	-1.733 Connectic ut	1.674 Oklahoma
Female Legislators	25.1%	7.70	11% Wyoming	40% Arizona; Nevada
Gender Pay Gap	20.56%	4.334	11% New York	30% Louisiana; Utah
Women in High Status Occupations	39.60%	0.033	31% Nevada	48% Maryland; Massachus etts
Feminist Influence (index with the 3 variables above)	5.14E-09	0.78	-1.423 Louisiana	1.633 Vermont
Nonwhite Population	30.94%	16.03	6% Vermont	81% Hawaii
Gross State Product Per Capita	$49,141.8 8	8,848.06	$32,447 Mississippi	$66,500 Massachus etts

Pearson bivariate correlations were calculated in order to test for multicollinearity, or strong correlations, among the independent variables (Tables 3, 4, and 5 respectively; see Appendix B). The bivariate correlations indicate which variables are highly correlated

and whether they are statistically significant. Two independent variables are perfectly correlated when Pearson's $r = 1.00$; strong correlations between variables with a significant p value can bias the standard errors and regression coefficients (Hoffman 2004). Many of the variables in this study demonstrated a statistically significant inverse relationship with one another. For example, as the bivariate correlations show, where there is a larger interest group effect by religious conservatives, there appears to be less of an impact by feminists as an interest group ($r = -0.733$; $p < 0.05$). There is also a negative relationship between the strength of religious conservatism and government ideology ($r = -0.729$; $p < 0.05$), which highlights what can already be intuited – where religious conservative constituents make up a greater percentage of the population, there are less liberal (or more conservative) ideologies held by state lawmakers.

The variance inflation factors (VIFs) were examined and a factor analysis was performed as additional approaches to test for and address multicollinearity. A VIF with a value closer to 10 suggests that the variable could be considered as "a linear combination" of other predictor variables (UCLA Statistical Consulting Group, n.a.). However, others contend that in a regression model with relatively few observations, the rule of thumb can be as low as 4.0 (O'Brien 2007). The mean VIF was 2.68, with the largest VIF registering at 5.52 (abortion attitudes). While the VIF scores alone do not indicate any issues, the factor analysis suggests otherwise.

The factor analysis identifies correlations and variances in the data while also effectively summarizing patterns across similar measures of data. The factor loadings generated from a factor analysis that have a value greater than 0.5 indicate suspicion over

multicollinearity. Several of the key predictor variables produced factor loadings greater than 0.5 and were addressed by transforming the collinear variables into a standardized[14] index, or scale.[15] Using a scale reduces multicollinearity, allows for more variation, and increases the available degrees of freedom in a cross-sectional analysis where there are relatively few observations (N=50).

Multivariate Regression Results

Six Poisson regressions models are shown in Table 6. The results display the standardized coefficients and the standard errors for each variable. The first model tested only government ideology on family planning policy restrictiveness. As such, this model naturally faced omitted variable problems, but it served as the baseline upon which the full model was built. The baseline model suggests that for every one-unit change towards a more liberal government ideology, the difference in the logs of expected counts of restrictive family planning policies is expected to decrease by 0.728 ($p < 0.01$).

The subsequent models added each control variable in succession to test their cumulative impact on the key social and political indicators shaping family planning policy restrictiveness. The models' goodness of fit was determined using the post-estimated AIC values and the chi-square (χ^2) values from the Pearson goodness-of-fit. The AIC values

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[14] Standardization puts the independent variables on an identical metric of comparison by measuring its relative impact and importance in terms of standard deviation units (mean = 0, variance = 1) (StataCorp 2014).

[15] The scales were produced using the Cronbach's alpha command in Stata, which computes inter-item correlations (covariances) and Cronbach's alpha (Acock 2014). The scale standardizes the items in the scale, produces the sum of the individual predictor scores, and reverses the scoring for the items that have negative correlations with the factor that is being measured (StataCorp 2014).

provide an estimate for how much information is lost when a particular model tries to explain extent to which a state is more lenient or more restrictive with its family planning programs. The chi-square statistic is a test of the null hypothesis. A model is determined to be a good fit for the data when the AIC and chi-square values are low (and statistically insignificant) relative to other models (UCLA Statistical Consulting Group, n.a.). As anticipated, the models improved in their goodness of fit with the inclusion of each variable with Model 6, full model, demonstrating the best fit (AIC = 143.644; $\chi^2 = 40.845$).

The analysis suggests that, holding all other predictors constant, the most important determinant of the extent to which states are more or less restrictive in their distribution and use of family planning funding is the political ideology of lawmakers in each state. As the regression results show, government ideology had a consistently significantly effect ($p < 0.01$) on the count of family planning policy restrictions, net of the effects of religious conservative interests, feminist interests, and the racial-ethnic context of a state. After additionally controlling for gross state product per capita and the percent of women in need of publicly funded family planning services, government ideology continued to be the most statistically significant indicator of policy restrictiveness in each state. As Table 2 shows, the higher the government ideology score of each state – that is, the more liberal the state lawmakers' ideologies are – the less restrictive are their family planning funding policies, holding all other explanatory variables constant.

Religious conservatives as an interest group (measured as a scale which includes the rate of the Evangelical Protestant population per 1,000 people, citizen ideology, and anti-abortion attitudes) also had a significant impact on family planning policy

restrictiveness, albeit to a lesser degree. When holding constant feminist interest group effects and states' racial-ethnic context, the difference in the logs of the expected counts of family planning policy restrictions increased by 0.503 ($p < 0.05$) with every standard deviation change in religious conservatives' interest group effects. Consistent with the theories on punitive reproductive policy making, conservatives' interest group effects, the strength of which is implicit in the size of the religious and politically conservative populace, is indeed a significant indicator of whether a state will have a higher count of restrictive family planning policies, but only prior to controlling for other social and political state-level forces. After including the percent of the population that is nonwhite, religious conservatism was no longer influential; it remained insignificant with the inclusion of the remaining two control variables.

Reproductive scholarship suggests that policies such as abortion and maternal and child health are likely to receive greater support when women hold political, institutional, and economic positions of power. I find, however, that feminist influence – measured as a standardized index that includes the percent of the state legislature that is female, the gender pay gap, and the percent of women in high status, white collar occupations – did not demonstrate any statistically significant effects on the count of family planning funding restrictions across any of the regression models. Future analyses could assess whether more direct measures of feminist interest group effects (e.g., the number of feminist organizations and nonprofits or membership data) might yield different results.

The racial-ethnic context of a state also did not demonstrate a statistically significant impact on state-level family planning policy restrictiveness. However, the

number of women aged 13-44 in need of publicly funded family planning services (i.e., the demand for services) does appear to influence policy restrictiveness. The results suggest that, holding all other variables constant, the difference in the logs of expected counts of family planning policy restrictions increase by 0.048 ($p < 0.05$) with every one standard deviation increase in the number of women in need.

CONCLUSION

This chapter reviewed the ways in which family planning policies have been influenced by various competing and complementary social and political forces to form the politics of family planning policy. Previous research suggests that family planning policy making in the U.S. is complex, with multiple interests – including social conservative, fiscal conservative, religious, and feminist ideologies – working together and in opposition to influence policy (McFarlane and Meier 2001; Nelson 2015; Shapiro 1985). The scholarship to date, however, has not fully considered the social and political determinants of contemporary family planning policy making. Although the literature on the politics of reproductive policy has identified the salience of religious and anti-abortion ideology on abortion policy making, its role in the sharp rise in family planning funding restrictions has not been given similar empirical attention. Thus, the purpose of this study was to explore the extent to which institutional and ideological forces – including legislative ideology and religious conservatism, in addition to feminist interest group effects and racial-ethnic contexts – influence state-level family planning policy restrictiveness.

Research on the politics of reproductive policy emphasizes how public opinion on salient issues like abortion can effectively influence the direction and extent of policy

making on reproduction, fertility, and sexual health (Medoff and Dennis 2011; Medoff, Dennis, and Bishin 1995). The political mobilization of the Religious Right, for example, has had a major impact on reproductive politics, but in this case, their influence on contemporary family planning funding restrictions appears to represent only part of the story. My analysis showed that, after controlling for all other explanatory variables, the ideological leanings of lawmakers was the strongest predictor of whether a state would have more or fewer restrictions on their family planning programs. This finding is consistent with the perspective that emphasizes the role of state actors (Amenta and Poulsen 1996; Orloff and Skocpol 1984) and electoral politics (Burstein and Linton 2003) as important determinants of policy outcomes, as well as prior research findings regarding the importance of partisanship in reproductive policy making (Medoff 2002; Medoff and Dennis 2011).

Although feminists' interest groups effects were insignificant, this does not suggest that women's elevated political and economic status – measured as the percent of female lawmakers, the gender pay gap, and the percent of women in prestigious occupations – does not and cannot influence social policies impacting women. It merely suggests that public conservatism and anti-abortion sentiments are currently more salient and effective in shaping reproductive policies. This is likely related to the growth of their institutional control across state legislatures since 2010, which only gained greater strength with the 2016 presidential election.

This study also found that the size of minority populations does not necessarily factor into restrictive family planning policy making; however, this too does not necessarily

suggest that states' racial-ethnic context does not have any impact on reproductive, especially fertility control, policy. Historically, family planning programs have been supported by eugenicists and white conservatives as an economically efficient means of slowing the rising rate of the nonwhite population. Present-day family planning policy in the U.S. continues to be a blend of contradictory politics that are enmeshed in social and religious conservatism, reproductive health and rights advocacy, and implicit, if not coded, racism and classism. Today, the more palatable, socially acceptable frames of social support from fiscal conservatives (as well as left-leaning advocates of publicly supported family planning) tout publicly funded family planning programs' ability to prevent future social costs associated with unplanned pregnancies, including Medicaid-paid childbirths, welfare, and according to some even crime, specifically by providing low-income women of color access to contraception. This outlook, however, is inherently racialized and problematic; it is an extension of the "culture of poverty" or "cultural deficiency" framework which views high fertility rates among low-income women and women of color as a culprit of social problems. These dynamics may not have been captured in the current study, but they exist in the public and political rhetoric around race, class, and reproduction and may contribute to the views and political successes of conservative lawmakers. Future research on the politics of family planning policy might consider how to best capture these dynamics and the extent to which they play a role in policy formation.

It is additionally and equally important that researchers consider how the politics of family planning restrictions are experienced in the day-to-day lives of women who rely on publicly supported programs in order to access basic sexual and reproductive health

care. In the next chapter, I explore how anti-abortion and other restrictive family planning policies and cutbacks have intensified the challenges to accessing family planning and reproductive health care. Specifically, using qualitative methods and a case study of the Rio Grande Valley of south Texas, I explore how family planning funding regulations and cutbacks have impacted low-income Latinx women who have previously relied on these programs.

Table 3: Pearson Bivariate Correlation Matrix (p < 0.01; p < 0.05**

	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*
1. Family Planning Restrictions	1												
2. Evangelical Protestants	0.554**	1											
3. Abortion Attitudes	0.493**	0.610**	1										
4. Citizen Ideology	-0.487**	-0.556**	-0.747**	1									
5. Religious-Conservative Influence (scale)	0.587**	0.829**	0.902**	-0.881**	1								
6. Female Legislators	-0.388*	-0.562**	-0.614**	0.463**	-0.627**	1							
7. Women in High Status Occupations	-0.332**	-0.301*	-0.464**	0.439**	-0.461**	0.191	1						
8. Gender Pay Gap	0.275*	0.296*	0.678**	-0.540**	0.579**	-0.494**	-0.405*	1					
9. Feminist Influence (scale)	-0.437**	-0.509**	-0.771**	0.634**	-0.733**	0.741**	0.701**	-0.834**	1				
10. Nonwhite Population	-0.092	0.12	-0.375**	0.16	-0.159	0.112	0.014	-0.358**	0.213	1			
11. Government Ideology	-0.590**	-0.496**	-0.651**	0.757**	-0.729**	0.489**	0.476**	-0.480**	0.635**	0.065	1		
12. Gross State Product Per Capita	-0.409**	-0.525**	-0.573**	0.397**	-0.572**	0.174	0.616**	-0.327*	0.490**	0.128	0.406**	1	
13. Women in Need	0.128	0.048	-0.194	-0.012	-0.052	-0.077	0.043	-0.360**	0.143	0.434**	-0.016	0.172	1

Table 4: Variance Inflation Factors for the Independent Variables

	VIFs
Abortion Attitudes	5.52
Evangelical Protestants	2.88
Citizen Ideology	2.75
Gross State Product Per Capita	2.66
Gender Pay Gap	2.52
Female Legislators	2.39
Women in High Status Occupations	1.99
Nonwhite Population	1.79
Demand (% women in need)	1.58
Mean VIF	2.68

Table 5: Factor Analysis - Factor Loadings and Uniqueness Variances

	Factor	Uniqueness
Evangelical Protestants	0.676	0.543
Abortion Attitudes	0.843	0.290
Citizen Ideology	-0.808	0.349
Female Legislators	0.562	0.680
Gender Pay Gap	-0.670	0.516
Women in High Status Occupations	0.459	0.783

Table 6: The Social and Political Determinants of Family Planning Policy Restrictiveness

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Intercept	0.178	0.132	0.131	0.123	0.109	0.048
	0.146	0.152	0.152	0.154	0.156	0.167
	-0.728**	-0.487**	-0.503**	-0.522**	-0.548**	-0.503**
Government Ideology	0.157	0.188	0.192	0.194	0.194	0.186
Religious Conservative Influence		0.439**	0.488*	0.503*	0.402	0.468
		0.191	0.226	0.226	0.244	0.249
Feminist Influence			0.096	0.146	0.183	0.175
			0.239	0.254	0.255	0.266
Nonwhite Population				-0.092	-0.169	-0.333
				0.151	0.159	0.197
Gross State Product					-0.169	-0.213
					0.159	0.165
Women in need						0.048*
						0.167
N	50	50	50	50	50	50
AIC	144.69	141.708	143.542	145.161	146.017	143.644
Pearson Goodness-of-fit (chi2)	57.136	46.719	46.690	45.735	45.456	40.845

The figures shown above are standardized coefficients and standard errors.
** $p < 0.01$; * $p < 0.05$

CHAPTER 3
CAUGHT IN A TRIPLE BIND: LATINX WOMEN'S BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTH CARE IN THE RGV

INTRODUCTION

In the U.S., working class Latinx women fare generally worse than white, higher income women in nearly every indicator of reproductive health. They experience disproportionately higher rates of sexually transmitted infections (STIs), HIV, unintended pregnancies, repeat teen pregnancies, and maternal and infant mortality (Rosenthal and Lobel 2018; Dehlendorf, Rodriguez, Levy, Borrero, and Steinnauer 2010). They also have the highest rates of cervical cancer diagnoses and, only second to Black women, the highest rates of cervical cancer mortality (Texas Department of Health State Services 2019; American College of Obstetricians and Gynecologists 2015).

These disparities are even greater in areas marked by high rates of poverty and large gaps in the uninsured rate. In Texas, for example, and particularly along the southernmost border in the Rio Grande Valley (RGV), the disparities in reproductive health are especially acute and remain dire (Nuestro Texas 2015, 2013). There, Latinx women experience significantly higher rates of STIs and unintended, teen, and repeat pregnancies (County Health Rankings and Roadmaps 2019); the cervical cancer mortality rate is 30% higher than the rest of Texas – and 55% higher than the U.S (Boom et al. 2018; Texas Department of State Health Services 2018). Moreover, between 2007 and 2015, the RGV has seen a 115% increase in the average of HIV incidents (De La Garza et al. 2019). There is thus a reproductive health crisis in the RGV.

The existence of this crisis is consistent with the social determinants of health (SDH) perspective. This framework claims that health care outcomes are largely shaped by the structural determinants and conditions of people's lives, including: "the distribution of power, income, goods and services" as well as "their access to health care, schools and education; ...and homes, communities, and rural or urban settings" (Blas et al. 2010:5). As the SDH perspective would posit, the social determinants of women's reproductive health reflect, in large part, the socioeconomic conditions of the RGV. In "the Valley," as it is affectionately referred to by locals, more than one in three people among the 1.3 million residents (over 90% of whom are Latinx, specifically Mexican, descent) live below the poverty line (Ura 2016). Women are especially economically marginalized. In the metropolitan areas of the RGV, forty-five percent of households living in poverty are female-headed households, yet only less than 30 percent of households are female-headed (Center for Public Policy Priorities 2017).

Health care access is also a persistent, pervasive, and systemic problem in the RGV. Each of its four counties is designated as a "Medically Underserved Area and Health Professional Shortage Area" (United States-Mexico Border Health Commission, 2014). The health care infrastructure along the border is severely under-resourced and, as such, is unable to meet the needs of the community (Boom et al. 2019). Meanwhile, thirty-eight percent of the population lacks health insurance, and nearly half of women of reproductive age (15-44) are likely to be uninsured – compared to just one out of four across the state (Tingle, Haynes, and Li 2017). The significant disparities in Latinx women's reproductive health, thus, can largely be traced to the barriers they face to *accessing* sexual and

reproductive health care (SRHC) services. As Price and Hawkins (2007) suggest, the concept of SRHC access denotes more than just the physical receipt of services and care. Access refers to "the extent to which services may be obtained at a level of effort, and of monetary, opportunity, and social cost, that are acceptable to and within the means of poor, marginalized and vulnerable people" (Price and Hawkins 2007:30). The common barriers that restrict Latinx women's SRHC access are well-documented in previous research. Socioeconomic status (SES), a lack of health insurance, under-resourced health care infrastructures, in addition to other factors such as a lack of access to transportation, immigrant status, and language discordance are among the various *structural barriers* that prevent Latinx women from utilizing SRHC services (Daniel et al. 2018; Downey and Gomez 2018; Ramos et al. 2010).

Latinx women often face additional *sociocultural* and *political barriers* as well. For example, sociocultural forces such as religiosity, the transmission of norms and expectations regarding traditional gender roles and sexuality, and parents' attitudes and beliefs about sex have also been shown to negatively impact women's health knowledge and thwart health-seeking behaviors (Rojas-Guyler et al. 2011; Romo, Berenson, and Segers 2004). Meanwhile, abstinence-only curricula requirements; restrictions on the provision of health care services, such as age- and citizenship-based eligibility restrictions which particularly affect adolescents and undocumented Latinx immigrants (Hooton 2005; Hock-Long et al. 2003); and the "fragility of political and financial support for sexual and reproductive health services" (WHO 2010:8) present political challenges for SRHC access.

Over the last decade, the political barriers to SRHC have intensified in Texas as conservative lawmakers imposed a series of anti-abortion cutbacks and restrictions to publicly funded family planning programs. Texas lawmakers' decision to target publicly funded family planning is of particular importance to understanding Latinx women's poor reproductive health in the RGV. Specialized, publicly funded family planning clinics have long served as an important and necessary public health and public assistance resource for women as they provide access to a range of basic, preventive SRHC services. Yet, between 2011 and 2013, conservative lawmakers slashed the state family planning budget by two-thirds and eventually restructured family planning funding altogether to ensure abortion affiliated clinics (i.e., Planned Parenthood) would not receive any public funds (White et al. 2015). As the research shows, these funding cuts and restrictions had a disastrous effect on SRHC access and outcomes across the state (Packham 2017; Stevenson et al. 2016; White et al. 2015). However, save for investigative reports by journalists (Zelinski 2020) and reproductive rights organizations (Nuestro Texas 2015, 2013), there are very few studies that have explored how Texas' anti-abortion policy making impacted Latinx women in underserved communities like the RGV. There is a small – albeit growing – body of research that has drawn attention to the interplay of Latinx women's barriers to SRHC as a set of nested effects (Morales-Alemán, Ferreti, Scarinci, 2020), and how intersecting barriers are embedded within social, political, and geographic contexts (Smith, Sundstrom, and Delay 2020). However, it is still less understood how Latinx women experience this convergence of barriers to SRHC while confronted with policies that specifically target SRHC. Also neglected in the broader literature on Latinx women's reproductive health, as

well as the SDH, is the role of larger, interconnected systems of inequality and relations of power (e.g., patriarchy, (hetero)sexism, white supremacy, classism/class inequality, etc.) undergirding the social determinants of SRHC access within particular sociogeopolitical contexts.

These gaps in the literature underscore – and echo (Hankivsky et al. 2010; Lepalme et al. 2019; Lopez and Gadsden 2016) – the pressing yet obvious need for the explicit incorporation of intersectionality (Collins 2000; Crenshaw 1991) in health disparities research. As feminist public health scholars argue, intersectionality has the ability to "[reframe] how public health scholars conceptualize, investigate, analyze, and address disparities and social inequality in health" Bowleg (2012:1267) by identifying the ways in which social inequalities – in this case, Latinx women's disparities in SRHC access and outcomes – are deeply embedded within multiple, intersecting, historically constituted systems of hierarchy, inequality, and oppression (Crenshaw 1991; Davis 1981). Intersectional frameworks are also committed to centering the lives of marginalized communities and women – an important dimension of health disparities research that is often excluded – as well as responding to the systemic roots of inequality in order to eliminate inequalities and injustices (Collins and Bilge 2020).

This chapter aims to fill the above gaps in the existing literature by bringing together the SDH and intersectionality perspectives to examine the *structural, sociocultural, and political barriers to SRHC access* as they are experienced by Latinx women in the RGV. My research is based on semi-structured, in-depth interviews with thirty (n=30) young, working class, Latinx women who live in the McAllen metropolitan

statistical area of the RGV. Twenty-five of the women interviewed have, at one point or another, relied on publicly funded family planning programs to access contraception and basic health care services; the remaining five are or were affiliated with the local family planning clinics as campus or community outreach advocates.

I find that there are three sets of barriers within the sociogeopolitical context of the RGV that compound women's SRHC challenges. My interview analysis also highlights the multiple, interconnected systems of inequality and relations of power that (re)produce the interpersonal, institutional, and political barriers to SRHC that RGV residents face. Finally, my research brings to the forefront women's lived experiences as reproductive agents (Carvajal and Zambrana 2020) in order to explore how women make sense of and navigate these barriers in an effort to meet their SRHC needs.

