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Barriers to Abortion Access: An Ethnography of the Clinic

by

Amelia Phan

Under the Direction of Kathryn A. Kozaitis, PhD

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

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ABSTRACT

Abortion access is constrained at various socio-cultural levels. While policy may be the most publicized level at which abortion access is determined, barriers to access are highly influenced by a variety of phenomena, including the cultural orientations of the clinic itself. In this thesis I examine the ways that the clinical context both enhances and constrains access to abortion. In this light, the abortion clinic is studied as a dynamic actor in an individual's pursuit of abortion, and one whose structures, protocols, and cultural orientations are not taken for granted, but rather analyzed through the lens of a praxis-oriented, critical anthropology. Data collected by participant observation, informal and in-depth interviews, and surveys reveal the ways that community-level stigma of abortion along with the legacy of biomedicine manifest at the clinical level to both intensify and mitigate salient logistical, cognitive, and structural barriers to abortion.

INDEX WORDS: Abortion access, Abortion clinics, Health equity, Ethnography, Medical anthropology, Reproductive justice

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2022

Barriers to Abortion Access: An Ethnography of the Clinic

by

Amelia Phan

Committee Chair: Kathryn A. Kozaitis

Committee: Jennie Burnet

Cassandra White

Electronic Version Approved:

Office of Graduate Services

College of Arts and Sciences

Georgia State University

May 2022

DEDICATION

This thesis is dedicated to the many who have struggled with and continue to struggle with obtaining critical healthcare, including abortion access, and to those who have spent endless hours in the research, activism, and organization of better ways to build community health.

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An immense thank you to my committee, Kathryn A. Kozaitis, Jennie Burnet, and Cassandra White, who not only serve as role models of exceptional anthropologists, but who also spent two long years supporting my growth as a student and researcher. Thank you for helping me develop a justice-oriented, anthropological perspective that I can carry with me throughout both my career and personal life. The time that I spent learning from you three has made me proud and energized to be an anthropologist. I also want to thank the clinic at which this study took place for trusting me as both an employee and a researcher and for inspiring me in their pursuit of better ways to build equitable healthcare access. Additionally, I am grateful for the team at The Center for Reproductive Health Research in the Southeast, who provided funding for this study's analysis. Finally, thank you, Elizabeth Mosley, for your encouragement and kindness as a colleague in this field of reproductive and sexual health research and advocacy.

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PREFACE

If the aim of anthropology is to understand human differences and similarities, and if the practice of public health is to ensure the wellbeing of the community, then this project exists at the nexus of the two fields as a way to investigate how the diversity of human experience is to be incorporated into the practice of community health. What I am concerned with here is the individual's search for wellness by way of a treatment that is almost exclusively maintained by the field of biomedicine, our society's primary institution and authority concerning physical wellness and disease. This thesis explores the variety of journeys taken by those who wish to terminate their pregnancies and their interaction with the ultimate gatekeeper of abortion, the clinic. In essence, I explore the clinic as a dynamic actor in the landscape of abortion access, and one whose cultural orientations, including its ideologies, protocols, processes, and structures, both enhance and constrain access to the very service they intend to offer. The final aim of this thesis is to produce knowledge and recommendations for advocates, community organizations, clinics - for all interested members and affiliates of biomedicine and human rights - so that we may better facilitate the physical, social, mental, and spiritual health for all of those who pursue abortion as the best treatment for themselves and their families.

1 INTRODUCTION

“I feel so much better after that ultrasound. You don’t know how much guilt I’ve been wrestling with these past few days. That ultrasound lady just showed me how it’s all just a little sack of fluid. There’s no baby in there!” Tonya, a patient in her mid-twenties, had followed me into the office with an energy that was a refreshing, albeit rare, sight at the clinic. “Man, I feel good now,” she said. Despite the mask, her beaming smile was evidenced by the sparkle in her eyes. Yet, within a matter of milliseconds, the sparkle evaporated, as she pondered. “Well, I feel good for the most part...I do feel bad for all the other women in the waiting room though. They all seem so scared. I mean this whole process is so mysterious. You wait around and watch people get called back, then they come back out, then get called back again. All that mystery is nerve racking.” I welcomed the feedback, tempted to tease more details out of her, but there was already a stack of patient files waiting for me in the drop box outside the door. I gathered her medical information, and then I explained what to expect in the next couple of hours, before, during, and after the procedure. “Wait. The procedure is only ten minutes long?” I imagined a dropped jaw behind her blue mask. “I thought it was, like hours. That’s what they said over the phone.” Yet again, a patient was relieved to learn about the simplicity and brevity of an abortion. What they did not understand, or perhaps what we did not make clear, was the litany of steps that preceded the event, culminating in hours of long wait, and apparently, long awaited angst. With an air of relief, Tonya declared, “Well, I guess I’ll have to chat with some of the ladies out there about this, maybe that’ll lift their spirits!”

Throughout this thesis, I use the framework of critical medical anthropology (CMA) to analyze the clinical encounter as a space in which barriers and facilitators to abortion are both amplified and constrained. Through the lens of CMA, I have sought to understand and respond to

issues of abortion access in terms of the interaction between macrolevel structures, such as those of policy, the clinical institution, and popular beliefs on abortion, and the micro-level experience of contemplating and negotiating abortion access (Singer 1995). The clinical institution is perceived not as a static entity, but rather a dynamic actor in a woman's pursuit of abortion. Thus, the seat of power from which abortion clinics operate is a main variable of analysis (Singer 1995), while I use an ethnographic approach to highlight the lived experiences of women as they negotiate their encounter with the clinical institution.

This thesis is a