In order to put my study's findings into context, I first outline the importance of intersectionality in SDH research followed by a review of the previous literature on the social determinants of, or barriers to, Latinx women's SRHC access. I then discuss my findings. Consistent with the literature on Latinx women's SRHC access, the challenges my respondents describe center around issues related to socioeconomic status and financial hardship (structural barriers), and familial and societal pressures of traditional religious beliefs and "sexual silence" (Davila 2005) as referenced above. Of particular importance to this study are the political barriers to SRHC that emerged as a result of extreme cutbacks and restrictions to family planning programs enacted in Texas since 2011 (Texas Policy Evaluation Project 2020). The loss of funding disproportionately affected access in the RGV and further compounded the existing structural and sociocultural barriers, as it forced

nearly a third of clinics to shut down in a region that was already recognized as a "medically underserved area." The clinic closures and increased costs of services made it increasingly difficult to schedule a timely appointment or access their preferred method of contraception.

As my respondents' narratives illustrate, SRHC access in the RGV is shaped by a highly unique convergence, or matrix (Collins 2000) of structural, sociocultural, and policy barriers. These barriers not only intersect with but compound one another, and thus place low-income, uninsured Latinx women in this particular region within a multiply disadvantaged position that I refer to as a *triple bind* of reproductive oppression.[16] Using an intersectional feminist perspective, my concept of the triple bind draws attention to the intersecting, mutually reinforcing systems of oppression and relations of power (i.e., patriarchy, heterosexism, neoliberal capitalism, and neoconservative governance) that structure and (re)produce the persistent SRHC inequities that are embedded within this specific social, political, and geographic context. Each barrier is enacted and experienced via multiple "domains of power" (Collins 2009, 2017).

These power domains, along with SRHC and other inequities, however, can also engender resistance. Women's accounts document the ways in which they exercise reproductive agency and autonomy and are able to do so with the help of publicly funded family planning programs. Some women even utilized publicly funded family planning services as a strategic act of resistance to the conservative political climate that they

[16] Although the triple bind does not assume or propose causality, it does offer a "plausible heuristic" that can be used to make sense of the significant and persistent inequalities in SRHC access and outcomes along the south Texas border.

perceive as a threat to their physical health and reproductive rights. For most, accessing publicly supported SRHC services at specialized family planning clinics was also their primary route to obtaining basic, preventive, routine health care services that, some say, they otherwise would have gone without.

I conclude the chapter with a brief discussion of the implications of my study for scholars, advocates, and lawmakers. I argue that the *triple bind* and its consequences for Latinx women's health accentuate the urgent need to expand rather than restrict access to SRHC.

THEORETICAL FRAMEWORK: INTERSECTIONALITY & THE SOCIAL DETERMINANTS HEALTH

Many feminist, critical race public health scholars argue that the extant SDH literature has been lacking in its consideration and analyses of the larger, intersecting social processes that produce and perpetuate unequal health experiences and outcomes (Bowleg 2012; Graham et al. 2011; Hankivsky and Christofferson 2008; Lepalme et al. 2019; Lopez and Gadsden 2016; Palencia, Malmusi, and Borrell 2014). This is largely because, despite its multidisciplinary relevance and application, there has been a dearth of intersectional analyses in studies of social inequalities in health. Intersectionality is a feminist, critical race, praxis-oriented theoretical and analytical framework that understands gender, sexuality, social class, race-ethnicity, nativity, and other social identities and experiences as intersecting axes, or categories, of power that are constructed and maintained by the multiple, intersecting, mutually reinforcing systems of inequality in which they exist (e.g., patriarchy, (hetero)sexism, classism/class inequality, white supremacy, etc.) (Collins 2000;

Crenshaw 1991; Davis 1981). The intersections of these axes of social inequalities represent what Patricia Hill Collins refers to as a "matrix of domination" (Collins 2000) – a power grid of systems, structures, and relations of domination that produce varying degrees of privilege and oppression and that vary across and within social, historical, political and geographic contexts (Collins and Bilge 2020).

The incorporation of intersectionality into SDH and health disparities research – what Lopez and Gadsden (2016) refer to as an "intersectional health equity lens" (IHEL) – provides a paradigmatic shift "for studying the social determinants of health, reducing health disparities, and promoting health equity and justice" (Lopez and Gadsden 2016:1).[17] Consistent with the central tenets of intersectionality, an IHEL locates the SDH and health disparities within a complex web of interconnected, overlapping social inequalities that are embedded in systems of inequality (Lepalme et al. 2019). The social inequities in sexual and reproductive health, as Collins would argue, are inevitable outcomes resulting from particular context-specific configurations in the matrix of domination.

In order to better understand the complexities and persistence of health disparities within historically marginalized communities, intersectional frameworks aim to make conceptual and empirical linkages across multiple micro-, meso-, and macro-level determinants of health and demonstrate the ways in which these intersect to produce disparate health outcomes and experiences. Lopez's (2013) work on racialized-gendered

[17] Various labels have emerged in the effort to promote the use of intersectionality public health and health inequities research, including: "radical contextualization of health" (Chapman and Berggren 2005), "racialized-gendered SDH" (Lopez 2013), and "intersectional health equity lens" (Lopez and Gadsden 2016).

SDH achieves this end. She reveals the multilevel and multidimensional mechanisms of racialized-gendered SDH by linking "embodied health disparities of lived race-gender" (micro-level) to neighborhoods, schools, local social contexts (meso-level), and state and federal policies and political economic structures (macro-level). There is also a small but growing body of research that "looks beyond a normative listing of disparities" through a socioecological approach in order to unravel the various layers through which health inequities emerge (Schminkey et al. 2019:2).

Still, some argue that there is a need for explicit analyses of power and power relations in health disparities and reproductive health research (Sen et al. 2020). Power is a central tenet of intersectional feminist theory, but "how and why" power reproduces health inequities, according to Lepalme et al. (2019), has not been addressed. Patricia Hill Collins' (2009, 2017) "domains of power" provides a useful tool that can be used to analyze unequal health care access and outcomes within an intersectional framework. According to Collins, power is a visible and, more importantly, relational force that is organized and exerted onto people via four interrelated mechanisms or "domains," including:

> (1) a structural domain, where social institutions of a society, such as banks, hospitals, schools, corporations, retail establishment, government agencies, and health care, routinely discriminate in favor of whites and against everyone else; (2) a disciplinary domain, where modern bureaucracies regulate race relations through their rules and practices, primarily surveillance; (3) a cultural domain, where ideologies, such as white supremacy, patriarchy, and heterosexism, are constructed and shared; and (4) an interpersonal domain that shapes social relations between individuals in everyday life (Collins 2000:72).

The domains of power demonstrates the importance of understanding the particular social, political, geographic contexts in which people live as they fundamentally shape and

reinforce interpersonal and cultural (e.g., ideas, norms, and expectations) realms, disciplinary rules, institutional arrangements, policies, and political-economic structures.[18] Moreover, it allows for a "more finely tuned analysis" of the mechanisms (i.e., processes or relations of power) that tie micro-level experiences of health inequities to macro-level systems of inequality. From the individual level of socioeconomic status and social interaction to the cultural realms of ideas and social norms to the institutional level via laws and regulations, women's SRHC access is shaped by interweaving social processes and relations of power.

Finally, as a praxis-oriented political project, intersectionality is committed to centering the lives of marginalized women and is equally committed to responding to the systemic roots of inequality in order to eliminate inequalities and injustices (Collins and Bilge 2020). Focusing solely on the SDH often obscures how power and multiple marginalities are experienced and challenged at the individual level. Intersectional frameworks of health inequities, however, deepen and broaden our understanding of racialized-gendered disparities in health care access and outcomes, the processes that (re)produce them, and the ways in which women assert their own agentic power.

Recognizing the strengths and utility of each framework, I bring together SDH and intersectionality to frame my research on Latinx women's structural, sociocultural, and political barriers to SRHC access in the RGV. First, I use the SDH perspective to identify the determinants that create multiple and multi-level barriers to various forms of SRHC

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[18] As Collins notes, the domains of power are intended to serve as heuristic, rather than explanatory theoretical model, that allows for a closer examination of the ways in which power relations and the inequalities they produce are organized and maintained.

access including SRHC information, the affordability of services, and the ability to seek and receive care. Identifying the barriers to SRHC using the SDH framework provides a useful roadmap that can be used by public health professionals and advocates seeking ways to expand access to SRHC and promote women's reproductive autonomy.

Meanwhile, intersectionality allows me to critically analyze the structural, sociocultural, and political barriers to SRHC access as they are experienced by Latinx women in my study and the intersecting, mutually constitutive social structures, institutional arrangements, and power relations that (re)produce them. Using the conceptual tools provided by intersectional feminist scholars, I discuss how this matrix of intersecting and compounding barriers produces, via domains and relations of power, a uniquely experienced, context-specific *triple bind* of reproductive oppression. I also use the central tenets of intersectionality to investigate the ways in which Latinx women experience as well as resist the boundaries that shape their ability to access SRHC.

PREVIOUS RESEARCH: THE SOCIAL DETERMINANTS OF LATINX WOMEN'S BARRIERS TO SRHC

The social determinants of health (SDH) framework provides key insights to understanding Latinx women's reproductive health disparities as it decenters and challenges biomedical interpretations that often very narrowly focus on biological, psychological, and other individual-level determinants of health. The consensus among most public health and reproductive scholars, as well as major health organizations including the World Health Organization (WHO) and the Centers for Disease Control (CDC), is that sexual and reproductive health disparities are rooted in various social

determinants, or "upstream factors," that emerge within and across interpersonal, social, ecological, and system levels. Quantitative research that uses a SDH perspective to study Latinx women's SRHC largely looks at disparities in reproductive health diseases, teen and unplanned pregnancy, and (under)utilization of contraceptives and other SRHC services (Horowitz, Pace, and Ross-Degnan 2018; Thompson et al. 2016; Rosenthel, VandeVusse, and Schuh 2020). Meanwhile, much of the qualitative research assesses women's reproductive attitudes, perceptions, and experiences, contraceptive preferences, health-seeking behaviors, and provider-level interactions (Aparicio et al. 2016; Liddon, Steiner, and Martinez 2018; Kossler et al. 2011), or provide a comprehensive review of Latinx women's reproductive health and disparities in family planning (Haider et al. 2015; Hock-Long et al. 2013; Ramos et al. 2010).

Although this literature on Latinx women's SRHC is extensive, much of it tends to give primacy to specific determinants such as individuals' socioeconomic status (SES), poverty, religiosity, acculturation, and parental influence and does not address how the confluence of these and other determinants collectively act as persistent *barriers* to their SRHC *access*.[19] Indeed, only a few studies explicitly examine Latinx women's experiences with a spectrum of multi-level barriers to SRHC access within specific social, political, and geographic contexts (Cristancho, Garces, Peters, and Mueller 2008; Mann et al. 2016; Morales-Alemán, Ferreti, and Scarinci 2020; Smith, Sundstrom, and Delay 2020). Below, I synthesize my review of the literature on Latinx women's reproductive health by

[19] Uncovering the multiple layers of SRHC determinants is usually "beyond the scope of the paper," or they are addressed in concluding discussions on ways to address health inequities or areas of future research.

identifying various determinants as barriers to access. I organize these barriers into three broad categories or typologies – structural, sociocultural, and political barriers. Individually and in combination with one another, these three sets of barriers greatly hinder Latinx women's SRHC access and profoundly shape their health-seeking behaviors and experiences. After laying out the list of barriers, I then discuss how intersectionality is an important and necessary analytical framework that will broaden our understanding of Latinx women's barriers to SRHC access.

Structural Barriers

Structural barriers are the social, economic, legal, and political processes that produce "group-differentiated vulnerabilities to harm, including health disparities, as well as group-differentiated access to goods, services, and resources" (Dehlendorf 2010:212). Socioeconomic status (SES, typically operationalized across a combination of educational, income, and occupational dimensions), lack of health insurance, the high costs of health care services, and under-resourced health care infrastructures (Minnis et al. 2013; Penman-Aguilar 2013) are among the most common structural barriers to health care access. Low-income women and low-income women of color are disproportionately impacted by structural barriers that present significant financial obstacles to seeking and receiving SRHC services (Boom et al. 2018; Cristancho et al. 2008; Minnis et al. 2013; Penman-Aguilar 2013).

There is firm theoretical and empirical evidence (see Phelan, Link, and Tehranifar 2010) to suggest that, like most if not all other health inequities, the persistent disparities in Latinx women's reproductive health is primarily a function of SES as a "fundamental

cause" of health. [20] This is because, as the theory posits, the social conditions produced by SES generate unequal access to the various material and nonmaterial resources needed to minimize health risks including "money, knowledge, power, prestige, … social support and social network[s]" (Link and Phelan 1995:87). And within a fragmented, privatized, under-resourced health care system like the one in the U.S., health insurance coverage is a necessary material resource. Lower SES Latinx women, however, face formidable challenges to accessing health insurance in order to meet their health care needs. Compared to any other racial-ethnic group in the U.S., they make up the largest percentage of those who are uninsured (Kaiser Family Foundation 2018a). Despite the significant gains in health care coverage as a result of the Affordable Care Act, nearly one in four Latinx women are likely to be uninsured compared to one in six white women, and the disparities in coverage are widest for Latinx women of reproductive age (National Partnership for Women and Families 2019). And while Latinx women's participation in the labor market is comparable to white women's, they are much more likely to hold low-wage jobs that do not provide health insurance benefits.

Without health insurance or the ability to afford to pay for health care costs out of pocket, lower SES Latinx women are less likely to be able to access contraception, routine check-ups, cancer screenings, prenatal care, and other SRHC resources and services needed to live a healthy life. Then there are additional logistical issues of SRHC access, however,

[20] It is important to note that racial-ethnic disparities in reproductive health persist because, as Phelan and Link (2015) contend, like SES, racism is also a "fundamental cause." Racism is a fundamental cause of racial differences in SES; it is also a fundamental cause of health inequities independent of SES.

that are also largely dependent on SES-related factors. For example, whether a woman can physically get to a clinic to obtain care is determined by her access to personal or public transportation, her hours of employment or the ability to get the necessary time off from work to tend to one's personal health care needs, and access to childcare (Branch et al. 2010; Dehlendorf et al. 2010).

Finally, health care institutions present additional structural barriers to SRHC access. Inadequate health care infrastructures as a result of insufficient funding and shortages of health professionals, especially in rural areas, create significant challenges to accessing health care services across the board (Boom et al. 2018; Robards et al. 2019). Meanwhile, navigating health care institutions can be especially difficult for immigrant women (Betancourt, Colarossi, and Perez 2013) and women with limited English proficiency (Chaufan, Hong, and Fernandez 2017). Language discordance and the absence of an interpreter, for example, make it difficult to communicate with physicians and navigate health care institutions (Cashman et al. 2011). Studies reveal that language barriers also affect the quality of health care services received. Physician biases and institutionalized racism, and racist stereotypes towards immigrants and low-income Latinx women have been shown to undermine the quality of care received (Metzl and Hansen 2014), thus making patients reluctant to return for follow-up visits or to seek preventative medical care in the future (Mann et al. 2016).

Sociocultural Barriers

For many Latinx women, sociocultural norms and expectations are another important determinant of reproductive health care access, as they often shape women's

knowledge about and, therefore, ability to seek out this type of health care. Sociocultural forces are the broader normative beliefs and expectations that influence individuals' attitudes, behaviors, interactions, and experiences. Prior research finds that the familial and institutional transmission of traditional, conservative, and religious beliefs regarding (women's) sexuality, premarital sex, and contraception often play a central role in Latinx women's health and SRHC decisions, although we should be careful not to over-generalize about Latinx women or overlook their cultural diversity. Such research indicates that these sociocultural normative beliefs often promote and reinforce a "sexual silence," particularly among parent-adolescent communication and interactions, as well as shape women's perceived lack of parental support when it comes to SRHC-related concerns.

Although Latinx families and the experiences within them vary across socioeconomic, political, geographic, and other dimensions, ample research shows that "familismo," or familism, often plays an important role in Latinx youth's knowledge about and access to reproductive health care. The notion of familism[21] prioritizes "strong attachments to, emphasis on, and identification with family interests and welfare" (Kaplan et al. 2001:672). This often includes an adherence to traditional gender roles and heteronormative sexual scripts. In her work, Lorena Garcia (2009) discusses how Latinx girl's and women's sexuality is frequently defined and regulated within a rigid, heterosexual "virgin-whore" dichotomy that valorizes women who are chaste and abstinent until marriage (conceptions of sexual purity) and denigrates those are who are sexually

[21] Although the cultural importance of familism and distinct gender roles are known to shift across generations and time, the strength of familism as a traditional value system still tends to be stronger among Latinxs compared to non-Latinx whites in the U.S. (Kaplan et al. 2001).

active and expressive (ultimately denying them of their sexual agency and desire). These gendered constructions of Latinx sexuality are rooted in and reinforced by the conservative religious ideologies of Catholicism that valorize girls' and women's virginity and condemns premarital sex as well as contraceptive use (Shenker 2000).

Many common sociocultural normative beliefs about sex common within the United States generally and among the Latinx community in particular render sex as an intimately private and taboo topic of discussion. These often promote a "sexual silence" (Davila 2005; Gilliam 2007; Villar and Concha 2012) that systematically structures parent-adolescent communication in Latinx families. Previous studies on Latinx parent-adolescent communication find that parents, especially those who hold more traditional, conservative attitudes towards gender and sexuality, often feel reluctant to discuss matters of sex and sexual health with their children (Driscoll et al. 2001; Gilliam 2007; Jimenez et al. 2002; Rojas-Guyler et al. 2011; Romo, Berenson, and Segers 2004). The prevailing belief among religious and conservative Latinx parents is that conversations about sex and reproductive health encourage sexual activity and promote promiscuity (Caal et al. 2013). Parents, instead, often encourage abstinence or use "scare tactics" that emphasize the negative effects of sex in order to discourage sexual activity (Gilliam 2007; Romo et al. 2002). As research shows, however, open discussions and practical information about sex and sexual health is associated with greater sexual and reproductive competence, including the increased likelihood of (as well as more consistent) contraceptive use (East et al. 2005; Velazquez et al. 2017), and, as more recent studies show, the odds of HPV vaccination uptake (Lechuga et al. 2020).

As previous studies suggest, this sexual silence and lack of open communication about sex and sexual health creates a sense of stigma and shame that constrains Latinx women's ability to seek SRHC information and services. In their study on young Latinx women's perceptions of parental approval to seek and obtain SRHC services, Caal et al. (2013) discover that most women perceive a lack of parental support due to cultural beliefs about sex; they also find that most made efforts to hide their health-seeking behaviors from their parents out of fear and shame. For example, while some women would hide their birth control, others would opt out of their parents' health insurance or travel to a clinic in another part of the city just to avoid their parents discovering their use of SRHC services.

Political Barriers

Political forces have long influenced whether, and the extent to which, women can access SRHC and meet their reproductive needs. Undergirding many education and health policies and programs are conservative moral proscriptions about sex and reproduction. This is particularly true of abstinence-only education programs, which denounce and discourage premarital sex, promote values of chastity and uphold marriage "as the expected standard of human sexual activity," and stigmatize "out-of-wedlock" births as a social ill (for a review of U.S. abstinence-only programs, see Santelli et al. 2017). Through censorship and the provision of misinformation, abstinence-only programs create an important political barrier to medically accurate, evidence-based and comprehensive information about sex education and SRHC. As Santelli et al. (2017:273) point out abstinence-only programs "inherently withhold information about human sexuality and may provide medically inaccurate and stigmatizing information."

Access to medically accurate sexual and reproductive health education, however, is only one component of the political barriers to SRHC. There are additional, legal challenges that restrict immigrant women in particular from being able to obtain SRHC services. For example, many legal immigrants are ineligible to enroll in health insurance coverage through Medicaid and the Children's Health Insurance Program (CHIP) during their first five years of legal residency due to federal laws. Although some states have made limited exceptions to the "five-year bar" for pregnant women and those age 18 and younger, these barriers to health insurance for many legal immigrants persist in most states (Hasstedt, Desai, and Ansari-Thomas 2018). Meanwhile, undocumented immigrants, including DACA recipients in many states, are generally unable to access public and private health insurance (Giuntella, Osea, and Jakub Lonsky 2020).

Still, there are additional political hurdles to SRHC access that have emerged over the last decade as states have imposed various abortion-related sanctions on the provision and use of public funding for family planning programs (Guttmacher 2017). Some of the restrictions on publicly supported family planning include prohibiting the use of state funds for abortion counseling and referral; a priority system for the distribution of funds that disadvantages family planning providers; blocking specialized family planning clinics that offer, counsel on, or are affiliated with abortion services from receiving state funding altogether; and, more recently, blocking federal Title X and Medicaid reimbursements to Planned Parenthood and its affiliates

Texas' decision to politically target publicly funded family planning devastated the state's health care safety net and made it even more difficult for uninsured, poor, and

working-class women to access family planning and reproductive health care services. Lawmakers targeted one of the few, and for many only, resources that promotes and enables their basic human right to reproductive autonomy and control while providing necessary preventive health care. As White and her colleagues' (2016) findings reveal, between 2012 and 2013, clinics served 54 percent fewer clients than they did in 2011 as 25 percent of the state's family planning clinics closed their doors while many others had to reduce their staff and hours of operation as well as transition from sliding scale to fixed price fees, which increased the costs of services for clients. The clinic closures also increased the distance needed to travel to get to the nearest clinic, which resulted in fewer mammograms, decreased contraceptive use, and increases in the overall birth rates, especially among teens and low-income women, within two years of the funding cuts and restriction (Lu and Slusky 2016; Packham 2017; Stevenson et al. 2016; White et al. 2015).

Although previous studies provide important quantitative empirical evidence on the consequences of defunding SRHC in Texas, very few have examined how these policies were experienced by low-income, Latinx women along the border in the RGV, who were disproportionately affected by the loss of funding (Nuestro Texas 2015, 2013). Similar to other policies that have targeted women's fertility and reproductive autonomy – such as, for example, the "no new child" rule under the 1996 welfare reform act (Reese 2005) – defunding and restructuring publicly funded SRHC reproduced and compounded gender, racial-ethnic, and socioeconomic inequities in reproductive health. In the predominantly Latinx region known as the RGV, nine of 32 clinics that received state funding closed while others reduced their staff and business hours. Women were met with an increase in copays

and the costs of services, and, at times, could not obtain their preferred method of contraception (due to either a lack of supplies or the lack of staff). And as Nuestro Texas – the collaborative human rights campaign by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health – documents, the consequences were far worse for women living in the unincorporated areas of the RGV known as *colonias*.[22]

Reconceptualizing Latinx Women's Barriers to SRHC

There are still many key elements in need of further research that could enhance our understanding of Latinx women's reproductive health-seeking behaviors and health outcomes and promote greater access to SRHC. For example, how have these challenges around and barriers to SRHC access been experienced more recently by marginalized women who are in need of publicly supported health care? In what ways do their health experiences intersect with other social inequalities associated with gender, social class, race-ethnicity, geography, etc., and how are those intersecting inequalities linked to the broader structural forces that shape their everyday lives? How do women make sense of, navigate, and overcome the multiple barriers that prevent them from meeting their SRHC needs? These questions underscore the need to include intersectional feminist theory in health inequities research.

Intersectional feminist theory also carves a path for examining situations and contexts in which all three sets of barriers to SRHC access are experienced simultaneously. Collins' matrix of domination and the domains of power heuristic are particularly useful

[22] To restate, *colonias* are unincorporated communities that are marked by extreme poverty and lack basic living necessities such as electricity, sewage systems, potable water, and paved roads.

analogies that advance this understanding. Latinx women nor their SRHC access are shaped by a single axis of inequality. Rather, Latinx women's identities, their reproductive health and experiences, and their (in)ability to access and utilize preventive health care services are shaped by multiple, intersecting axes of social division that work together and influence each other (Collins and Bilge 2016). Analyzing the systems, relations, and domains of power allows us to go beyond the "normative listing" of barriers to help explain how and why these multi-level barriers to SRHC access (individually and in combination with one another) disproportionately disadvantage Latinx women and produce significant inequities in their reproductive health outcomes.

To be sure, the structural, sociocultural, and political determinants that act as barriers to accessing SRHC are not uncommon and can impact women regardless of race-ethnicity or socioeconomic status. For example, white women with conservative religious or political family backgrounds may also experience a lack of social support for seeking sexual and reproductive health services; or they, too, may live in an area where clinics are inaccessible. However, using interview data, I demonstrate that the intersection of these structural, sociocultural, and political barriers to SRHC access in the RGV produce a very distinct form of disadvantage that is not commonly experienced – much less empirically explored – elsewhere. I conceptualize these compounded disadvantages as a "triple bind of reproductive oppression" and suggest that the triple bind has much, if not everything, to do with the persistent reproductive health disparities along the border.

I advance this notion of the triple bind by using the "power-conscious lens" of intersectional feminist theory to consider the ways in which SRHC access and outcomes

are embedded within the particular sociogeopolitical context of the RGV of south Texas; makes visible the power dynamics that link my respondents' lived experiences of SRHC access with the structural forms and relations of inequality that produce them; and draws attention to how the women in my study navigate and resist them to meet their SRHC needs, thus underscoring the importance of SRHC access for their reproductive health and in their reproductive lives.

PARTICIPANT CHARACTERISTICS & METHODS

My qualitative analysis of Latinx women's barriers to SRHC access in the RGV is based on in-depth, semi-structured interviews with 30 working class Latinx women, twenty-five of whom are current or former consumers of publicly funded family planning programs. The remaining five are or were affiliated with the local family planning clinics as campus or community outreach advocates. A comprehensive list of my participants' demographic characteristics can be found on Table 1 in Chapter 1. That chapter also provides a detailed description of my sampling design and interview methods.

It is important to restate women's educational attainment and religious affiliations as those characteristics relate to the structural and sociocultural barriers to SRHC illustrated through their narratives. Among the 30 women interviewed, all but two had at least "some college" experience: six had some college experience but no longer enrolled; five were currently enrolled in college; and seventeen held a bachelor's degree – four of whom held an advanced degree. Most respondents, like other local residents, had modest incomes (median household income in the RGV is $34,009) and had health insurance at the time of interview. While a majority were employed (n=27), two-thirds of all respondents had either

employer-provided insurance (n=15) or were enrolled through their family's health care plan (n=5), while the remaining third had public health insurance (n=4) or were uninsured (n=6).

Respondents varied in their religious affiliations. Many women (n=12) do not identify with or are committed to traditional, orthodox religion. As these women indicated, they consider themselves as spiritual (n=4), agnostic (n=4), or atheist (n=4). Secularization theories would posit that the high number of atheist and agnostic women in my sample is related to the "liberalizing effect" of higher education (Wuthnow 2007).[23] The existing research, however, is as torn as the debate about secularization theory. For example, Mayrl and Uecker (2011) find that college students are no more likely than non-students to develop liberal religious beliefs; instead, changes in college students' religious beliefs are more closely tied to network effects with many students sustaining their religious beliefs, practices and commitments due to the "multiplicity of social worlds on college campuses" (Mayrl and Uecker 2011:14). Indeed, slightly over half (n=17) of the women in my interview sample indicated a religious affiliation, which could potentially lend itself to the notion that higher education is not a "faith-killer" after all. While six women consider themselves as non-denominational Christians, ten identify as Catholic. Finally, one indicated an affiliation with the Church of Jesus Christ of Latter-Day Saints and one respondent identified as pagan/brujx.[24]

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[23] Secularization theories can be traced back to classical sociological thought on the rise of modern societies – e.g., Comte's law of three stages, Weber's concept of rationalization, and Durkheim on the transition from mechanical to organic solidarity.

[24] Brujx refers to a queer form of bruja, or brujeria, an ancestral Latinx spirituality.

My analysis of the interview data below reflects their accounts of the various structural, sociocultural, and political determinants of SRHC access, their experiences within the context of Texas' draconian anti-abortion family planning policies, as well as accounts of the ways in which they circumvent or challenge barriers to meet their SRHC needs. Overall, I find that in the RGV and for the women in this study, federally qualified family planning clinics have served as an important public health and public assistance resource by providing access to basic, preventive SRHC services. Each respondent, whether as a recipient of services (n=25) or as a staff member and advocate (n=5), was impacted by Texas' decision to target publicly funded family planning programs in the effort to regulate abortion care providers.

FINDINGS: CAUGHT IN A TRIPLE BIND

As displayed in Figure 1 below, the structural, sociocultural, and political barriers to SRHC access that my respondents face constrain multiple dimensions of access beyond the material or physical receipt of services. Additional dimensions of access, originally outlined by Price and Hawkins (2007), include: *affordability* (monetary cost); *availability* (supply of resources); *acceptability* (social cost); *convenience* (level of effort required); and *knowledge* (health information) (Price and Hawkins 2007:31-32). Figure 1 also uses the conceptual and analytical tools provided by intersectionality to illustrate how and why the convergence of the structural, sociocultural, and political barriers to SRHC access places working class, uninsured Latinx women in the RGV in a triple bind of reproductive oppression.

Table 7: Latinx Women's Barriers to Sexual and Reproductive Health Care Access in the RGV

Social Determinants of Access	Dimensions of Access	Systems of Inequality & Mechanisms of Domination	Domains of Power
STRUCTURAL BARRIERS **geographic (regional)/political context*			
<u>*Socioeconomic Status*</u> Income; Lack of health insurance <u>*Health Care System & Institutions*</u> Under-resourced local infrastructure; Cost of health care services	<u>*Affordability*</u> Cost of services <u>*Convenience*</u> Transportation; distance needed to travel <u>*Availability*</u> Providers; supplies; provision of services	<u>*Neoliberal Capitalism*</u> Privatized health care system; Income inequality; Weak social support programs	Structural
SOCIOCULTURAL BARRIERS **social/geographic (regional)contexts*			
<u>*Family*</u> Religiosity (Orthodox Catholicism); Parental attitudes/beliefs towards premarital sex <u>*SRHC Education (informal)*</u> Misinformation <u>*Community*</u> Transmission of cultural norms, values, practices	<u>*Knowledge*</u> Health information & literacy; Health-seeking behaviors <u>*Acceptability*</u> Perceived lack of support; Sexual silence <u>*Convenience*</u> Accessing SRHC as a dependent	<u>*Patriarchy; (Hetero)sexism*</u> Gendered system of domination; Social construction of gender/sexuality; Sexual conservatism; Stigmatization of (women's) sexuality	Interpersonal Cultural Disciplinary
POLITICAL BARRIERS **social/political/geographic (state) contexts*			
<u>*SRHC Education Policy (formal)*</u> Abstinence-only regulations/curricula <u>*Reproductive Policy*</u> Family planning cutbacks, regulations, & restructuring; <u>*Public Health Policy*</u> Refusal to Participate in Medicaid Expansion; Increased funding for pregnancy crisis center	<u>*Knowledge*</u> Health information & literacy; Health-seeking behaviors <u>*Availability*</u> Loss of funding, providers; Reduced supplies, provision of services <u>*Affordability*</u> Increased cost of services	<u>*Patriarchy; (Hetero)sexism*</u> Neoconservative, anti-abortion policies; Anti-abortion ideology; Sexual conservatism; Stigmatization of (women's) sexuality	Structural Cultural Disciplinary

The elements laid out in Figure 1 are mapped out in each section below as I present the structural, sociocultural, and policy barriers to SRHC access as they were experienced by young, working class Latinx women along the south Texas border. Respondents' lived experiences regarding the (in)ability to access SRHC provide rich, qualitative evidence of the ways in which their reproductive health knowledge, health-seeking behaviors, and ability to seek and receive SRHC services are "triply bound" by the matrix of intersecting barriers. From the household to the community to the policy levels, these barriers are deeply integrated in their everyday lives by way of neoliberal capitalist, patriarchal, and heterosexist systems of inequality.

As Collins (2009, 2017) would suggest, the extent to which neoliberal capitalist, patriarchal, and heterosexist systems of inequality are expressed as barriers to SRHC access whether within or across any of the structural, cultural, interpersonal, and disciplinary domains of power are dependent on particular social, political, and geographic, or spatial, contexts. The RGV of south Texas represents a specific sociogeopolitical context wherein structural, sociocultural, and political barriers come together and a produce this triple bind of reproductive oppression. The triple bind is not necessarily causal or deterministic. Still, it represents a very distinct matrix of barriers that exacerbates working class, uninsured Latinx women's reproductive health vulnerability by compounding the hurdles to SRHC access that they must confront.

Women's reproductive health knowledge, health-seeking behaviors, and ability to receive SRHC services are shaped by several layers of social, economic, and political forces that compound one another as barriers to SRHC access. In each section below, I also

illustrate how each set of barriers, as a mechanism of inequality, is rooted in (and is the result of) larger, interconnected systems of inequality, and locate these mechanisms within the various domains of power through which they are enacted – as well as resisted.

As the interview data reveal, the disparities in Latinx women's SRHC access and outcomes in the RGV result from socioeconomic inequalities as well as broader sociocultural forces of religiosity and traditional, social conservatism at home and in the community. Accessing SRHC was further complicated by Texas' family planning policies. The funding cuts and regulations wreaked havoc on an already-vulnerable health care infrastructure in the RGV by further reducing the availability, affordability, and convenience of accessing SRHC services obtained at specialized family planning clinics. For the majority of respondents, prior to these cutbacks, publicly funded family planning programs were a primary means of accessing routine health care services – and, for many, they still are.

Although women describe several challenges regarding their ability to secure SRHC, their accounts also document how these challenges engender their resistance. With the help of publicly funded family planning programs, they are able to assert their reproductive autonomy and agency. And as some women express, utilizing publicly funded family planning is a necessary act of resistance in a broader political climate that continually poses a threat to their reproductive health and rights.

Structural Barriers to Access

(Affordability)

Language discordance (Branch et al. 2010) and a lack of "cultural competency" in health care institutions (Metzl and Hansen 2014) are less of a concern in the RGV than they are for Spanish-speaking women in other parts of the U.S. as the majority of the population as well as health care professionals in the RGV speak both English and Spanish.[25] Still, the structural barriers to accessing and utilizing SRHC services that my respondents identify are the same insurmountable barriers that prevent millions of people in the U.S. from accessing health care in the U.S. Structural barriers such as the inability to access health insurance and afford the cost of health care services are challenges (read: consequences) that are inherent in a neoliberal capitalist economy (a particular *system of inequality*). In addition to the vastly unequal distribution of income, wealth, health care, and other material resources, neoliberal capitalism – via the structural domain of power – upholds (indeed, promotes) a privatized model of health care that inevitably excludes individuals from accessing health-promoting information and services largely on the basis of socioeconomic status or social class.

For low-income Latinx women in the RGV, lack of health insurance and the inability to afford to pay out of pocket for health care services is a persistent barrier to accessing SRHC services. The majority of women cite a lack of income or "money problems" as the primary reason they were previously or are currently unable to obtain SRHC services. Letty's experience as a 26-year-old full time student and "just under full

[25] Only 19 percent of Hidalgo County speaks English-only (United States Census Bureau 2018).

time" waitress provides an illustrative account of the multiple challenges that many RGV women experience as a result of financial hardship. Health insurance is simply unattainable when working a minimum wage job while trying to pay rent and other necessary bills. At her previous waitressing job, Letty says:

> *I would make like $150-170 on tips a week and I would have to save for rent. Insurance stuff, you know, that kind of stuff is out of the question. There's no way. That's a luxury and yeah you would have to risk it because insurance is just not possible as a college student. I didn't even have a car, so I had to ride a bike to work in order to get money to pay my rent to go to school.*

Women in the RGV simply cannot afford health insurance nor the costs of health care services. Whether it was paying for health insurance or "paying sixty dollars a month for birth control," as Tanya (26) expressed, both were considered "luxuries that were out of the question." Tanya describes, "Now a days I also go to Mexico for like certain doctor exams or medications and that seems like such a hassle, but it's that or nothing because I'm poor. Any way of getting a pelvic exam or getting birth control or a breast exam very cheaply or free is a God-send."

Lily (31), a part time college student and single mother of 11-year-old twin daughters describes how these financial barriers to SRHC access have been a lifelong challenge. "Growing up I, you know, never really had a lot of cash on hand, you know. I also had a very ill parent that was always in and out of the hospital. So, you know, it was not like I could always just ask my family for money."

With more than 30 percent of the RGV's population living in poverty and nearly half of reproductive-aged women lacking health insurance (Tingle, Haynes, and Li 2017), it is no surprise that respondents cite health care costs as the most common and persistent

obstacle to accessing SRHC in the region. As Rita, a "broke college student," puts it, "We're in a low-income area and a lot of us don't have a whole lot of money to be spending on a whole lot of things." Rita's reference to the broader community sheds light on the extent to which financial hardship is not just a matter of individual plight but a common experience in the RGV.

Sociocultural Barriers to Access

(Knowledge, Acceptability, Convenience)

Whether or not women are able to access SRHC is also largely dependent on the extent of their "health literacy," or the "capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Kindig, Panzer, and Nielsen-Bohlman 2004:32). The social acceptability of utilizing SRHC, however, is shaped by gender norms and expectations. Like social class, gender and sexuality are categories that are embedded in and thus reinforce particular systems of inequality, specifically patriarchy and heterosexism. As interrelated systems of inequality, patriarchy and heterosexism, thus, have a significant impact on women's SRHC. As respondents' narratives reveal, women's SRHC access is in many ways shaped by "sexual silence" as a lived experience that is rooted in sociocultural norms. The lack of open communication about matters of sex and sexual health not only play a central role in women's SRHC literacy, or knowledge, but also influences their health-seeking behaviors and decisions.

Sexual Silence Respondents describe their Catholic upbringing and the absence of conversations about sex as having a significant impact on their understanding of SRHC.

Without any provocation, almost every woman talked about how conversations about sex and sexual health "just didn't happen growing up." The extent of the conversations they had with their parents, usually with their mothers, typically never went beyond the topics of menstruation or abstinence. As Veronica, 25, describes, "Being in a Mexican family, talking about sex and all these things, they weren't really talked about. … Getting your period was the most that was talked about and that's it. 'Taking care of yourself' means, like, no sex basically."

Traditional, religious attitudes and beliefs that render sex as a taboo topic of conversation are woven into the social and cultural fabric of the RGV as well. Veronica elaborates on how this sexual silence is not only ubiquitous, but has also had real, life-altering consequences for young girls. She provides the following anecdote:

> *In middle school, 6th grade, I had a friend who got pregnant, had a miscarriage, and got pregnant again in 7th grade, had a baby, 8th grade had another baby, and it was so on and so forth. It was like she was pregnant every other year. And nobody was saying anything. No one talked about it. There was no like, 'Hey, there's condoms and there's birth control' because kids I feel were going to have sex regardless.*

Learning how to identify one's own SRHC needs in addition to trying to figure out how to navigate the health care system "is a scary experience," Amy (30, PhD student, former reproductive health educator) says, "especially in our Catholic community where we just don't talk about getting a pap smear or getting your period…we just don't."

Because of the prevalence of Catholicism and the interpersonal and cultural customs of sexual silence it engenders, the majority of women state that they did not know much about their own sexual and reproductive health until they reached their early 20s, and as a result, did not know how or where to access SRHC. As Jenny (27) shares:

> *The one time I wanted to get on birth control…I didn't really know where to get it. And I didn't really want my parents to know that I was sexually active. Even though I was older, it's just not something that I wanted to discuss with my mom.*
> *They are very Catholic. I wouldn't say conservative. I would say just very, you know, old school. They never talked about sex with me ever. I never got the talk about, you know, "you should be careful," so I never, I just never grew up being comfortable talking about sex with my parents or with my mom.*

Jamie (29) works as a community health educator and notes how common this discomfort is among people of all ages in the community. She also makes reference to the added layer of barriers posed by Texas' abstinence-only education requirements in its public schools:

> *So, I go out into the community, and I give out information about the free services that we offer at our clinic. I also go into high schools sometimes, high school classes, to talk about STIs and STI prevention -- but not about birth control because the rules are really weird in Texas because of the whole abstinence-only thing. And then in college classes I will teach about birth control, STI prevention, and healthy relationships. But, yeah, most people are just really uncomfortable talking about sex though. It's like, we're not talking about dildos and vibrators here. Like we're just talking about birth control!*

Parental Support As previous studies have shown, this sexual silence not only impacts women's knowledge about sexual and reproductive health, it also shapes the extent to which they perceive their parents as disapproving of their health-seeking behaviors (Caal et al. 2013). Sarah (22), for example, knows that her mother explicitly disapproves of her SRHC behaviors. "She has told me sometimes, like, she would prefer that I'm not on birth control…[but] she has her own beliefs and I have mine." Only one woman mentioned being able to openly communicate about sex and reproductive health with her mother. Most other respondents' accounts are similar to Jenny's experience; they feel uncomfortable or "shy" with the idea of disclosing to their parents their SRHC concerns and prefer to keep those

matters private. Veronica, now engaged to be married, still feels compelled to conceal her SRHC decisions from her parents:

> *It's a little bit sad that, like, with my mom, I don't think she knows that I'm on birth control, but I felt a little bit like I was going against my mom's back. But I can't be like 'Oh I'm having sex and using birth control, but at least I'm taking care of myself.' I feel weird that my mom has no idea.*

Two women indicate that although they had access to health insurance through their parents' employer-provided insurance plans, they chose to enroll in publicly supported SRHC programs in order to access contraception and other preventive SRHC services outside of their parents' purview. As Carrie (32) shares:

> *What prompted me to go [to Planned Parenthood] really was the fact that I didn't want my parents to know that I was sexually active. And I was a college student, so I didn't have insurance or tons of money to…spend on a gynecologist visit. I really didn't know one, a gynecologist, or what to even ask for when I went. So I just thought, if I go to a Planned Parenthood clinic, then they'll pretty much kind of guide me in the direction that I need to be going - as far as like a gynecologist and STI testing and all that good stuff goes.*

For Anna (26), however, the perceived lack of parental support has made her reluctant to seek SRHC services altogether, including preventive cancer screenings. Anna lives with and was raised by her father, so she "didn't grow up with a lot of maternal support." At the time of the interview, she had only ever received two pap smears in her life. She shares how, for her, it has been "mostly a shame-based thing, like, just being afraid. Even though, you know, I know it's important, I'm not really in the place where I feel like there's other women that understand, like at my house you know, it's just me and my dad." Even as adults, most women still do not engage in open dialogues with their parents about their

sexual health because of a perceived lack of support, sense of embarrassment or guilt, or combination thereof, and as a result, delay seeking health care services and resources.

As gathered from their accounts, the sociocultural barriers my respondents face are mechanisms that are experienced within and across multiple domains of power. While women's perceived lack of parental support exists within an interpersonal domain of power, their lived experiences with sexual silence as a result of the stigmatization of sex both in the home and in the community include both interpersonal and cultural domains. Meanwhile, the compulsion to conceal their sexual and health-seeking behaviors from their parents, although largely interpersonal, also cuts across cultural and disciplinary domains of power.

Political Barriers to Access

(Availability, Affordability, Convenience, Knowledge)

While structural and sociocultural barriers are persistent SRHC challenges commonly experienced among Latinx women all across the U.S., in Texas, family planning policy restrictions added a third dimension to the barriers limiting access for Latinx women in the RGV specifically. For working class Latinx women in the RGV, the loss of funding and its impact on clinics in their communities added a third dimension to the barriers limiting their reproductive autonomy and health care access.

The political barriers to SRHC access in Texas were the result of neoconservative political efforts to deliberately defund and regulate publicly funded SRHC as a way of penalizing, or punishing, clinics that provide, or are merely affiliated with, abortion care. Rooted in heteropatriarchal systems, these policies aimed to enforce moral, anti-abortion

values using political and institutional means. As a mechanism of domination, neoconservative SRHC policies represent that ultimately (re)produced and upheld gender and sexuality (and, in this case, social class) as axes of oppression. Patriarchal, heterosexist policies – indeed, the ability, or power, to implement such policies – were enacted within and across structural, cultural, as well as disciplinary domains of power. Those who were disproportionately affected were low-income, uninsured, women of color who are of childbearing age.

As my respondents note, Texas' family planning policies profoundly impacted their ability to seek and obtain SRHC services. Like clinics all across the state, several clinics across the RGV had to reduce their hours of operation, lay off staff, and increase the costs of services and supplies (Nuestro Texas 2013). Three dominant themes emerged in my respondents' accounts of trying to access affordable SRHC services in the midst of, and the years following, Texas' policies. Many faced increased fees and could no longer afford SRHC services; they experienced greater difficulty scheduling a timely appointment with a doctor and longer wait times once at the clinic; and they noticed a new, lasting confusion and frustration over where to go to obtain care.

Cost of services Due to the prohibitively high costs of various contraceptive methods, birth control is the most commonly sought service at local family planning clinics. While most low-income, uninsured women are eligible for fully subsidized care, some are required to pay a partial, income-based fee. By 2013, however, 28 percent (nine of 32) of the RGV's clinics that received state funding had closed their doors, including four of the six Planned Parenthood clinics. That same year, Texas decided to drop out of

the joint-federal state family planning program, which covered nine dollars for every one dollar the state spent on SRHC-related expenditures, in order to fully defund Planned Parenthoods across the state. Amy says she "definitely felt hit when they cut Planned Parenthood out of the Women's Health Program. It was really hard to find a clinic that knew what they were doing, were easily accessible and had the Medicaid program. Most of them didn't even help patients apply for it. Planned Parenthood did…they held your hand pretty much because," as quoted earlier, "it is a scary experience, especially in our Catholic community."

As clinics shut down, providers had to scale back on the provision of care and charge for services that were previously free if not significantly subsidized prior to Texas' funding cuts and restrictions (Nuestro 2013). Many women found it difficult – if not impossible – to obtain the contraception and preventive health care they had previously received at their local family planning clinics. When Leslie tried to renew her enrollment in Medicaid, she was denied because the child support she received from her son's father was now calculated as part of her annual income. Leslie (32, part-time Master's degree student and single mother) shared that she felt "so confused and shocked because, I mean, your child support is for your child." She could no longer afford to get the contraception she was seeking and considered it both unreasonable and unethical to "pay for [her] birth control with [her] son's money." From roughly 2011 to 2014, in order to supplement the loss of funding, specialized family planning clinics made adjustments to their sliding scale fees, which inevitably increased the amount women had to pay out-of-pocket for services. Nancy (27, restaurant manager) remembers how she used to pay "nothing or at most five

dollars" for her monthly birth control prescription before she was disqualified from receiving fully subsidized SRHC via the Texas Women's Health Program. She recounts how the increased fees caught her by surprise. "I couldn't pay $40 a month for birth control! That may not seem like a lot to other people, but around here, and especially at 23, that's just not something people can swing."

Longer Wait Times It was also common, and expected, to have to wait longer periods of time until women were able to see a doctor or schedule their next appointment. When Jenny couldn't schedule a timely appointment at the Planned Parenthood clinic in her hometown of Weslaco, she "tried to make another appointment at another office in McAllen" four towns away, but as she recounts, "their wait times were, like, months and I couldn't really wait that long." Those who were able to schedule an appointment at a clinic in McAllen found that they "still [had] pretty heavy wait times even if you have an appointment." Jessica (30, law student) says, "I remember it took like 2 or 3 hours until I was seen." Jenny eventually decided to "just give up. In fact, I didn't get my first pap smear or have any sort of, like, STD testing until, like, 2-3 years ago because I [eventually] went to the school clinic once I started school."

Those who worked with the local Planned Parenthood as college interns or community outreach educators describe the ways that Texas' policies impacted SRHC access as they experienced it "on the inside." In 2011, Cindy (32) was working as a campus outreach coordinator, but "once the big major cuts happened back then, they let me know that I was going to be let go because they didn't have Title X funding anymore, which was how my job was funded…" According to Cindy's rough estimate, there was about a 20

percent reduction in staff all around. Amy was lucky to be able to keep her job as a health educator; however, as she states: "After the funding cuts, we had virtually no money to see clients much less keep every staff member on board. Whenever there would be cuts, we would have to reduce our hours or reduce the amount [sic] of clients just [so] we could absorb the cost." When asked if she thought the cutbacks affected the quality of services and care women received, without skipping a beat Amy replied:

> *Oh yeah definitely! We were having to reduce the amount of one-on-one time with patients from, like, fifteen minutes to ultimately… trying to make sure that from the time you bring them back to the time they leave all happens within fifteen minutes. … I don't think we ever kicked anyone out or said, like, 'Hey your time's up.' But then there would be a backlog in terms of patients, so patients were having to spend, you know, upwards of two hours in our waiting room. … We were trying to rush things as much as possible, but clients were having to spend, like, pretty much like their entire morning in our office just waiting.*

Confusion In 2014, the board of directors for Planned Parenthood of Hidalgo County made the decision to disassociate from the nationally-recognized organization and rebrand under a new name, Access Esperanza, in an effort to meet the new eligibility requirements mandated by Texas' programmatic changes, restore funding, and serve its communities. "We decided that if we want to stick with what our mission is – which is to provide free to low and affordable health care for community members – this is what we have to do," says Jamie.

When the board of directors decided to let go of their affiliation with Planned Parenthood, Sam (26) was directly and immediately impacted. While in college, Sam worked as a campus SRHC outreach intern and witnessed firsthand the ways in which the closing of Planned Parenthood not only impacted their livelihood, but their peers and other

women in the broader community as well. To be sure, rebranding as Access Esperanza allowed for the restoration of (and increase in) funding and, thus, facilitated the provision of additional services and resources. Simply changing its name, while superficial and unnecessary, had major implications for women's SRHC access in the RGV. As an "insider," Jamie notes how

> *Access Esperanza is now offering more services – we're doing diabetes, cholesterol, hypertension, high blood pressure testing and management. We're opening another clinic and we're getting a lot more funding opportunities. And there's no stigma attached to our name because we're not Planned Parenthood.*

However, as Sam and many other women mention, rebranding further complicated SRHC access as it created additional confusion over how and where to obtain care.

> *There are people who still think there are not Planned Parenthoods left in the Valley, like there's no place to get these services at all because [Texas'] smear campaign, this misinformation. It's like "Oh they shut down." But nobody really talked about them opening up again, so I still get messages from women who want to know if there's anything like Planned Parenthood in the Valley since they closed and I have to tell them like "Oh, no. It's open, it's just now called Access Esperanza.*

Although the clinic changed in-name-only, Reyna (21, undergraduate student and community activist), too, felt lost and unsure about how to access the care she needed. "Whenever I needed health services, I honestly did not know where to go. I was like 'Planned Parenthood is still a thing, right? Where the hell do I go to get myself tested?' And I know that happened to a couple of other of my friends too."

At the time the interviews took place (2017), there was still a significant, community-wide deficit in knowledge about how and where to access SRHC services. Now as an outspoken advocate, Reyna says that friends will usually message her asking where

they can get a pap smear or birth control. “It's been, what, 5-6 years since the cuts happened in Texas, but people are still super in the dark about what clinics they can go to sign up for the Healthy Texas Women program.” Echoing this sentiment, Olivia (26 and also a former recipient of, and outspoken advocate for, publicly funded SRHC) explains how “there are people who think there’s no place to get these services anymore…and that is pretty much one of the biggest difficulties of people accessing services… not knowing that the services are still available.” To date, there are only six publicly funded clinics specializing in family planning that are still operating across the entire four-county region of the RGV (as opposed to the 10 that existed prior to 2013). Four of those clinics are Access Esperanza, all of which are in Hidalgo County. The other two are the only remaining Planned Parenthood clinics, each located in a different city.

As evident throughout the interview data presented above, RGV represents a specific social, political, and spatial context that compounds barriers to SRHC access, producing a triple bind of reproductive oppression. This triple bind of reproductive oppression is a matrix of domination that, arguably, is experienced by my respondents as well as other working class Latinx women along the border. It is important to note that while some of these three barriers may be found in other communities, the collective strength (as well as impact) of the combination of these three barriers in the RGV represent a highly unique and extreme circumstance of disadvantage. In part, this is because reproductive policies are more punitive in Texas than in other most other states – Texas is ranked last (50th) when it comes to women’s health policy (United Health Foundation

2019).[26] In addition, not only is the poverty rate in McAllen two times higher than the state's rate, the broader region of the RGV and each of its four counties represent four of Texas' top five poorest counties (Ura 2016). They also rank among the poorest across the entire U.S. (Census.gov 2019). These political and economic factors combined with the social forces of Catholicism as a historically dominant religion along the border ultimately catalyze the sociogeopolitical context-specific phenomenon of the triple bind.

Still, as Collins assures us, where there is domination there is also resistance (Collins 2017). Below, I explore the recursive relationship between domination and resistance, focusing on how women make sense of and exercise agency over their SRHC struggles.

Reproductive Agency, Health Care Utilization, Political Resistance: The Importance of Publicly Funded Family Planning Programs

Although they identify various challenges they have faced, the majority of my respondents have been able to access SRHC at one point or another by visiting local, specialized family planning clinics. Their SRHC-seeking behaviors and decisions have been largely driven by a sense of reproductive agency; the need to access basic, preventive health care such as cancer screenings and routine check-ups; and, for some, a growing fear over perceived political threats to women's reproductive autonomy, health, and futures.

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[26] The United Health Foundation (2019) provides a state-by-state comparison of the health of women, infants, and children. Their rankings model uses 55 measures of health organized across five categories of health determinants and outcomes, including behaviors, community & environment, policy, clinical care and health outcomes. Texas ranks 50th in the policy and clinical care categories. Overall (all five categories combined), Texas ranks 49th when it comes to women's health and 43rd for women's, infants', and children's health collectively.

Reproductive Agency Whether or not women have the means to access contraceptive and other family planning services largely determines whether and when they will become pregnant and whether they are able to realize their educational and career goals. The desire to delay or prevent childbearing through family planning is an exercise in reproductive agency that is motivated by what Carvajal and Zambrana (2020) refer to as "aspirational capital." Aspirational capital, they contend, is "the ability to maintain desires and ambitions despite unfavorable circumstances and significant obstacles" (Carvajal and Zambrana 2020:11). The majority of my respondents had either enrolled in or completed college. The ability to access publicly funded SRHC services at a time when their lives were characterized by extreme job and health precariousness, therefore, was something they regarded as paramount to their success. Reflecting on her adult life and the accomplishments she had reached thus far, Alicia (30, former community health educator, or *promotora*) credits her educational and professional success, in large part, to the fact that she was able to avoid an unwanted pregnancy because she had access to SRHC services at no cost.

> *I have been sexually active since I was about 18 and, if at any point, I would have gotten pregnant, I wouldn't be where I am now. I have a master's degree, I'm doing this new internship, I worked with different members of the community, I was a promotora… If there was a child involved, I'd probably… have to live with my parents, get a part time job or something. I wouldn't have done all this amazing outreach that I've done so far.*

With limited financial and health care resources, publicly funded family planning clinics provide my respondents as well as millions of other women across the U.S. with the means to plan for and achieve their goals as they see fit. For Sarah, access to SRHC gave her a sense of sexual agency as well. As Sarah puts it:

> *I mean having access to these reproductive services and to birth control I mean it's a way for me to control when I want to be pregnant, which is after, you know I graduate, once I have a job, once I feel ready…so having this gives me power over my own body to choose. I don't want to be pregnant now, but I still want to enjoy being sexually active and I want to enjoy intimacy with my partner…having access to this I think is really important.*

When Melissa (33 and now a mother of two) was raising her first child, she was working part-time and had just transferred from community college to finish her bachelor's degree at a local four-year university. Within her first semester, she became involved with the student organization VOX: Voices for Planned Parenthood and discovered the Texas Women's Health program. Determined to "stay the course," she enrolled almost immediately. "My job wasn't consistent enough and my family's livelihood really depended on me," Melissa recounts. "I couldn't stop to be pregnant again, I had a 4-year-old, so if I was going to finish college, I couldn't have another baby." These concerns are similarly expressed among the four other women who are mothers to young children.

Among the 25 women who do not have children, fourteen say that they either hope to or think they "probably will" have children someday, "just, not right now." Letty shares that although she and her partner of six years eventually want to start a family, the possibility of becoming pregnant while she is still in school is a major concern, as she feels it would impose significant personal, financial, and educational setbacks.

> *I always thought to myself, "Can I afford this? Can I do this? Can I have a child right now?" You know that I mean? Then I'm going to have to put school on the back burner, and then, you know, I can't start my career and all that stuff…. Being able to get free birth control is literally helping me plan for my future.*

While six women express ambivalence over having children, five state that they have made a conscious decision to remain childfree. For these women, the desire to avoid

an unwanted pregnancy has instilled a sense of personal responsibility that they believe will benefit their own personal well-being as well as the quality of their personal relationships. As Carrie describes:

> *I always knew… I never wanted to have children and once I was in a relationship where that could happen… I wanted to be able to prevent that. I didn't want to have an abortion later or have to have a child or you know… whatever. I wanted to… be able to also foster a healthy relationship with my partner, you know. It's invaluable.*

Health Care Utilization Access to subsidized SRHC not only enables women to exercise reproductive autonomy and fertility control; it also provides a central and necessary route to obtaining and utilizing basic, preventive health services. For my respondents and thousands of other women in the RGV, publicly supported family planning programs have served as their first – and sometimes only – access into the health care system. Prior to registering for publicly funded SRHC, some women had either gone without medical care or crossed the border into Mexico to meet their health care needs, a means of accessing health care services that is not uncommon for people in the RGV given the border's proximity. As Kristen (29) details, "I would go to Mexico for all my medical stuff. It would still cost a lot, but it was cheaper," she says. "But with the Texas program, everything was free, so it was a big relief physically and financially." Like Jenny, Christine (27, naturalized citizen) states that prior to receiving subsidized SRHC, she had "never been to a doctor or even a dentist check-up, like, at all."

Three of the women interviewed experienced firsthand how the (in)ability to afford annual breast and cancer screenings can be "a matter of life and death." The preventive care obtained via publicly funded family planning programs was potentially lifesaving for

both Lily (31) and Amber (33), both of whom are single mothers to pre-teen children. After receiving “abnormal test results,” Lily was referred to another clinic for a biopsy, which, to her relief, came back negative. Amber, meanwhile, discovered that not only did she have HPV, but that the HPV had caused her to develop precancerous cells. While HPV is an extremely common and preventable infection, nearly all cases of cervical cancer are attributed to chronic HPV that had gone undetected and untreated (Center for Disease Control 2019). Olivia, 26, however, continues to live in fear:

> *I have a history of reproductive cancer in my family and…it should not be ignored because of lack of income. I literally could not afford well-women screenings anywhere else but Planned Parenthood under the Texas Women’s Health Program.*

In Jenny’s concluding remarks, she humbly states, “I know I’ll probably only have [access to publicly funded family planning] for this coming year … but I’m really grateful that I can have it until I hopefully finish college and I can get real insurance where I can actually go to…the dentist and the eye doctor.” However, without private, employer-provided health insurance and without access to publicly funded health care, most women are left with only two alternative options for accessing SRHC resources. A few say that they would continue to seek resources in Mexico, but many more are like Nadia and say that they “probably, honestly, would just go without it.”

Political Resistance The difficulty of accessing publicly funded services and clinics post-2011 created a deeply felt anxiety among women in terms of the ability to meet their current and future SRHC needs. Indeed, many of my respondents felt as though Texas’ restrictions were an unapologetic affront to reproductive health and safety. Sam, for instance, experienced how the ideologically motivated cuts and restrictions to family

planning affected the clinics and women in their community. In their view, “They (politicians) don’t care about any of that going on down here, they don’t care if we die because they’re gonna save hypothetical babies.” Rita expresses how she felt a similar outrage. “On one hand you have these politicians who are against abortion or against, you know, women choosing if they want to parent or not,” she stated, “but then you also have this other side where they're cutting funding to these family planning services that would prevent the need to go to an abortion clinic.” She further elaborates on the politicization of women’s SRHC access by adding:

> *It's just ridiculous because you don't want people to have abortions and you're going to shame them and judge them for it, but you also don't want people to have safe sex. You don't want people to have access to condoms. You don't want people to have access to Plan B, to any kind of birth control.*

The precariousness of SRHC access as a result of neoconservative policy making has been an ongoing experience for women in Texas since 2011. The 2016 presidential election, however, only exacerbated the fears, anxieties, and perceived threats to women’s health and rights. Some respondents share how they made deliberate decisions about their reproductive health out of fear over the larger conservative political climate both in the state and across the country that, they saw as a serious and growing threat. Having already experienced the throes of health care access for several years, Jenny describes how she as well as several of her closest friends made a conscious decision the night of the election to go apply for the Healthy Texas Women program as soon as possible. She says, “Once Donald Trump got elected, I was like ‘Okay, definitely I have to apply for this program.’” Jenny’s experience described below captures the lived realities of being a low-income,

uninsured woman in a state so politically conservative that it is deemed "hostile to women" (Nash 2019).

> *I remember watching the election night take place and my five girlfriends were all saying that.... and we're all in very different relationships and points in our life and we all just looked at each other like "What are we going to do?" Some of us had insurance but the three of us that didn't, we were like… All our futures seemed really unsure, so I just needed to make sure that I was going to be okay in case anything happened. With everything that was going on and the kinds of conversations that were at the end, we didn't know if it was going to stay open. With that and with the way Texas does things, I felt like it was just safer to go. I got an IUD [that] I had scheduled for December because it just seemed like everything got flipped around overnight. I just felt like, I'm 27, I have like a year left of college, I don't have health insurance, and I work a part time job. And I'm in a long-term relationship… Kids are just not on my mind and to think that any options that I had were going to get taken away…I couldn't risk it.*

The utility – indeed, necessity – of publicly funded SRHC is a salient aspect in young, working class women's everyday lives. The stress experienced by their inability to afford reproductive care, however, has been compounded by broader state and national political climates that continually pose a threat to their rights to reproductive health care and autonomy. Because the majority of my respondents have the first-hand experience of knowing how essential SRHC access is to their well-being and livelihoods, they view lawmakers' decision to target publicly funded SRHC not only as punitive and oppressive but also senseless. As Ellie (28) explains, women in need of access to SRHC are:

> *[J]ust asking for some bare necessities, and our yearly exams or checkups or whatever to be fulfilled without having to worry if we can afford it or not. Because if you can't afford it, then you know, we're going to go 5, 6, 7 years without a mammogram or without getting tested for STDs or without a pap smear or, you know, someone who can't afford birth control but can get it somewhere else. These things are kind of necessities for us and it's not like we take advantage.*

In an effort to convey just how dire SRHC access is for marginalized women, some respondents even try to appeal to neoliberal reasoning. From this perspective, promoting women's reproductive autonomy by expanding access to contraception is a cost-saving strategy that women like Melanie (39) argue should garner nonpartisan support.

> *If I have an unwanted kid and I can't afford it, I'm gonna get on Medicaid and food stamps and all that stuff to help me out, you know. So it's kind of, like, lay off a little bit and then you'll see, you know, that it's not so bad after all – being allowed abortions or birth control at an extremely low cost, because it kind of benefits both parties if you really want to think about it.*

Although it is unclear whether Melanie truly internalizes this perception of becoming a potential financial burden to society as a result of an unwanted pregnancy, it, nevertheless, unveils an additional layer of complexity in how women make sense of and promote access to SRHC services.

CONCLUSION

As my study's findings reveal, in the RGV along the south Texas-Mexico border, young, working class Latinx women's reproductive health sits at an intersection of three sets of dominant and pervasive barriers to SRHC access. In the RGV, structural, sociocultural, and political barriers to SRHC are operating simultaneously, compounding one another, and consequently exacerbating their vulnerability to reproductive health risks. The structural barriers respondents identified centered around socioeconomic inequities, specifically the lack of health insurance and the inability to pay for health care expenses out of pocket. Second, SRHC knowledge and health-seeking behaviors were significantly affected by parents' attitudes and beliefs about sex, the lack of open communication about sex and sexual health due to a cultural norm of "sexual silence." Sociocultural norms that

stigmatize and silence conversations about matters of sex and reproduction have direct impacts on women's sexual and reproductive health knowledge, or health literacy; and the extent of their health literacy determined whether, when, and how they are able to access SRHC services. Although previous research discusses the notion sexual silence among Latinx families and their effects on women's SRHC decisions, contexts in which sexual silence extends beyond the family and is reflected throughout the community has been less considered. Finally, women experienced the effects of Texas' cutbacks and regulations to publicly funded family planning programs and clinics. Many women found that they could no longer afford the increased cost of services, access their usual and preferred methods of contraceptive, and schedule a timely appointment. They also witnessed how the policy effects rippled throughout their community when their peers and other women in the RGV no longer knew where to go to seek and obtain SRHC services.

The convergence of these barriers and the ways in which they were experienced by my respondents inform my concept of Latinx women's triple bind of reproductive oppression in the RGV. Rooted in intersectional feminist theory, the triple bind captures how the matrix intersecting barriers to SRHC access in the RGV produces a unique situation of disadvantage that emerges and persists precisely because of the particular sociogeopolitical context in which the RGV exists. As a border community that is over 90 percent Latinx, religiosity and traditional conservative values are ubiquitous social forces that, although not uniformly shared, make up the social context of the RGV. The RGV is also embedded within the broader political context of the state of Texas and, thus, is subject to the neoconservative, anti-abortion reproductive policies that defund and restrict

women's access to SRHC. Ultimately, the determinants that make up the contours of the triple bind emerge and persist because of the neoliberal capitalist, patriarchal, and heterosexist systems of inequality that undergird policies, norms, ideas, and practices; the structural, sociocultural, and political barriers to SRHC represent various mechanisms of inequality that are carried out with and across what Collins (2009) refers to as the structural, cultural, interpersonal, and disciplinary domains of power. The triple bind and the SRHC challenges it generates, I argue, are uniquely (if not exclusively) experienced by economically marginalized Latinx women in the RGV.

Consistent with the extant literature (and conventional wisdom), my interview data illustrate the importance of SRHC access and the significance as well as necessity of publicly funded family planning programs. For my respondents and many other women across the RGV, local family planning clinics serve as a primary, often times exclusive means of accessing preventive health care. The subsidized SRHC services received at these clinics not only have afforded them the ability to exercise their reproductive autonomy; for some, they have also potentially afforded them their lives. It is not surprising, then, that political threats (whether real or perceived) to women's reproductive health, rights, and futures can act as an impetus to seeking out and securing SRHC. The decision to seek out family planning services, particularly, long-acting reversible contraceptive methods, was a strategy deemed necessary to ensure they could meet their health care needs while there was still the ability to access services – and while reproductive health care and rights were still protected.

CHAPTER 4
REPRODUCTIVE RIGHTS ON THE MARGINS: LATINX WOMEN'S MOBILIZATION AROUND REPRODUCTIVE HEALTH CARE POLITICS IN THE RGV

INTRODUCTION

As discussed throughout this dissertation, Texas is among the states most notorious for its anti-abortion policy making. Feminists and advocates of family planning have criticized these policies as an attack on women's reproductive health and rights, the broader effects of which have been documented by public health researchers (Stevenson et al. 2016; White et al. 2014). National organizations like the Center for Reproductive Rights and the National Latina Institute for Reproductive Health have come together in an effort to advocate for and organize RGV women's reproductive health care rights (Nuestro Texas 2013). However, attention to low-income women's experiences and the experiences of women of color as *consumers* of publicly funded reproductive health care, as well as the processes through which they themselves mobilize around reproductive health care politics, has been understudied by reproductive, welfare, and social movement scholars.

This chapter seeks to fill this gap by exploring the ways in which Texas policies were perceived and challenged by current and former recipients of publicly funded family planning programs. The central question of this chapter is: *What mobilizing factors influence whether low-income Latinx women in the RGV mobilize in response to punitive reproductive policy making and engage in political activities that defend and promote reproductive health, rights, and justice?* The emphasis here is not on mass mobilization or the *types* of political activities, but rather, individuals' micro-mobilization processes – or their "pathways to mobilization" (Viterna 2006).

Like Chapter 3, my findings are based on in-depth, semi-structured interviews that I conducted with Latinx women who live in the McAllen metropolitan statistical area. This analysis, however, is based on a subset of the 30 women in my full interview sample. In this chapter, I focus on the 25 women who have received publicly funded family planning and reproductive health care services – whether currently or in the past. As discussed in Chapter 1, the women in my interview sample are predominantly young, college-educated, low-income Latinxs (some of whom identify as queer). While this sample certainly is not representative of all Latinx women in the RGV or their experiences with sexual and reproductive health care politics, my interviews help us to better understand the experience among many Latinx women living along the border, especially young, college educated, and politically conscious women.

In this chapter, I contribute to the scholarship on micro-mobilization patterns by examining the socio-economic, political, cultural, and emotional processes that both enable and constrain economically marginalized Latinx women's mobilization around the politics of reproductive health care policy in a south Texas border town. The chapter begins by situating the empirical discussion on low-income Latinx women's mobilization around reproductive health care politics in the RGV within the social movement scholarship. In addition to the conventional structural and personal barriers to political participation, attention is paid to the mobilizing processes of social movement organizations (SMOs), networks (social movement communities, or SMCs, and social ties), and emotions (particularly grievances and empowerment). The emotional processes that also inhibit mobilization is of considerable importance to this study. While most of the literature on

the role of emotions for political participation tends to focus on the facilitative effects of emotions for political participation, research on the ways in which emotions can discourage or prevent individuals from mobilizing remains understudied. Thus, one objective of my research is to contribute to the dearth of empirical work that considers emotions as a *barrier* to political participation.

Consistent with previous social movement scholarship, I find that material and ideological resource mobilization by social movement organizations, access to personal and organizational movement networks (social movement communities), and emotional resonance (particularly with grievances and feelings of empowerment) help to galvanize some women's political engagement with reproductive health care politics. For others, however, political non-participation is related to structural barriers to participation and/or a calculated decision to avoid emotional strain. SMOs' are especially important for politicizing (Frease 1975; Levitsky 2014) women around sexual and reproductive health and politics, and for providing the necessary material resources that facilitate participation.

Women's involvement with (or knowing someone who is involved with) a broader network of activists and social movement activities (SMCs) also significantly influences their political participation in reproductive health care politics. Finally, grievances (manifested as feelings of anger and a sense of injustice) and empowerment (i.e., pride and a sense of efficacy) are central to mobilizing – and often sustaining – political activity. Many women express grievances over both the structural and cultural constraints shaping their physical and informational access to reproductive health care as motivations for

“getting involved” (e.g., anti-abortion reproductive policies, patriarchal gender ideology, Catholicism, and sexual conservatism).

Unlike previous research, my research highlights the emotional dynamics that not only encourage but also discourage individuals from political engagement. As the interview data reveal, emotions (e.g., feelings of shame, social discomfort and anxieties, and activist burnout) act as *barriers* to political participation. Nonparticipation, thus, is based on a rational, calculated decision to avoid emotional strain – a cognitive process that is referred to as “emotion management” (Hochschild 1979; Norgaard 2006). Still, for some, political participation is inevitably limited by personal constraints such as discretionary time, employment, childcare, transportation – i.e., their biographical availability (McAdam 1986) – as well as their structural availability, or their access to informational networks that tend to provide the necessary details for event participation (Schussman and Soule 2005).

Finally, I situate my respondents’ mobilization within the political, cultural, and ideological contexts that shape sexual and reproductive health care politics for women in the RGV. I argue that their activist experiences in the RGV reflect the culturally- and geographically distinct “border feminism” (Anzaldua 1987; Pardo 1995, 2017; Saldivar-Hull 1991); their resistance and advocacy are part of a longstanding battle to secure sexual and reproductive agency in the face of political, institutional, and cultural constraints. Women, ultimately, are seeking to challenge both policy and the stigmas surrounding female sexuality by promoting sexual and reproductive health education and awareness.

THEORETICAL PERSPECTIVES ON MICRO-MOBILIZATION PATTERNS

The processes through which individuals become politically engaged are addressed across a variety of structural, cultural, and social psychological approaches in the study of social movements. Structural approaches emphasize the political, economic, and social conditions that facilitate movement emergence, mobilization, and political action (Skocpol 1979). They include theories on movement organizations and resource mobilization (McCarthy and Zald 1977), political process or opportunity structures (Meyer 2004), and the importance of networks (McAdam 1988; Tarrow 2011). Cultural approaches, on the other hand, stress ideational and discursive practices as particularly influential for movement mobilization (Hart 1996). For example, they consider the mobilizing effects of collective action frames (Snow and Benford 1988), media (Amenta et al. 2009), and collective identities (Taylor 1989). Meanwhile, social psychological perspectives emphasize emotional mechanisms and processes that drive participation (Jasper 2011), including grievances, efficacy, and politicized identities (Van Stekelenburg and Klandermans 2013).

While it is beyond my scope here to provide a comprehensive overview of the theoretical literature, it is necessary to review the structural, organizational, and social psychological dynamics relevant to this chapter. As will be seen, grievances often serve as an initial catalyst for mobilization; however, grievances alone do not guarantee that individuals will become politically active. Social movement organizations, networks, and individual-level factors are all important in mobilizing people. Moreover, different emotions may animate or stymie movement participation. For example, whereas feelings

of pride and efficacy often mobilize individuals, other emotions such as shame and burnout can end up preventing some from participating. The bodies of work discussed below offer a multilevel theoretical framework that sensitizes us to working class Latinx women's mobilization around reproductive health care politics in the RGV.

Grievances and Threats

Political participation, as Klandermans and Oegema (1987) lay out, evolves first from movement sympathy. Once a person becomes a sympathizer of a movement, they next become a target of mobilization attempts, and then become motivated to participate. To sympathize with a social movement is to have an emotional resonance with the movement's goals, activities, and grievances. As McKane and McCammon (2018) succinctly note, a grievance is a form of emotional or psychological discontent, stemming from moral indignation to frustration over perceived inequalities and injustices. Individual and collective grievances are experienced across issues such as relative deprivation, socio-economic marginalization, and structural conditions (e.g., state repression, weakened economies, etc.). Grievances can develop slowly over a period time, or they can be suddenly imposed, as was the case with the election of the 45th president of the United States (McKane and McCammon 2018).

While grievances can be felt individually, from a social movement perspective they are not solely individual-level problems, but rather, "everyday problems subjectively experienced by social groups and communities" (Almeida 2018:44). Such collective emotions are typically felt on a large scale to generate social action. In their classic work, *Poor People's Movements*, Piven and Cloward (1977) stress how collectively held

frustrations over widespread social and economic "dislocations" act as an effective mobilizing force among the working class. From a comparative historical framework, they point to the shared grievances felt by the "disruptive effects" of mass unemployment during the 1930s and the battle over civil and welfare rights during the 1960s.

While collectively experienced grievances are a precondition for social action, grievance construction or formation is integral to the mobilization process (Levitsky 2014; Stekelenburg and Klandermans 2013). Indeed, without politicized grievances, the sequential processes of mobilization and social change are not likely to ensue. Levitsky (2014) makes this case in her examination of the reasons behind the lack of political demand-making by caregivers for state-supported long-term care for the elderly and disabled. She maintains that caregivers' political inactivity is due, in part, to a prevailing ideology of family responsibility that does not consider "longstanding 'private' needs" like caregiving as "matters of legitimate public deliberation and decision making" (p. 35). Mobilizing individuals, thus, is heavily reliant on establishing a collectively shared grievance through first redefining acceptable situations as unjust in tandem with an "oppositional consciousness"[27] that identifies a culpable target for political redress. Formal organizations are often highly effective in the social construction of grievances given the extent of their political means and reach (Buechler 1993).

[27] Mansbridge and Morris (2001:25) define oppositional consciousness as "an empowering mental state that prepares members of an oppressed group to undermine, reform, or overthrow a dominant system."

In recent years, there has been renewed interest in exploring the role of grievances and threats for social movement mobilization (Almeida 2003, 2018; Dodson 2016; McKane and McCammon 2018; Pinard 2011). A threat, according to Pinard (2011), is the perception of a *potential* loss; this may entail the loss of economic resources, social status, power, or even political representation. If potential for loss becomes a realized loss, the ensuing perception of harm or injustice then constitutes a grievance. As Pinard (2011) and others purport, threats can intensify preexisting grievances, the emotional responses to which have the potential to further mobilize individuals and sustain collective action. For example, McKane and McCammon (2018) find that the suddenly imposed grievances of the 2016 presidential election of a misogynistic, anti-immigrant candidate was a prime rationale motivating participants to attend the 2017 Women's March; however, also motivating participants was the fear of impending threats to reproductive and immigrants' rights imposed by the incoming administration. The grievances and perceived threats associated with the Trump win were widely cited by participants as reasons to march.

Shared grievances and threats are fundamental to individual and mass mobilization. Yet, to better understand how grievances and threats are understood and become catalysts for collective action, we must understand the role of social networks and social movement organizations in processes of mobilization (Cable 1992).

Social Movement Organizations & Social Networks

The means and processes through which (in)formal organizations facilitate political participation is a dominant theme in the study of social movements and is a major focus of resource mobilization theory in particular. At its core, the resource mobilization framework

posits that people's access to material and non-material resources and situational opportunities is necessary for stimulating mobilization (Jenkins 1983; McCarthy and Zald 1973, 1980).

According to resource mobilization theory, social movement organizations (SMOs) play a particularly important role in recruiting and mobilizing political participants. An SMO is a "complex, or formal, organization which identifies its goals with the preferences of a social movement and attempts to implement those goals" (McCarthy and Zald 1977). Whether highly bureaucratic or loosely structured, they are able to engage in consciousness-raising and recruitment strategies through the proliferation of material and non-material resources (Jenkins 1983; McCarthy and Zald 1977). Material resources may include money, labor, time, literature, spokespersons or representatives, and technology among several other resources. Non-material resources include formal networks, personal connections, legitimacy, public attention and support, authority, solidarity, and a sense of belonging (Fuchs 2006). SMOs' formal, organizational structure and the extent of their available resources grant them the scope of influence to construct grievances and threats, transmit ideology, mobilize individuals, and, in many ways, sustain political activity. One way in which SMOs may use resources to mobilize people is by incentivizing political participation (Klandermans 1993) or withholding incentives from nonparticipants (Olson 1965). Incentives often are thought of as solely material or "utilitarian" benefits (e.g.,

opportunities for transportation or travel);[28] social incentives (membership-restricted activities); and normative incentives (public goods and policies).

Social movement theorists discuss the ways in which affiliated and pre-existing networks and social ties mobilize potential recruits (McAdam 1986). If people are members of more than one organization (Curtis and Zurcher 1973; McAdam and Paulsen 1993) or if they know someone who is active in an organization (Snow, Zurcher, Ekland-Olson 1980), they are more likely to participate in a political activity. The quality and strength of those organizations and interpersonal relationships are additionally important indicators of participation (McAdam 1986). Closer, more affective ties generate a greater sense of loyalty and commitment to others which, in turn, can motivate social and political action (Arnold 2011). Social ties between organization members and nonmembers also facilitate activist recruitment by providing access to informational resources about protests and other events through channels typically closed to nonmembers (e.g., event invites, newsletters, meetings, etc.) (Verhulst and Walgrave 2009).

Individuals' access to networks and informational resources via interpersonal relationships – otherwise known as their "structural availability" (Schussman and Soule 2005) – can largely determine whether a person will become a political participant. These formal and informal relationships between and among politicized organizations, groups, and individuals exist within broader social movement communities (SMC) (Buecheler

[28] The social phenomenon of volunteer tourism, or "voluntourism," is one example of materially incentivized participation and has become a point of scholarly interest and contention in recent years (see McGehee 2014 for an overview).

1990). SMCs encompass a "range of cultural and social organizations, help develop and sustain a shared sense of identity" and "provide ideological and material resources to both individuals and organizing projects" (Van Dyke 2017:367).

SMCs typically are unstructured and non-hierarchical; however, like SMOs, SMCs also disseminate ideological and institutional resources, promote and implement tactical strategies, connect people via (in)formal networks and relationships, and sustain collective identity and action (Buechler 1990). Because of this, social movement scholars like Suzanne Staggenborg (1998) suggest that rather than think of SMOs and SMCs as a distinct, alternative forms of organization within movements, we should consider SMCs as including *all* actors – individual, organizational, and cultural – that share and promote the goals of a single social movement or even multiple and intersecting social movements (Staggenborg 1998). Building on Buechlor's (1990) concepts, Staggenborg (1998:182) suggests that SMCs:

> *encompass all actors who share and advance the goals of a social movement: movement organizations; individual movement adherents who do not necessarily belong to SMOs; institutionalized movement supporters; alternative institutions; and cultural groups. ... Other organizations within SMCs, such as feminist health clinics or women's music festivals, differ from SMOs in that they exist to provide services or to educate or entertain participants in the community.*

This all-encompassing web of individuals, organizations, and groups make SMCs a crucial if not key part of the process of micro and mass mobilization. The growth and success of women's movements, for example, have always involved coalitions of political and cultural organizations and networks of loosely affiliated activists (McCammon 2001; Van Dyke 2017). The forces driving women's mobilization during the women's health

movement of the 1970s in particular was a culmination of efforts by formal groups like National Organization for Women (NOW) and the Repeal of Abortion Laws (now the National Association for the Repeal of Abortion Laws, or NARAL) and informal networks of individuals, community organizers, and political actors (Freeman 1978). A social movement community of feminist and reproductive health activists, scholars, medical experts, community clinics, and organizations actively challenged the explicit and implicit ways that heterosexism and patriarchy within medicine and science justified and maintained women's subordinated status (Morgan 2002). Collectively, these grassroots and organizational activist coalitions redefined private reproductive health care needs as public, political issues, and matters regarding women's fertility and reproductive health were extended beyond the narrow, biologically deterministic framework of motherhood to include their implications for women's self-determination, quality of life, and life chances (Cleland et al. 2006; Nelson 2015).

Emotions and Mobilization

Once dismissed as reactive and irrational elements fueling crowd or "mob" mentality, emotions as a legitimate mobilizing force are now included across a wealth of theoretical and empirical discussions about individual and collective protest behavior. Bringing affect into social movement analysis has challenged many of the structuralist approaches to movement mobilization by demonstrating the various ways in which emotions are deeply embedded throughout different processes and stages of a social movement, from activist recruitment efforts to individuals' motivations for and outcomes of political participation. Whether alongside or in the absence material resources, feelings

of anger, injustice, pride, and self-efficacy are often at the heart of individuals' political participation.[29]

To be sure, material resources and situational opportunities are needed to establish political traction, but resource mobilization and collectively felt grievances in and of themselves do not equally motivate all sympathetic or aggrieved individuals to become political participants (Klandermans and Oegema 1987). Movements must also engage in "emotion work" to attract recruits and encourage activist participation. Emotion work, whether premeditated or nonstrategic, requires organization and individual members of a movement to "provide affective pedagogies to participants and supporters, authorizing [as well as suppressing] ways to feel and to emote" (Gould 2009:255). Gould (2002) shows ACT UP, the direct-action AIDS movement that sprung up during the 1980s and flourished well into the 1990s, was particularly effective because of street activists' emotion work in handling the emotional responses to the AIDS crisis; the perception of constricting political opportunities amid the crisis (namely the lack of political redress by government officials); and feelings of anger and grief within the LGBTQ community. Personal losses were redefined as political tragedy and grief and anger were transformed into a sense of injustice; the mobilization of emotions manifested into direct, oppositional activism.

Emotions may also be used strategically as rational actors make calculated decisions based on perceived risks and opportunities, especially in situations of "high-risk

[29] Elaborating on the emotional dimensions of protest behavior is far too big of an intellectual feat for our current discussion. For exceptional overviews, see Jasper 1998, 2011 and Skelenburg and Klandermans 2013).

activism" (McAdam 1986). The perceived and experienced risks and costs, in turn, may either encourage or discourage sustained participation. During the Salvadoran civil war, for example, peasant insurgents' (campesinos) activism against state repression and violence generated "emotional in-process benefits" of empowerment-through-defiance[30] that sustained their participation and mobilized others (Wood and Goodman 2001). As Wood captures, the campesinos' insurgency allowed them to express moral outrage and experience a deepening sense of pride through an assertion of political agency; the outcome was a positive feedback loop of political participation.

Although understudied in the social movement scholarship, emotions may also deter or act as a barrier to political involvement. The emotional energy behind social movements can alienate sympathetic bystanders or provoke fears and anxieties (even shame) over perceived ramifications of political involvement (Jasper 2011). As Cox (2011) lays out, situations (especially those that are particularly confrontational), people's possible experiences of the situation, and the possible outcomes (post-traumatic stress, anxiety, fear, shame, depression, etc.) each and collectively can discourage activists and nonactivists from mobilizing. In this case, the conscious decision of nonparticipation is a strategic use of emotions – often referred to as "emotion management" (Hochschild 1979) – whereby an individual's perception of a situation leads to an "act of modifying, suppressing, or emphasizing an emotion…to fit societal expectations" (Norgaard 2006:384).

Still, others may be deterred from participation simply because they feel too tired,

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[30] Empowerment occurs at the individual, interpersonal, and institutional levels, where the person develops a sense of personal power, an ability to affect others, and an ability to work with others to change social institutions (Gutierrez 1990:150).

overwhelmed, or "burned out" (i.e., the state or process of mental exhaustion) to participate (Chen and Gorski 2015). Often times feeling burned out has as much to do with personal, lived experiences as it does with some of the more objective stressors brought about by institutional, personal, and cultural constraints – things like work, family, and even gendered expectations (Cox 2011). The presence or absence these and other types of constraints is what McAdam (1988) refers to as individuals' "biographical availability." Although McAdam (1988) is theorizing from a structuralist perspective, full-time employment, the demands of marriage, and family commitments – as well as other personal constraints such as age, class background, transportation, access to childcare – can act as both structural and emotional barriers to political participation.[31]

The findings presented below are based on a subset of interviews with the 25 Latinx women who have previously received publicly funded family planning and reproductive health care services. I analyze participants' responses to questions regarding their politicization and political mobilization around issues related to reproductive health care access and rights. The questions focused on their participation in an SMO, involvement in feminist SMCs, their affective social ties (friendships) with other social movement participants. I also explore how participants discussed their political attitudes and behaviors

[31] McAdam's discussion of biographical availability referred largely to the structural and material costs and risks of political participation. Costs refer to "expenditures of time, money, and energy that are required of a person engaged in any particular form of activism, while the risks refer to "the anticipated dangers—whether legal, social, physical, financial, and so forth—of engaging in a particular type of activity" (McAdam 1986:67). For example, younger people, like college students, are more likely to be political participants because they have more time and are likely to be freer of competing social roles, commitments, and relationships since they tend to be unmarried and attending school rather than working (Wiltfang and McAdam 1991).

in relation to their sociocultural context, especially their religion, political or cultural conservatism, and their family background.

Consistent with prior social movement scholarship, I find that material and ideological resource mobilization by SMOs, access to personal, affiliated, and informational networks (SMCs and social ties), and emotional resonance (particularly with grievances and feelings of empowerment) galvanized women's political engagement with reproductive health care politics. Still, some women were less (or not at all) participatory in efforts to defend family planning programs against cutbacks. While personal constraints (biographical availability) were common obstacles, there were also emotional barriers to mobilization. In this case, lack of participation was based on a rational, calculated decision to avoid emotional strain – a process previously referred to by Arlie Hoschshild (1979) as emotion management.

FINDINGS

The analysis below of my respondents' mobilization pathways is structured by the following themes: 1) the significance of social movement organizations (resource mobilization); 2) networks (social ties and social movement communities), and 3) emotions, especially those related to grievances and empowerment, shame, discomfort, and burn out. These pathways, however, are not mutually exclusive, ideal types, as many were motivated to participate in political activities through a confluence of these paths and processes.

Social Movement Organizations & Resource Mobilization

Because of their formal, bureaucratic structure and resource availability, SMOs typically are well-equipped, from a structuralist perspective, to recruit participants and mobilize sympathizers around perceived threats and grievances. As the interview data reveal, majority (72 percent) of my respondents first became politically aware of and were mobilized around sexual health education and reproductive health care politics as undergraduates at the University of Texas Rio Grande Valley (UTRGV) through their exposure to – and, for many, eventual direct involvement in – reproductive health and rights SMOs on campus. The campus chapters of SMOs were especially crucial in facilitating an oppositional, feminist consciousness as many participants were not only previously unaware of reproductive health care politics; they also were unaware of sexual and reproductive health knowledge more broadly, including their own.

At UTRGV, some of the more commonly known student chapters of reproductive health and rights SMOs include: *Unite for Reproductive and Gender Equity* (*URGE*) *RGV*, *Texas Rising* (a chapter of *Texas Freedom Network*), and *Access for Sex-Ed* (formerly *VOX: Voices for Planned Parenthood*).[32] As a campus and community outreach program of Access Esperanza, a local chain of family planning clinics located across the McAllen MSA, *Access for Sex-Ed* is one of the more active student organizations at UTRG. According to the student organization's website, Access is dedicated explicitly to:

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[32] In 2014, as a result of a loss in funding due to Texas' decision to bar Planned Parenthood from receiving state funding and in an effort to reclaim funds, the Planned Parenthood Board of Directors in Hidalgo County made the decision to cut ties with the national organization and re-brand under the name Access Esperanza (Ura 2014).

> *[Educating] students about sexual health, where to find services, and how to advocate for the reproductive health care programs and services people take for granted. Members pass out information and condoms, hold movie viewings, participate in UTRGV sponsored events and develop their own awareness and fundraising events* (ACCESS, n.d.).

As a college-based SMO, *Access for Sex-Ed* is sustained through the financial resources provided by Access Esperanza that are dedicated to campus and community outreach. Just as it did when operating as a Planned Parenthood affiliate, Access Esperanza has been able to establish and maintain a visible and active presence at the university by hiring an intern[33] to serve as president of the campus chapter of the organization – an incentivized form of participation. The president of *Access for Sex-Ed* and the elected student members (albeit to a lesser extent) are responsible for disseminating the material and ideological resources provided by and on behalf of Access Esperanza with the goal of recruiting, educating, politicizing, and mobilizing college students around sexual and reproductive health care politics.

Consistent with resource mobilization theory, *Access for Sex-Ed*'s mobilization efforts were particularly successful at the university, as forty percent (n=10) of the women I interviewed said they were drawn to their first meeting specifically because they saw a flyer or visited an informational booth on campus. Through its student member advocates and the mobilization of material resources, *Access for Sex-Ed* recruited attendees and volunteers to regularly held, student-led meetings and campus events. Resources used to

[33] The intern is assigned the role of President. The student organization then holds annual elections to fill the roles of vice-president, treasurer, and other officer positions depending on recruitment success. All other members are unpaid and, typically, self-nominated.

recruit attendees included advertisements through the use of flyers that were posted throughout the university. The flyers were usually printed on bright, fluorescent paper detailing the meeting time and location. Providing free lunch and condoms were additional resources used to attract (and incentivize) student attendance. When asked about her introduction to *Access for Sex-Ed*, Anna (26) recounted:

> *I saw there was [sic] a lot of flyers everywhere of different clubs and stuff. I kind of giggled like, 'Oh wow they're talking about sex!' It was this big pink paper poster and it was like free condoms and pizza. I was like is this a joke I've never seen this. It was so unreal and so cool to me. I decided to go and sure enough they had free pizza. They were giving out condoms like candy.*

Access for Sex-Ed also hosted educational booths (i.e., "tablings") on campus throughout each semester that were intended to promote safe sex, healthy relationships, and sexual health; provide information on how to access health care resources through the network of Access Esperanza clinics; and showcase the organization in an effort to mobilize students. The free condoms offered at the tablings sparked a genuine curiosity and interest among many passersby and mobilized many of my respondents' into attending their first meeting. As Tanya (26) expressed, "For me, it was seeing condoms being handed out. I would see people tabling, giving out condoms…which was like, so incredible that they were giving them out. For me that made it like, 'Okay, this is okay.'" Growing up in predominantly Catholic communities and families, most women did not openly talk about, much less openly embrace, sexual agency. Whether strategically or unintentionally, the advertising of free condoms served, in part, as a "sensitizing apparatus" (Traini 2009) intended to grab people's attention and recruit members.

SMOs are also highly effective in mobilizing the ideological resources needed to recruit participants and encourage political involvement. As the interview data reveal, those who became politically active in reproductive health and rights politics were largely motivated by the "eye-opening" experiences of attending the *Access for Sex-Ed*'s student meetings. Discussions and information-sharing helped (further) develop women's burgeoning feminist consciousness. As respondents attended the meetings, they became exposed to new conversations that shed light on topics about sexual and reproductive health that they otherwise did not have in school, with their families, or in their communities. Letty (26) described her experience in attending the *Access for Sex-Ed* meetings. As she elaborates:

> *The meetings were every Wednesday at 12:15 and they would talk about different, well they would have different topics about everything. Every STD, and it was not only that, it was pregnancy, or like 'Oh let's study about the vagina and what to expect if you have an infection. What it should look like or a yeast infection.' I didn't even know what a yeast infection was until I went to these [meetings]. ... It was a whole new world. I took a blindfold off my eyes. I feel like I had just jumped out of ignorance. ... It was kind of like a really neat experience to further your knowledge in sex that was never even spoken in the house or around school at least in high school.*

Letty's traditional, Catholic upbringing had a profound impact in her process of mobilization. Her and so many other women felt that they experienced an awakening of some sort. As Valerie (30) expressed in a similar vein: "For a long time I didn't even know anything about how my body worked or the things I had to worry about or be aware of. No one really talks about having to go and get a pap smear, things like that." Meanwhile, as Jenny (27) shared she, too, had not discussed sexual health until she started attending meetings hosted by *Access for Sex-Ed*.

> *My parents are very Catholic. I wouldn't say conservative. I would say just very, you know, old school. … And they never talked about sex with me ever. I learned that all through college. Being in a Mexican family, talking about sex and all, these things just weren't really talked about.*

Because no one was talking about sexual and reproductive health care in their own personal lives, some women had been unaware of the types of health care resources available and how to access them simply before attending a meeting. Sam (26) notes how their first meeting with Access was "Great. It was comfortable, everybody was open and honest about their concerns and it gave me a chance to see…that you don't have to be ashamed, that there is assistance, you know, financial assistance for people that are looking for reproductive health care."

Talking openly about sex and sexual health was a new, enlightening experience that aided in women's reconceptualization of their sexual and reproductive agency. Like the feminist practices of the women's health movement in the 1970s, student-led SMOs like *Access for Sex-Ed* and others engaged in consciousness-raising efforts that were "reinterpreting one's individual experiences, seeing them as shaped by social forces, and identifying as part of a group with shared experiences" (Whittier 2017:377). Through sexual health education and advocacy, *Access for Sex-Ed* (re)defined reproductive health to be matters of political rather than private concerns. Further, through the provision of material support via student-led SMOs (which often provided transportation and opportunities for travel),[34] several women soon became active participants off campus, and

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[34] Transportation and opportunities for travel to the state capitol to participate in "Texas Legislative Lobby Day," a civic engagement event wherein citizens and advocacy organization engage with state representatives and their staff.

engaged in consciousness raising efforts of their own that aimed to challenge the cultural (conservative religious ideology) and political (state and national politics) constraints to reproductive health and autonomy in the RGV.

Networks

While mobilization via SMO resource mobilization is a common point of entry, it is well known that individuals' recruitment is likely to be more effective if they know someone who is already active in the organization (Snow, Zurcher, and Ekland-Olson 1980). Of the twenty-five women I interviewed, eleven (44 percent) were mobilized to become politically active in reproductive health and rights SMOs like *Access for Sex-Ed* or *URGE* through a friend, or affective tie. When Alicia (30) was an undergraduate, Access was still operating as VOX. Alicia eventually became deeply involved with VOX and later Planned Parenthood, but she attributes her introduction to the world of reproductive health and rights to her college classmate, Melissa. As Alicia describes, "It's actually a funny story, like, I had seen all of the posters on campus and I was just like 'Oh, whatever. It's not my thing.' But I took a class with Melissa Garza…she was the one who was like forcing me to go, so I'm like, 'Okay, fine, whatever.' … I'm happy that she dragged me because that's where I met new people and learned how to get more involved in VOX."

For Ceci (25), her entry into reproductive health care and rights politics occurred alongside the development of a friendship. "I had a friend; we knew each other online and then we had a class together. In 2015 she went to join URGE and she had told me about it. She was like, 'You should come join, I think you would like this club.' She knew where I stood on other issues, so I started going to the club meetings." Alicia's and Ceci's

experience reflect not only the facilitative effects of social ties, but also the ways in which organizational membership can help foster additional personal ties.

Knowing someone who was involved in the broader networks of activists and supporters of reproductive politics (i.e., the social movement community) also increased the likelihood of political engagement. As previously noted, SMCs are comprised of formal and informal networks of politicized individuals, organizations, cultural groups, community spaces, and all other actors who share the goals of a social movement. Within the RGV's reproductive health, rights, and justice SMC is a network of local and national advocacy organizations, including: Whole Women's Health Alliance, South Texans for Reproductive Justice, La Frontera Fund, Jane's Due Process, Feministxs Unidxs (fully student-led organization), Texas Latinas Rising (of the Center for Reproductive Rights), and Planned Parenthood Texas Votes. In addition, within the SMC are local businesses, non-profits, and community spaces that are sympathetic to and supportive of reproductive health and rights. This network of politicized individuals and organizations also intersects with and addresses other social justice issues specific to the RGV and its communities, including LGBTQA+ visibility, immigrant rights and protection, the militarization of the Texas-Mexico border, and the social, political, economic, and environmental impact of the border wall.

Because McAllen is a relatively small city (approx. 150,000 people), the social movement community is a common source of information sharing, consciousness raising, and recruitment. A little over half of the women (n=13) in my study became aware of reproductive health care politics because they were plugged into or knew someone who

was involved in the local activist and SMC networks. Some (n=8) were already affiliated with other organizations when they came into SMOs like Access and URGE, while others were made aware through their participation in the local music and arts scene.

Sarah (22), for example, was first involved with the Texas Freedom Network. "The reason why I got involved in *Access for Sex-Ed* is because of a lot of the people that are in those progressive organizations on campus. It's kind of like a network. It's like the same people. So first I got involved with [*Texas Freedom Network]*…and then once I came to college, I asked to meet up with one of the organizers and they told me about the other organizations on campus." The individuals and organizations heavily involved in the local SMC communicate, coordinate, and support each other in their efforts to politicize students on campus and the community at large. Kristen (29) started out as an active participant in the campus chapter of the *Sierra Club*, an environmental justice organization, and attended her first *VOX* meeting upon invitation from her friend who was serving as the vice-president. Jamie (29), Amy (30), and Natalie (25) were also each involved in other SMOs on campus.

Other respondents learned about reproductive health and politics through community events. Anna (26) starting point on her pathway to politicization was through friends who were affiliated with VOX. "I had friends that were doing the *Vagina Monologues* and I thought, you know, this is such an empowering experience. … From there, I met a lot of people that worked at Planned Parenthood or VOX, because they have similar ideas. I knew that I was a feminist and I knew where my values were." For Jenny (27), "There was this band that we really like, Los Skagaleros, and one of the singers was

an active member in…South Texas Reproductive Justice, something like that. … They were really active with that and that's when we kind of became aware."

Networks of activists and organizational leadership coalitions often form within SMCs which work to further facilitate mobilization (McCammon 2001; Taylor 1989). As Reyna, a 21-year-old now highly active political participant, informed me, the reproductive health and rights SMC has its own informal leadership coalition that tries to meet each month to share information and organize events. In fact, Reyna's own politicization around reproductive health care politics occurred through her attendance at a cross-coalition community event. At the time (April 2016), Reyna had just become involved with *Progressive Young Democrats*, another student organization on campus. She had agreed to volunteer at the snack table during a public screening of *Trapped* (Porter 2016). *Trapped* is an award-winning, feature-length documentary that examines how anti-abortion laws have impacted patients, doctors, and clinics across the U.S. since 2010.

Reyna and a few other interviewees were not aware of the extent to which conservative state legislators had been targeting reproductive health care until they saw *Trapped*. The screening of the documentary, in a very real sense, served as a process of grievance construction over Texas' anti-abortion policies.

Having not previously seen the film, Reyna remembers how formative the screening was in the development of her own oppositional consciousness and the impact it had on her decision to become more politically involved.

> *It was intense. I didn't know any of the of this was happening, but I learned. I was like, okay, I should clearly get involved. I had just known everything about what was happening with like the primary elections and voting and I wasn't too involved in like specific issues, so just going to that screening I*

> *learned what was happening around abortion services and abortion access, especially in the south.*

Reyna mentioned that she had briefly crossed paths with the president and intern for *Access for Sex-Ex*, Tina, at the film screening. A few months later, they crossed paths again through the local music scene at the first annual *Justicia* event, an abortion fundraiser organized by an informal network of local activists and musicians. After formally meeting Tina, Reyna become fully invested in reproductive politics.

> *Knowing that she was in the music scene that I was really into, I guess we just created this bond. ... We mingled there and just created this friendship. We've been able to plan together and enjoy music together. I've been able to grow through her and her knowledge because she's been doing the work for a year or two longer than me, and I've been able to learn a lot from her.*

Reyna and others mobilized around reproductive politics because of the structural and situational factors that facilitated their oppositional consciousness to the issues. However, their energetic willingness to be politically engaged was still largely dependent on their emotional experiences.

The Mobilizing Effects of Emotions: Threats, Grievances, and Empowerment

There is a general sense of outrage among feminists over the political affronts to reproductive health care access and rights. Perceived as a relentless attack on women by older, conservative men, many of those who effectively mobilized into political action out of anger and a sense of injustice (i.e., shared threats or grievances). Women identified with the grievances over the institutional as well as cultural constraints to accessing reproductive health care services. A sense of empowerment further motivated women, as they developed confidence in their assertion of agency through action and discourse.

Those respondents who were more aware of the policy side of reproductive politics in Texas shared a sense of outrage over the onslaught of conservative reproductive policy making by predominantly white, older, men. Rita (24), for example, expressed considerable frustration by the barrage of anti-abortion policies.

> *The entitlement of being a politician, being a lawmaker, who has the ability to make these policies, make these laws, and control the people... Like a lot of them, like, want to control people and control women specifically and they've been doing it, like, nonstop…and still I am surprised every day. There's no break, like there's no fucking break, like no matter which turn you take there's no break, these politicians, they don't give you a break.*

Sam echoed a similar sentiment of anger when she said to me, "I think it's a bunch of white men with their dicks and advice trying to make everybody miserable and limit our freedom and bodily autonomy (exhales)." The overarching idea is that there has been a "War on Women" since the 2010 Republican take-over across several state and national offices, and it has been deeply felt by women in Texas. As Jamie (29) noted, "Basically, all of these attempts to limit access to family planning or limit and restrict access to abortion is pushback against, like, progressive feminism."

Rita's decision to take part in political action was, in large part, influenced by her own experience with abortion. Although her initial motivation was highly personal, she described how it was her experience at that first abortion rally that further fueled her anger and ultimately convinced her to get more deeply involved.

> *I remember vividly being there for the first time, being at a protest to protect, you know, abortion access and…I just remember vividly, like I'm even feeling it right now, getting really anxious…because I hadn't ever been to a protest. And I just had this adrenaline rush of like, "Oh my god. There are people like this coming to this clinic and screaming at women!" It was just such a weird experience to like, be in the presence of these men who were so aggressive and felt so entitled to, you know, take up the space that*

they were taking up and expressing how they felt about a woman's choice - or person's choice - to terminate a pregnancy, and it's just, I just, I think it instilled in me this, like, kind of fire to fucking keep getting more involved and keep learning more about this stuff because, like, I saw it. And it was fucking real in that moment when, you know, I'm standing there and I have these large men screaming, like, being so hostile and aggressive about something that they will never experience.

Through their political participation, several women experienced a deep sense of empowerment and efficacy – what McAdam (1982) refers to as "cognitive liberation" – as well as the intrinsic reward of raising awareness and "giving back." As cited earlier, respondents spoke about feeling empowered by being able to talk openly about sex, sexuality, and reproductive health. Throughout the interviews, it became clear that what many of the women were experiencing for the first time was agency over their own sexual health. As Dana (24) shared:

[O]ne of the main reasons, like, why I started doing all of this reproductive rights and reproductive health RJ work is because when these cuts were happening, I was still a junior in high school. So whenever I needed health services, I honestly did not know where to go. ... So the mere fact that I didn't have any of that information when I needed it is a big reason why I became involved. I wanted to give back.

One of the goals of the larger reproductive health, rights, and justice movement is to promote healthy and safe relationships. Alicia recounts the moment that inspired her to become politically involved with Planned Parenthood. Her voice cracked as she held back her tears to describe a life-changing experience during one of her annual visits for a wellness exam at her local Planned Parenthood clinic:

I didn't grow up in the best of households… and if it wasn't for Planned Parenthood to tell me, like, "This is wrong. This should've never happened to you," I wouldn't know where I would be. [They] gave me strength to get out of my situation and really made me want to help other girls in my

> *situation because there's so many other girls just like me, maybe even in worse situations, and they need help. And I want to be there to give it to them…*

Alicia soon became involved with Planned Parenthood as a *promotora* doing reproductive health and healthy relationships outreach at local community and vocational colleges, and on several occasions has traveled to protest anti-abortion reproductive lawmaking on the steps of the Texas state legislature.

As evidenced throughout the interview data and across the social movement literature, emotions are a source of energy for political engagement. However, the data revealed that emotions were also rational and salient barriers that influenced their minimal or lack of political engagement. For these women, nonparticipation was a form of emotion management (Hochschild 1979; Norgaard 2006).

Emotions as Barriers to Participation

Like all social movements, not everyone who is sympathetic to and supportive of sexual and reproductive health care politics is motivated to become a political participant. Indeed, 28 percent of the women interviewed had not been (n=3) or were no longer (n=4) politically active around reproductive health care politics. As expected, respondents who did not (or no longer able to) engage politically were unable to due to work and family commitments (i.e., their biographical availability) and lack of access to informational networks (i.e., structural availability). But for some women, emotions played a significant role. The findings suggest that emotions were highly effective in thwarting their political participation.

Three of the women I spoke to did not feel comfortable being publicly outspoken due to social anxieties and an overall discomfort with confrontational situations. For Jenny (27), her decision to avoid public political confrontation, even on social media websites, is more personal.

> *You know since I did have an abortion it kind of is a very personal issue, you know what I mean? So, when I see stuff about it online or when I read things about, you know, a reproductive law or funding for programs…I just, I get kind of, I wouldn't say emotional, but kind of like I'm attached to this certain issue because of what has happened. So, I refuse to do like Facebook politics, you know? When I read the comments and when I read the articles, of course I'm like infuriated and disgusted that some people just don't- like are so backwards in thinking. … When it comes up with a person that I'm speaking to or whatever, like, I definitely tell them how I feel though. I just don't necessarily tell them, you know, I've had an abortion.*

To be sure, Jenny's discomfort is not from the experience of having received abortion care in and of itself; her apprehension toward public political confrontation is sourced in the discomfort she experienced outside of the clinic the day she went in for her abortion. As she recounts, a woman and her husband were yelling across the fence in an effort to dissuade her from going into the clinic. The aggressiveness of anti-abortion protesters appeared to be a common source of anxiety for other women as well, including those who had otherwise been more politically active. Although Sarah has been actively involved with SMOs on campus, she cited fears of retaliation by right-wing extremists as a primary reason for being less publicly engaged with reproductive health care politics. She says she tries to further demonstrate her views on social media, but when it comes to political demonstrations she says:

> *I am not as heavily [involved] as I would probably like to be just because I feel sometimes I'm a little bit scared of Radicals on the opposing side…I mean I see a lot of things about violence breaking out in like these*

situations. It's a little scary for me to - I mean props to those that are out there and that are fighting for these rights - but for myself, I'm a little bit scared about putting myself out there too much. Yeah that's the only thing that kind of pushes me back a little bit.

Participating in events that were hosted by the SMOs on campus, she says, felt "more, like, a 'professional setting,' you know, so it kind of made me feel a little more safe *[sic]*…as opposed to being in a rally or something." Since 2014, Rachel (27) would regularly volunteer as a clinic escort,[35] but has recently begun to feel less and less comfortable. As Rachel describes:

Recently I haven't really been going because it has been giving me a lot of anxiety. ... You get a lot of church people who will go and the things they yell, they spit, they tell us we're murderers and that we're killers. And then sometimes [patients] will be like, "I'm just going for my pap smear!" And they'll just yell back and it's like people don't even understand what's going on here. People will drive around and, like, it's kind of scary…I feel really nervous.

The centering of anti-abortion politics in states like Texas within the politically divisive climate of the current presidential administration has made it difficult for some to maintain their level of involvement in reproductive health care politics. Still, others' lack of participation was the result of activist or political burnout – in other words, from simply feeling emotionally exhausted from their previous involvement. Jamie (29), who was politically engaged within and across a variety of SMOs as an undergraduate (from the Sierra to Club and the Texas Freedom Network to Planned Parenthood and now Access Esperanza), has come into a sort of apathy with respect to direction action activism. "I love

[35] A clinic escort is someone who volunteers at an abortion clinic to assist patients in and out of the building, acting as shields to distract them from potential harassment from anti-abortion protestors.

advocacy," she said, "but I think the political part when I worked for the Planned Parenthood Texas Votes just, like, completely turned me off from politics." When I asked what she meant by this, she went on to describe a sense of apathy she had developed as a result of the low voter turnout during the 2014 Texas Gubernatorial election.

> *After Wendy Davis didn't win, abortion clinics closed and then opened and closed. Everyone was super, like, all about protesting, and I was like, "I'm tired of protesting! You guys didn't fucking want to vote, so I'm done!" So, I was done, and I'm still a little done from that.*

Jamie not only is demoralized by the low voter turnout and electoral outcome; she noted that she also is just "too tired" at the end of the days to engage in any political efforts in addition to the advocacy work she does as a community health educator for Access Esperanza. "When you're young you think you can do 20 things and it works out. And it used to work out, but I just can't keep up anymore. College students do have time; they don't have as much responsibility."

Understanding role of emotions for political nonparticipation, thus far, has been understudied in the social movement scholarship on mobilization. While all of the women I spoke to were sympathetic to the goals, tactics, and larger feminist ideals of reproductive health care politics in the RGV, some of my respondents were confronted with emotional *barriers* to political engagement. The emotional barriers, however, were based on rational, calculated decisions. Emotion management, for them, was an explicit recognition of the emotional state that situational factors provoked, and a redirection of actions intended to help them avoid emotional strain.

CONCLUSION

This purpose of this chapter was to frame our understanding of whether and how recipients of publicly funded family planning services in the RGV of south Texas mobilize around reproductive health care politics, particularly in response to conservative, anti-abortion legislation that has defunded and strictly regulated programs and clinics. As my interview data reveal, campus chapters of local and national reproductive health and rights SMOs and network ties – specifically within SMCs as well as affective, friendship ties – play significant roles in mobilizing Latinx women around reproductive health care politics and perceived threats to, or grievances related to, SRHC access. My research confirms the importance of resource mobilization by SMOs and the presence of SMCs as being highly effective in mobilizing political participants.[36]

The emotional processes both facilitating and inhibiting mobilization turned out to be of considerable importance to this study, as previous social movement research examining the facilitative effects of emotions for political participation have largely overlooked the extent to which emotions can discourage individuals from mobilizing. Respondents' feelings of anger and frustration were rooted in an emotional resonance with grievances over anti-abortion politics, real and perceived threats to women's reproductive

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[36] One key difference that is worth further consideration, however, is the unequal presence – and, therefore, possibly differential impacts – of SMOs at each of the universities in the RGV. Prior to its merging in 2013, UTRGV existed as two separate universities, UT Brownsville and UT Pan American. There is significantly greater SMO representation in the upper valley campus. As such, there appears to be significantly more political activity along with a denser, closer knit SMC. While this may be due to social, political, and economic forces in addition to or outside of the stronger SMO presence in the McAllen as opposed to the Brownsville MSA, it still would be worthwhile to empirically investigate the (relative) extent and impact of SMOs' resource mobilization efforts on campus in the lower valley as well.

health imposed by the state as well as the Trump administration, and the local sociocultural context of Catholicism that has shaped women's (mis)understandings of their own sexual and reproductive health. Through the development of an oppositional consciousness to reproductive health care politics and through their own experiences with accessing reproductive health care, many respondents felt empowered and asserted their agency through their political participation. Emotions, however, were also effective in preventing political activity. Experiences with social discomfort and anxieties (sometimes rooted in fear of confrontation or violence), as well as emotional exhaustion, especially from earlier political engagements that were unsuccessful, kept some women on the sidelines when it came to participation in public events.

In highlighting low-income Latinx women's mobilization around reproductive health care politics in the RGV, the goal of this study was to shed light on the lived experiences of marginalized women in an economically vulnerable region, as both these women and the RGV remain underrepresented within the broader social movements literature. This study also sought to highlight the larger gendered political and sociocultural dynamics that restrict women's reproductive autonomy. Working class Latinx women's political resistance to the structural, sociocultural, and political constraints on their bodies ultimately represents a "border feminist" struggle that is a situationally and geographically distinct lived experience for women along the U.S.-Mexico border (Saldivar-Hull 2001). The women in this study live in a state that is considered especially unhealthy for (United Health Foundation 2019) and hostile (Nash 2019) towards women. In addition, their communities, although largely Democratic, are predominantly Catholic. As discussed in

Chapter 3, the patriarchal structure and sexual conservatism of Catholicism has long stigmatized (women's) sexuality and, thus, silenced necessary conversations about sexual and reproductive health. Latinx women's experiences with and mobilization around reproductive health care politics in the RGV, thus, not only reflects but is an *active continuation* of the longstanding political and cultural resistance to oppressive gender ideologies and politics that Chicana feminist scholars have been lamenting for decades.

CHAPTER 5
RETHINKING RESTRICTIONS: PROTECTING, PROMOTING, AND EXPANDING ACCESS TO PUBLICLY FUNDED FAMILY PLANNING

INTRODUCTION

As discussed, (and evidenced) throughout my research, publicly supported family planning programs are a crucial public health care resource for women that are low-income, and under- and uninsured. The ability to access health-promoting and preventive health care resources including high-quality, reliable contraceptive methods, STI testing and treatment, and HIV/STI prevention among other services at reduced or no cost extends to marginalized women the basic human right to reproductive autonomy. Meanwhile, breast and reproductive cancer screenings provided via publicly funded family planning programs ensure that women are able to detect and treat the early signs of many fatal yet preventable diseases, particularly HPV and cervical cancer.

Reproductive and public health scholars, organizations, and advocates around the world recognize that women's health and well being, upward mobility, livelihoods, and freedom are largely dependent on whether they have the power to decide if or when they will become pregnant. These outcomes also depend on whether they are able to access vital, preventive health care resources to meet their sexual and reproductive health care needs. Lawmakers interested in challenging and regulating abortion rights, however, have overlooked (if not ignored) this as they continue to defund and impose restrictions on the provision of family planning programs. Predictably, family planning policy restrictions had disastrous effects on aggregate-level measures of women's reproductive health care access and health outcomes, particularly in Texas where anti-abortion policies abound (Fischer,

Royer, and White 2018; Lu and Slusky 2016; MacDorman, Declercq, and Morton 2016; Packham 2017; Stevenson et al. 2016; White et al. 2015, 2018). The impacts of these restrictive policies were especially acute for multiply marginalized women and, indeed, worse for multiply marginalized women in high poverty, medically under-resourced and under-served regions like the Rio Grande Valley (RGV), the southernmost region of Texas along the U.S.-Mexico border (Nuestro Texas 2013, 2015; Woo, Alamgir, and Potter 2016).

In this dissertation, I used a mixed-methods approach to studying the politics of family planning policy restrictions in the United States. My research provides a comprehensive, intersectional feminist understanding of this politics and its aftermath, which has been understudied by other scholars. The goals of my dissertation were three-fold. First, I provide a quantitative, cross-sectional analysis of the broader social and political forces shaping the politics of contemporary family planning restrictions in the U.S. Second, I document through qualitative methods the ways in which Texas' abortion-related restrictions to family planning compounded Latinx women's barriers to sexual and reproductive health care access in the RGV, particularly among current and former consumers of publicly funded family planning programs. Third, I uncovered the mechanisms and processes that enabled or constrained their political mobilization in response to anti-abortion policies and around reproductive health care politics.

In this concluding chapter, I first briefly summarize the primary findings of my research and the contributions that Chapters 2, 3, and 4 make to the scholarship on reproductive and welfare politics, the social determinants of Latinx women's reproductive

health care access, and individuals' pathways to political mobilization, respectively. I then describe the limitations of my dissertation research that future studies could address. Finally, because this project was informed an intersectional feminist approach, the remainder of the chapter is dedicated to highlighting the implications of my findings for policy and practice.

Overview of Major Findings and Scholarly Contributions

In Chapter 2, I asked: *Does religious-conservative politics explain the relative restrictiveness or leniency in states' family planning policy making?* I found that, unfortunately, for economically disadvantaged women in the U.S., the difficulty or ease with which they can access publicly funded family planning services is largely dependent on the ideological leanings of their state's lawmakers.

Specifically, my quantitative analysis of state-level family planning policy restrictiveness demonstrated that, holding other factors constant, the most important determinant of the extent to which states are more or less restrictive in their distribution and use of family planning funding was governmental, or lawmakers', ideology. Net of the effects of religious conservative interests, feminist interests, and the racial-ethnic context of a state, lawmakers' conservative ideology had a consistently significant effect on the count of family planning policy restrictions. The strength of the effects remained after additionally controlling for gross state product per capita and the percent of women in need of publicly funded family planning services.

To reiterate, welfare scholars have argued that states "may be sites of autonomous official action" by self-interested officials and bureaucrats whose goals are "not reducible

to the demands or preferences of any social group(s)" (Orloff and Skocpol 1984:730). The findings in Chapter 2, indeed, underscored the importance of state actors and the extent of their institutional political power. At the same time, the structure of institutional conditions and the types of policies engendered do not exist in a vacuum. It is important to note that, although lawmakers appear to be prioritizing their own partisan politics and anti-abortion ideologies, their institutional power and ability to shape reproductive health care policy is largely a function of the electoral process whereby like-minded political "allies" are elected into office. Thus, government, or lawmakers', ideology and the institutional conditions they create do matter, but it may also be that by shaping electoral outcomes, conservative, anti-abortion interests have been able to influence policy the most.

Chapter 2 contributes to the research on contemporary abortion-related restrictions to family planning and reproductive health care, first, by providing a quantitative analysis of the forces driving state-level policy making. Previous studies have put forward crucial evidence of the impacts of cutbacks and restrictions to family planning, especially in Texas (Fischer, Royer, and White 2018; Lu and Slusky 2016; MacDorman, Declercq, and Morton 2016; Packham 2017; Stevenson et al. 2016; White et al. 2015, 2018). However, to my knowledge, no other studies have empirically assessed the political forces behind these policies and the conditions under which they influenced state policies. To be sure – and as discussed in Chapters 1 and 2 – it is generally understood and well-accepted that religiosity and political conservatism are significant determinants of anti-abortion policy making as there is extensive literature to support this. Cutbacks and restrictions to publicly funded family planning and reproductive health care, however, are a relatively recent political

trend that began to gain traction after 2010 and are relatively understudied. Previous research has shown that, over the past century, family planning policies have been shaped by a complex web of gender, race-ethnicity, and social class dynamics. The relationship between conservatism or conservative ideologies and contemporary family planning restrictions cannot (and should not) be assumed a priori.

Thus, in my efforts to thoroughly research the politics of contemporary family planning policy restrictions, it was necessary to test the effects of conservative ideology using various measures. My analysis not only substantiated the influence of conservative anti-abortion interests on family planning policy. In particular, it showed that lawmakers' conservative ideology was more important than public opinion in determining which states adopted restrictive family planning policies.

Chapters 3 and 4 used qualitative methods to analyze the lived experiences of women who are disproportionately impacted by restrictive family planning legislation. Drawing attention to their lived experiences complements the existing quantitative research on policy impacts. While informative, aggregate-level statistics often "mask wide regional and local variation, as well as disparities across socioeconomic, racial, and ethnic groups" (Ranji et al. 2019:1). "Disaggregating" the data, so to speak, provides a richer, more humanized understanding of the effects of these policies on women's reproductive health and political lives. Moreover, the RGV, especially Latinx women who live there, are largely excluded from a lot of scholarship. The RGV is a high-poverty, medically underserved region along the U.S.-Mexico border with some of the most significant disparities in reproductive health (the cervical cancer mortality alone is 55 percent higher

than the average rates in the U.S.). It is important to know how policies that further complicate preventive sexual and reproductive health care access impacted, and are experienced by, women in need of subsidized health care in this region.

My qualitative analyses were based on in-depth, semi-structured interviews I conducted with a snowballed sample of 30 young, working class Latinx women (23 to 39 years of age) living in the McAllen metropolitan statistical area of the RGV; twenty-five were current or former consumers of publicly funded family planning programs; five were affiliated with the local family planning clinics as campus or community outreach advocates. In Chapter 3, I examined how funding cutbacks and restrictions to family planning impacted low-income Latinx women's sexual and reproductive health care access. In Chapter 4, I sought to uncover their sense of political agency and the conditions under which they did or did not mobilize around reproductive health care politics.

Chapter 3 demonstrated the ways in which restrictive reproductive health care policies intersect with local contexts, including socioeconomic demographics, sociocultural beliefs and traditions, and other social determinants of health to create a complex web of reproductive health inequities. In seeking to explain the various sexual and reproductive health care challenges Latinx women in the RGV face, this chapter offers an important example of how political climates can have a significant and modifying effect on women's reproductive health behaviors and ultimately further jeopardize women's reproductive health.

The effects of Texas' decision to slash its family planning budget by two-thirds in 2011 and then to ban Planned Parenthood from receiving public funding in 2013 created

additional political barriers to accessing sexual and reproductive health care. The loss of family planning funding forced nearly a third of specialized family planning clinics to shut down, increased the costs of services, and made it harder for women to schedule a timely appointment and access their preferred method of contraception. Even after local Planned Parenthood affiliates made the decision to disassociate from the national organization and rebrand as *Access Esperanza,* many women in the RGV were still in the dark about how and where to access family planning services. As my interview respondents suggest, the confusion was widespread among their peers and persists to this day.

The political barriers to SRHC access inevitably compounded the existing structural (e.g., the lack of local health care services and high cost of services) and sociocultural barriers (e.g., sexual silence and perceived lack of parental support) that many of my respondents and other women across the RGV must confront. I have argued that the confluence of these three barriers, the extent of their influence and impacts, and the ways in which they are experienced within the social, political, and geographic context of the RGV place working class Latinx women along the border in a "triple bind" of reproductive oppression. I illustrated how the triple bind is rooted in intersecting, mutually reinforcing systems of oppression and relations of power (i.e., patriarchy, heterosexism, neoliberal capitalism, and neoconservative governance) that structure and (re)produce the persistent inequities in reproductive health care access and outcomes in the RGV. Each barrier is enacted and experienced via multiple "domains of power" (Collins 2009, 2017) and impacted various dimensions of access (Price and Hawkins 2007).

My conceptualization of Latinx women's *triple bind of reproductive oppression* in the RGV fills an important gap in previous research on sexual and reproductive health access among Latinx women. Although these studies address a variety of economic, social, cultural, political, and individual-level determinants that affect Latinx women's access and utilization of health care, exploring how and why inequities in sexual and reproductive health care access are rooted in the broader, interconnected structures of inequality that (re)produce them had been understudied. My analysis of Latinx women's barriers to access in the RGV as a *triple bind of reproductive oppression*, thus, underscored the importance of applying intersectionality to the social determinants of health care. It also points to the importance and value of employing qualitative methods as it allowed me to provide a more comprehensive understanding of the ways in which reproductive health care access and outcomes are (re)produced within the sociogeopolitical contexts and systems of inequality in which women live.

While Chapter 3 helped us gain a better understanding of the intersecting challenges Latinx women in the RGV face when trying to meet their reproductive health care needs, it also cast a light on the ways in which Latinx women experienced and exercised reproductive agency when up against multiple, simultaneously occurring barriers to accessing health care – particularly in the context of political restrictions on family planning programs. My findings in Chapter 3 (and throughout the dissertation) demonstrated the importance of local, specialized publicly funded family planning clinics for providing low-income women access to contraception and basic reproductive health care.

Like many other residents in need of health care services, a number of my respondents stated that they cross the U.S.-Mexican border in order to obtain contraception and other reproductive health services in the absence of publicly funded family planning programs. For some women, the decision to secure long-acting reversible contraception via subsidized family planning services was a preemptive strategy motivated by fears and anxieties posed by the 2016 presidential election. Political campaigns promising to defund Planned Parenthood and overturn *Roe vs. Wade* alongside the rising wave of far-right populism across the U.S. instilled in these women a deep-seated sense that their reproductive health and rights would be under attack for the foreseeable future. The long-term effectiveness of IUDs (3, 5, and 10 years) made this an attractive solution that offered them assurance and the ability to secure fertility control in the face of uncertainty.

In seeking to better understand women's lived experiences within the context of reproductive health care politics, Chapter 4 offered a case study of Latinx women's political consciousness, agency, and mobilization in the RGV. It identified the processes through which they develop an oppositional consciousness as well as the factors shaping their political (in)action in response to grievances and threats. Drawing from social movement theories on micro-mobilization patterns, the central research question driving Chapter 4 was: *What factors influence whether low-income Latinx women in the RGV mobilize against punitive reproductive policy making and engage in political activities that defend and promote reproductive health, rights, and justice?*

To address that question, I analyzed a subset of the in-depth interviews, focusing specifically on the interviews conducted with the 25 women who were current or former

recipients of publicly funded family planning. I found that social movement organizations (SMOs) were a particularly important starting point for politicizing women around shared grievances and threats related to sexual and reproductive health and politics. They were also crucial in providing the necessary material and ideological resources that facilitate participation. Women's personal connections to a broader network of activists and social movement activities (SMCs) also significantly influenced their political participation in reproductive healthcare politics. Finally, grievances and threats (manifested as feelings of anger and a sense of injustice) and empowerment (i.e., pride and a sense of efficacy) were central to mobilizing – and often sustaining – political activity. Many women expressed grievances over the political, structural, and cultural constraints shaping their physical and informational access to reproductive healthcare as motivations for "getting involved" (e.g., anti-abortion reproductive policies, patriarchal gender ideology, Catholicism, and sexual conservatism).

As expected, emotional dynamics, such as anger over proposed or actual cutbacks in reproductive health care services, encouraged women's mobilization. I was surprised to find, however, that emotions also discouraged women from political engagement. Interviews revealed that various negative emotions (e.g., feelings of shame, social discomfort and anxieties, and activist burnout) acted as barriers to political participation. The decision to not engage or disengage was a form of "emotion management" (Hochschild 1979; Norgaard 2006) whereby these women made a rational, calculated decision to avoid emotional strain.

Still, for some, political participation was inevitably limited by personal constraints related to their lack of discretionary time, employment, childcare, transportation – i.e., their biographical availability (McAdam 1986) – as well as their structural availability, or their access to informational networks that tend to provide the necessary details for event participation (Schussman and Soule 2005). Many times, those women simply found other ways of staying engaged, such as consciousness-raising and reproductive health care advocacy via social media, that they perceived to be less emotionally taxing than public, physical forms of political activity such as protests or demonstrations.

My research in Chapter 4 builds upon the literature on the role of emotions for political participation, which often focuses on how emotions largely motivate political participation. My research reveals how emotional processes inhibit as well as motivate political mobilization in response to perceived threats and grievances. Although my research findings on emotions as barriers to mobilization may be limited in scope, they still present a significant conceptual and empirical contribution to the study of emotions for understanding the conditions under which individuals do or do not participate in political and social movement mobilization. Emotions are crucial in every phase and aspect of social movement mobilization (Jasper 2011). However, as we see, they can be just as effective in thwarting individual political participation as encouraging it.

Limitations and Suggestions for Future Research

Inevitably there were limitations in each chapter that can inform future studies of family planning policy restrictions, Latinx women's reproductive health care access, and their political mobilization around reproductive health and politics. First, although several

states have sought to defund and restrict family planning programs and clinics, there are many other states that have expanded access to publicly funded health care services via Medicaid expansions and increases in state appropriations for family planning programs, clinics, and services. Including both restrictive and expansive family planning policies in my analysis would have allowed for a quantitative, comparative assessment of leniency versus restrictiveness. In addition, cross-sectional analyses offer a glimpse based on a single time point. A time-series approach, however, would offer a more robust understanding of changes in the political, ideological, and policy making dynamics, especially in light of new federal regulations to Title X (i.e., the 2019 domestic gag rule) and other recent abortion-related restrictions at the state and federal levels.

Second, my interview data is neither a random nor representative sample. While I focus on one specific, predominantly Latinx region within the United States, Latinx women are not monolithic. In addition, an unintended yet anticipated consequence of using a snowball sampling method is that my findings might be a function of cohort effects. In particular, Latinx women without any college education are not well represented in my interview sample. Thus, I was unable to capture the heterogeneity of Latinx women's identities and lived experiences along the border, including experiential differences in regard to language barriers, immigrant status, religious beliefs and adherence, as well as living conditions and neighborhood effects (e.g., metropolitan areas versus *colonias*).

In addition, I did not include in my interview questionnaire questions related to LGBTQ experiences with SRHC and political mobilization, although some participants did discuss those experiences in the course of my interviews. Including more questions

regarding LGBTQ experiences and perspectives would have further enriched my research findings, especially since nearly one-third of my interview sample identified as part of the LGBTQ community. For example, current research has established that queer, lesbian, and transgender individuals experience significant barriers to health care that are unique and "significantly magnified" (Safer et al. 2016:2; Wingo, Ingraham, and Roberts 2018). Future studies should center the experiences of LGBTQ-identified Latinx individuals and their challenges to meeting sexual and reproductive health care needs that not only are similar to cisgender and heterosexual individuals (e.g., contraception, cancer screenings, obstetrics care) but also unique to lesbian women, transwomen, transmen, and gender nonbinary and nonconforming individuals as well (e.g., accessing inclusive, gender-affirming, stigma-free, culturally competent health care services and providers).

The qualitative findings of my dissertation demonstrated the salience of Catholicism as a sociocultural force throughout the community and in women's individual backgrounds and lives. Although they expressed strong support for reproductive health care access and reproductive rights, many of the women I interviewed who self-identify as Catholic still felt emotionally constrained by social and religious stigma in regard to their health-seeking behaviors and, in particular, their willingness and ability to engage in more public forms of political advocacy. Future studies might consider the ways in which women with deeply held religious beliefs make sense of, and navigate, experiences of 'emotional dissonance' between their reproductive rights advocacy and the religious and sexual conservatism of Catholicism in the RGV. Whether and how women as participants and nonparticipants reflect on their identities at this intersection of political and cultural values

would add greater depth, nuance, and richness to the study of social movements and reproductive health care politics.

In addition, the emotional processes shaping decisions to refrain from participation, whether as a result of religious identities, social anxiety, activist burnout need to be considered by both social movement scholars and organizations when theorizing and strategizing about mobilization processes, tactics, and campaigns. Incorporating emotions as barriers to political participation could provide additional insight on the pathways that may lead sympathizers into the social movement "free rider problem" (Olson 1965). By integrating emotions as barriers to political participation, social movement scholars and supporters can also begin to develop alternative understandings of how, why, and the extent to which individuals may actively engage in certain political projects and not others.

Finally, it would be naïve to overlook the legacy of systemic, racialized reproductive injustices in the U.S. Despite legal protections that ensure women are able to provide voluntary, autonomous, informed consent based on completely accurate health information, studies find that subtle biases persist in patient–provider interactions (Higgins, Kramer, and Ryder 2016). For example, research evidence suggests that health care providers tend to recommend long-acting reversible contraceptive (LARC) methods such as IUDs and implants more to poor women of color than to poor White women; they also tend to recommend LARCs more to poor White women than middle-class women (Dehlendorf et al. 2010). Other studies find that providers are resistant when it comes to patients' request for LARC removal or alternative contraceptive methods (Higgins et al. 2016). Biases, whether subtle or explicit, in patient-provider interactions sustain the ways

in which race-ethnicity, class, as well as citizenship or immigrant status influence women's contraceptive decision-making. It is imperative that future studies on Latinx women's reproductive health care access consider methodological and analytical approaches that can strike a balance between acknowledging women's reproductive agency while also recognizing the possibility of provider bias in reproductive health care and contraceptive counseling.

Protecting, Promoting, and Expanding Access: Implications for Policy and Practice

Reproductive health scholars, advocates, health care professionals, and organizations engaged in health disparities research are committed to understanding and eliminating the persistent disparities in Latinx women's reproductive health. Latinx women's sexual and reproductive health care access, health-seeking behaviors, and outcomes, however, are a complex web of social determinants that vary by local and regional contexts in many significant ways. And as we have seen, policies and political contexts can have a modifying effect on those determinants and exacerbate those existing challenges to meeting one's health care needs. Thus, in order to meaningfully reduce disparities, efforts must be made to ensure that low-income, uninsured Latinx women are able to access affordable, high-quality health care services. In this section, I discuss how my dissertation research and, more importantly, the experiences of the women I spoke with offers insights that can support political and community-level strategies that seek to protect, promote, and expand reproductive health care access and autonomy in the RGV.

Throughout this dissertation, it has been made evident that defunding and restricting family planning threatens women's health and limits their opportunities to

access care. Abortion-related sanctions placed on publicly funded family planning programs harm women's health by limiting their opportunities to access health care. In the RGV, where a significant portion of the population lives in poverty, lacks access to health insurance, and faces dominant social pressures of religious conservatism, funding cutbacks and restrictions to family planning were particularly consequential. As the women in my study revealed, lack of health insurance, the inability to afford the costs of services, and a norm of "sexual silence" collectively shape the extent to which women learn about their reproductive health care needs; they also largely determine whether and how they are able to meet those needs. Texas' restrictive family planning policies only compounded the structural and sociocultural barriers by adding a third political obstacle to care.

Documenting and describing this relationship between Texas' family planning policy restrictions and Latinx women's lived experiences in local contexts like the RGV offers a more nuanced understanding of their sexual and reproductive health care challenges. At the same time, it underscores the role of publicly funded family planning in helping them meet their health care needs, thereby helping to reduce inequities in reproductive health care access and outcomes.

In order to mitigate the significant reproductive health care disparities among Latinx women in the RGV (and across Texas), lawmakers must restore the family planning infrastructure as well as increase funding for sexual and reproductive health care services and expand access to health insurance coverage. This includes removing abortion-related restrictions on the allocation and provision of family planning funding as well as reversing

the "waiver" of federal Medicaid law (Sonfielf 2020),[37] both of which would increase the number of federally qualified family planning providers that can better serve the health needs of their communities. It is also imperative that Texas expands health insurance coverage, chiefly by implementing the Medicaid expansion provision of the Affordable Care Act.[38] Texas continues to have the largest uninsured population in the U.S.; participating in the Medicaid expansion would provide coverage for roughly 1.5 million uninsured Texans, according to research estimates (Cover Texas Now 2020; Garfield, Orgera, and Damico 2019).

In order to further promote and expand reproductive health care access, it is not enough to focus solely on health policy. A preponderance of research suggests that education policy also has powerful effects on women's reproductive literacy, autonomy, and well-being. Texas' public education system continues to emphasize abstinence-only sex education, despite medical and scientific consensus regarding its ineffectiveness relative to comprehensive sex education. As discussed in Chapter 3, abstinence-only education often disseminates medically inaccurate information and, thus, deprives teens and young women of the information and resources needed to care for their health. In addition, as Hoefer and Hoefer (2017) find, it also perpetuates outdated sexist and heterosexist as well as racialized stereotypes and instills fear and shame among adolescents

[37] The Medicaid waiver allows Texas to receive federal funding for its state-funded family planning (i.e., "spin off") program, Healthy Texas Women, which excludes federally qualified family planning clinics like Planned Parenthood from receiving public funds (Sonfield 2020).

[38] Medicaid expansion under the ACA extends coverage eligibility to nearly all individuals with incomes at or below 138 percent of poverty (Garfield et al. 2019).

by stigmatizing sexuality, sexual activity, and sexual health. Existing sex education policy should be revised to include curricula that promote reproductive health literacy via medically accurate, evidence-based, comprehensive sexual health information.

While reconfiguring Texas' reproductive health and education policies may seem to be a lofty, idealistic goal, I argue that suggested routes by which this can be accomplished are found in the insights gained from the quantitative and qualitative analyses of my dissertation. For example, in identifying the social and political forces behind state-level cuts and restrictions to family planning policy making, my research suggests that lawmakers' conservative ideology is a dominant, driving force. This can signal to organizers and advocates of family planning where and towards whom to direct political pressure; policymakers, after all, are elected representatives who (ostensibly) are subject to the needs and pressures of their constituents. It also suggests the efficacy of electing into political office "like-minded" lawmakers who are sympathetic to, and supportive of, women's reproductive health care and rights.

Meanwhile, in centering the lived experiences and struggles of Latinx women in need of publicly funded reproductive health care in the RGV, my qualitative research gives primacy to the role and strengths of local, experiential knowledge in efforts to eliminate barriers that limit access to health care services, education, information, and other health-promoting resources. As the findings in Chapter 4 demonstrate, Latinx women are, at once, challenging political institutions and policies (i.e., Texas' anti-abortion policies, cuts and restrictions to family planning programs and clinics, etc.) while also challenging the closely held and deeply embedded religious (Catholic) ideologies within their communities.

Through education and consciousness-raising, they are trying to de-stigmatize and normalize conversations about sex, sexuality, and sexual health. That is, they are shifting and redefining local sociocultural norms in an effort to promote women's sexual and reproductive agency, health, and rights.

Community health workers' (i.e., *promotoras'*) and organizers' outreach efforts alongside effective processes of resource mobilization by local and national social movement organizations, together, represent a broader social movement network of advocates and activists dedicated to reproductive health and rights in the RGV. Still, as the Nuestro Texas (2013) campaign poignantly argues, local action and advocacy does not negate the state (and federal) government's responsibility and obligation to ensure equality of health care access. Simply put, policies that obstruct access to contraception, obstetrics care, cancer screenings, and other preventive reproductive health care services violate women's basic human right to meet their health care needs and live a healthy life; many Latinx women in the RGV are unable to access this basic human right to family planning services and care.

CONCLUSION

There is evidence to suggest that most people do not support the defunding and restricting of publicly supported sexual and reproductive health care. Public opinion research by the Kaiser Health Family Foundation shows that nearly three-fourths of Americans (including Republican women and men) support Medicaid reimbursements to Planned Parenthood for non-abortion, reproductive-related care (Kirzinger et al. 2017). Yet, since this dissertation research was conducted, several state as well as federal

lawmakers have continued to impose abortion-related restrictions on the provision and use of publicly funded family planning programs. And, as Aiken and Scott (2017:10) lament, "family planning policy in the United States shows few signs of deviating from its trajectory."

At this time of writing, the most recent regulations were issued in early 2019 by the federal Office of Population Affairs (OPA) under the Trump administration. After several years of Congressional efforts to defund Title X, the Trump administration successfully imposed a "domestic gag rule" that prohibits Title X clinics from providing abortion referrals; it also requires a physical separation of abortion services and mandates prenatal care referrals for all pregnant women (Department of Health and Human Services 2019). The ruling has effectively forced Planned Parenthood to withdraw from the Title X program, which will affect eight Planned Parenthood grantees and 410 Title X funded Planned Parenthood clinics across the country (Kaiser Family Foundation 2019).[39] Prior to the ruling, Planned Parenthood received about $60 million annually and, through Title X funding, was able to provide sexual and reproductive health care services to more than 1.5 million women each year (Belluck 2019).

If abortion opponents' larger interests lie, in part, in reducing the rate of abortions, it is important to emphasize that policies that defund Planned Parenthood and other federally qualified family planning clinics are demonstrably ineffective. As Packham writes in her study on the impacts of Texas' defunding measures, "Although the primary

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[39]According to the Kaiser Family Foundation (2019), the ruling also affected 631 additional clinics that are no longer using Title X funds. These clinics are composed of city or state health departments, federally qualified health centers, and nonprofit organizations.

stated objective of the funding cuts was to decrease abortion incidents, I find little evidence that reducing family planning funding achieved this goal" (Packham 2017:182). Instead, Texas' family planning restrictions increased the rates of medically performed abortions, particularly among teens (Packham 2017), as well as "DIY" abortions (Hellerstein 2014; Zelinksi 2020). Much of the observed decreases in abortion rates among women older than 18 years of age were largely related to clinic closures (Jones, Witwer, and Jerman 2019), which, research finds, inevitably translated into increases in the rates of unintended and teen pregnancies along with associated increases in Medicaid expenditures for pregnancy- and childbirth-related costs (Stevenson et al. 2016). Policies that further constrain women's ability to access subsidized contraceptive and other preventive reproductive health services will not reduce the abortion incidence rate – and, more importantly, they will not reduce the *need* for abortion care.

Based on the empirical evidence above and throughout this dissertation, the domestic gag rule will undoubtedly have severe consequences for women's reproductive health care access and, worse, reproductive health outcomes. However, rather than relying on evidence-based research and addressing the documented health care needs of low-income, elite lawmakers are prioritizing conservative, anti-abortion ideology when it comes to sexual and reproductive health care policies. It is worth noting the demographic gap between those lawmakers and the women who are receiving or are in need of publicly supported family planning. The most active and vocal anti-abortion lawmakers are largely white, affluent, conservative men – a social position at the apex of intersecting privileges

– whose views, needs, and lived experiences sharply contrast with the women impacted by their reproductive health care policy making.

It cannot be understated that sexual and reproductive health care services provided via publicly funded family planning programs are vital to promoting the health, livelihoods, and life chances of women, children, and families, especially those at the intersection of multiple marginalities. In Texas and across the U.S., family planning funding cutbacks and restrictions – alongside a broken health care system – pose the greatest risks to the health and well-being of low-income Latinx (and other) women of color, yet lawmakers continue to promote these policies at their expense. They continue to jeopardize low-income women's health care access, exacerbate reproductive health disparities, and undermine their reproductive autonomy. Empowering these women and other advocates to mobilize against anti-abortion policies will be essential – indeed, imperative – in the efforts to improve reproductive health care access, reduce disparities, and protecting bodily autonomy and civil rights.

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APPENDICES

APPENDIX A: PARTICPITATION RECRUITMENT SCRIPT

Dear [prospective interviewee],

My name is Julisa McCoy. I'm a Ph.D. student in the Department of Sociology at the University of California, Riverside. I'm currently conducting my dissertation research and would like to invite you to participate in my study. My research is on the politics of family planning policy restrictions, and as part of my research, I'm trying to understand women's experiences with accessing publicly funded family planning services as well as their experiences with recent policies that have reduced or restricted funding for family planning programs. Do you think you might be interested in being interviewed for this research?

If not, I understand. Thank you for your time.

If so, here is some more information about the research I am doing. This study is exploring how restrictive reproductive policies in Texas have impacted consumers and advocates of publicly funded family planning in the McAllen metropolitan statistical area of the Rio Grande Valley of south Texas. The study aims to understand consumers' real and perceived challenges to accessing family planning services; how they make use of these services; the ways in which consumers and advocates perceive the politics of reproductive policy; and consumers' and advocates' efforts to navigate, mobilize, and challenge these politics to secure reproductive control. I believe that in order to do this, the study must allow women the platform to share their experiences with family planning

access and activism from their *own* perspectives. Fifty to sixty women will be recruited for this study.

My goal for this research is to highlight the reproductive healthcare needs of women in the RGV and the ways in which they push back against the politics around these issues to secure control over their reproductive lives. It is my hope that individual participants will benefit from voicing their own experiences by participating in a research project that ultimately hopes to shape state and federal policy making on expanding, rather than restricting, public family planning programs. It is my wish to help inform policies by disseminating my findings through my dissertation, academic journal publications, and popular publications.

If you decide that you'd like to be a part of this study, you will be participating in a semi-structured, but informal interview upon completion of a screening questionnaire. The questionnaire will ask for personal information, including immigration status, household income, and use of public assistance programs. The interview questions will ask about your experiences accessing and utilizing publicly funded family planning services here in the Rio Grande Valley, and any political involvement you have had around this topic. Your participation and all information provided will remain private and confidential. The interview should last anywhere from 60 to 90 minutes and will be conducted at a public location of your choosing. Participating in this research presents minimal known risks to you. You have the right to terminate the interview and/or your involvement in the study at any time and request that all records be destroyed.

If you are still interested, we will schedule a time to review the consent form, complete the screening questionnaire, and the subsequent interview.

APPENDIX B: CONSENT FORM

UNIVERSITY OF CALIFORNIA-RIVERSIDE

CONSENT TO ACT AS A HUMAN RESEARCH SUBJECT

The Politics of Reproductive Policy Restrictions: Family Planning Policy in the United States

PURPOSE OF THE STUDY

The study will explore how restrictive reproductive policies in Texas have impacted consumers of publicly funded family planning in the McAllen metropolitan statistical area of the Rio Grande Valley of south Texas. The purpose of this study is to understand consumers' real and perceived challenges to accessing family planning services; how they make use of these services; the ways in which consumers and advocates perceive the politics of reproductive policy; and consumers' and advocates' efforts to navigate, mobilize, and challenge these politics to secure reproductive control.

The study is led by Julisa McCoy, Ph.D. Candidate in the Department of Sociology at the University of California, Riverside (jmcco008@ucr.edu; (956)517-0503). The faculty sponsor for the study is Dr. Ellen Reese, Professor of Sociology at the University of California, Riverside (ellen.reese@ucr.edu).

PROTOCOLS FOR PARTICIPATION

The study is recruiting 50-60 English-speaking Latinas who are 18 years of age and older and are current or former consumers of publicly funded family planning in the McAllen metropolitan statistical area. Approximately 10-15 additional interviews with non-medical clinic staff and family planning advocates will be included in the study.

Participation in the study requires the completion a screening questionnaire that will gather personal information, including immigration status, household income, and use of public assistance programs. The screening questionnaire will be followed by an interview. The interview topics will cover questions about use of family planning services, ease or difficulty with accessing services, and experiences with political activism around family planning policies. The interview will be conducted at a location of the participant's choosing and will last between 60 and 90 minutes. If the researcher and the participant cannot meet in-person, the interview may be conducted via video call or telephone. The participant may be contacted for a brief follow-up interview if needed. With the participant's permission, the interview will be audio-recorded, but it is not mandatory.

Participation in this study is completely voluntary. You are free to decline to answer any questions, pause or withdraw from the interview, or terminate your participation in the study at any time without penalty. You may withdraw from the interview or the study by verbally notifying the researcher. If you choose to withdraw from the study, the researcher will not use any of the questionnaire or interview data. All recorded and written data and identifying information provided by the participant will be destroyed by the researcher within 30 days of withdrawal from the study.

PRIVACY AND CONFIDENTIALITY

Participants' rights to **privacy and confidentiality** will be respected and maintained. The researcher will assign **pseudonyms** during the transcription process to ensure that the participant's identity and personal information remains confidential; the participant's name and identifying information will not be used or revealed in the study.

Only the sole researcher, Julisa McCoy, will be allowed to conduct the process of obtaining, recording, and storing participants' information. All information provided by the participant will be stored on an encrypted, password-protected computer accessible only to the researcher.

RISKS AND BENEFITS

Participating in the study involves minimal known risk to you. Some of the questions will ask about political perspectives and involvement, which may evoke strong emotional reactions. It is important to the researcher that the participant feels comfortable during the interview; therefore, the participant may decline to answer any questions or may pause the interview as needed. If participants experience any discomfort or distress during the interview, the researcher will recommend a momentary break from the interview and will ask for verbal consent to continue the interview.

The participant will not be compensated or reimbursed for any costs resulting from their participation. Participants will benefit, however, from sharing their experiences with using publicly funded family planning programs by promoting a research project that aims to 1) shed light on the needs and demands of women living along the south Texas border region, and 2) ultimately help inform state and federal policy making on reproductive healthcare through the dissemination of the research findings.

You may contact the researcher with any questions or concerns about the study at jmcco008@ucr.edu or (956) 517-0503. You may also contact the faculty advisor at ellen.reese@ucr.edu or (951) 827-2930.

If you have any questions regarding your rights as a research participant, please contact the University of California, Riverside Office of Research Integrity at (951) 827-4802 or at IRB@ucr.edu.

I understand that my participation in this study is voluntary. I may refuse to answer any question or discontinue my involvement at any time without penalty. My decision to withdraw from the study will not affect my future relationship with the researcher or the University of California, Riverside. By checking "Yes" I indicate that I have read and understood the information in this consent form and have had the chance to ask any questions that I have about the study.

I consent to participate in this research project: [ ] Yes [ ] No

I consent to audio recording of my interview: [ ] Yes [ ] No

I consent to a brief follow-up interview, if needed: [ ] Yes [ ] No

__________________ _____________________ _______________

(Print name) (Signature) (Date)

APPENDIX C: INTERVIEW GUIDE

Questions for Consumers of Publicly Funded Family Planning

I. Family Planning Program Use

1. Do you currently use, or have you ever used public assistance programs (e.g., *Healthy Texas Women, Medicaid,* etc.) to get family planning and/or reproductive health care services? Services include: gynecological exams, contraceptive methods, pregnancy tests, HIV/STI tests, cancer screenings, etc.
2. How long have you used these programs for family planning and/or reproductive health care services?
3. If previously used, what is the reason you stopped using public family planning programs?
4. How did you learn about the availability of publicly funded family planning and reproductive health care services? Who told you about these services?
5. When was the first time you used public assistance programs to access these services and for what? Tell me about this experience.
6. How easy or difficult was it to enroll in and make use of the program?

II. Experience with Family Planning Program Access and Use

1. What types of services do you utilize most (e.g., contraception, wellness exams, screenings) and how often do you utilize them?
2. What has your experience been of these services?
3. Where do you primarily receive your family planning and/or reproductive healthcare services?

4. Why this particular clinic/location?
5. What has been your experience accessing family planning and/or reproductive health care services at this location?
6. How important has it been for you to be able to access reduced to no-cost family planning and/or reproductive health care services?
7. In the absence of these programs, how do you think you would otherwise access services/care, if at all?

III. Family Planning Politics and Politicization

1. Have you at any point experienced problems getting the family planning services, and if so, what were the issues?
2. What about any difficulty or obstacles to receiving family planning services and/or reproductive health care? What were the issues:
3. How do/did those problems affect your reproductive life and/or access to health care, if at all?
4. Are you familiar with the funding cutbacks and restrictions to family planning programs that have been passed by the state legislature in the last several years?
5. (If yes) In your view, what were the reasons for these policy changes (political/ideological versus economic/healthcare policy-making?)?
6. Do you feel that any of these policies affected you personally?
   i. Do you feel they affected your ability to *access* family planning programs or receive services/care?
   ii. Do you feel they affected the *quality* of services and care you received?

iii. Do you feel they had an impact on your reproductive health care decisions and/or reproductive health?

7. Did you feel there was a connection or relationship between the new reproductive policies and any problems you experienced: (Hoping to get at the existence of an oppositional consciousness around these issues.)
8. Were you ever approached by an organization or an individual or learned about cutbacks to family planning programs at a public event or meeting?
9. If yes, can you describe your experience and how you responded?
10. Did you consider or take part in any political involvement to challenge these and/or other reproductive policies? (Could be anything from sharing information (consciousness-raising) to protesting or testifying a public hearing.)
11. If you thought about taking some sort of action, but didn't or couldn't, can you elaborate on some of the reasons why?
12. If you did get involved, what was it for you that convinced you to get involved:
13. What sort of action(s) did you take to push back and why?
14. What was the experience like for you?
15. Did you encourage other people to get involved; if yes, how so? How did those people respond?
16. Have you had any other experiences with social activism in the past? If so, what were they?
17. Why is this issue in particular so important to you?

18. Are you still involved in any political/activist efforts around family planning and reproductive health care? If so, in what ways?
19. Do you think any of these efforts have been successful or impactful in any way? If so, can you describe why/how?
20. What are your hopes for reproductive politics and policies (or women's access to contraception and services such as wellness exams, screenings, and even abortion access) moving forward?

Questions for Family Planning Clinic Staff Members

I. Affiliation

1. What is your occupation/affiliation/title?
2. Where do you work and how long have you worked for this employer?
3. How long have you worked in the field of family planning and reproductive health?
4. Can you describe to me the type of work you do?
5. What has been your experience working in a field or with an organization dedicated to family planning and reproductive health?

II. Personal and Political Experience

6. What has been your personal experience doing this work in the Rio Grande Valley?
7. What has been your personal experience around the politics of reproductive health in this state and in this particular region of the state?
    i. Have state or local policies impacted your work or the clinic/organization (i.e., availability of services) more broadly?
    ii. If so, what types of policies and how?

iii. What are your thoughts on this matter?

8. In your experience or opinion, have these policies impacted the clients and their ability to access services?
9. In your experience or opinion, have these policies impacted the community at large?
10. Did you consider or take part in any political involvement aimed at challenging these and/or other reproductive policies? (Could be anything from sharing information (consciousness-raising) to protesting or testifying a public hearing.)
    i. If you thought about taking some sort of action, but didn't or couldn't, can you elaborate on some of the reasons why?
    ii. If yes, what was it for you that convinced you to get involved?
    iii. What sort of action(s) did you take to push back and why?
    iv. What was the experience like for you?
11. Have you had any experiences with social activism in the past? If so, what were they?
    i. If not, why this issue in particular?

III. Clinic Resources for Mobilization and Activism

12. Does the clinic/organization have any community outreach programs that educate the public about family planning services and policy-related issues? If so, can you describe the types of outreach efforts it has made and the public response to them?
13. Does the clinic organization encourage or help foster individual and community involvement in these issues? If yes, how so?

14. Has there been any social movement activity around access to family planning and reproductive health care?
    i. If so, what kinds of political action have occurred?
    ii. What role, if any, does the clinic/organization have in these?
15. In your experience/opinion, who has been or is usually (or most likely to be) involved in political activism around access to family planning services (and reproductive politics more broadly)? (Consumers, advocates, both?)
    i. Why do you think they are more involved than others?
    ii. What do you think *prevents* others from participating in political action?
16. Do you think any of these efforts have been impactful in any way, big or small?
17. What are your hopes for reproductive politics and policies (or women's access to contraception and services such as wellness exams, screenings, and even abortion access) moving forward?

Questions for Family Planning/Reproductive Rights Advocates – Non-recipients

I. Perspectives and Experience

1. What does the term "reproductive rights" mean to you? What about "family planning services"?
2. When and how did you become politically *aware* about the politics around reproductive policies? (Questions about *involvement* in next section.)
3. What has been your perspective on (and experience with) reproductive politics in Texas and in the RGV in particular?

4. Are you familiar with the policy and programmatic changes (e.g. funding cutbacks and restrictions) to family planning programs that have been passed throughout the last several years?
    i. (If yes) In your view, what were the reasons for these policy changes (political/ideological versus economic/healthcare policy-making?)?
5. Do you feel that any of the policies that affected funding and access to family planning services impacted you personally or anyone you know?
6. In your experience or opinion, did any of these policies have consequences for any of the local family planning clinics and the community at large? How so?

II. Activism

7. Were you ever approached by an organization or an individual or learned about the issue of restrictive reproductive policies/funding at an event or meeting?
8. If yes, can you describe your experience and how you responded?
9. Did you consider or take part in any political activity aimed at challenging these and/or other reproductive policies? (Could be anything from sharing information (consciousness-raising) to protesting or testifying a public hearing.)
    i. If you thought about taking some sort of action, but didn't or couldn't, can you elaborate on some of the reasons why?
    ii. If yes, what was it for you that convinced you to get involved?
    iii. What sort of action(s) did you take to push back and why?
    iv. What was the experience like for you?

10. Have you had any experiences with social activism in the past? If so, what were they?

10b. Why is this issue in particular so important to you?

11. In your experience/opinion, who has been or is usually (or most likely to be) involved in political activism around access to family planning services (and reproductive politics more broadly)? (Women who are directly impacted? Women fighting on behalf of other women and reproductive rights more generally?)
    i. Why do you think they are more involved than others?
    ii. What do you think *prevents* others from participating in political action?
    iii. How can these barriers to political participation be overcome?

12. Do you think any of these advocacy efforts have been successful or impactful in any way, big or small?

13. What are your hopes for reproductive politics and policies (or women's access to contraception and services such as wellness exams, screenings, and even abortion access) moving forward?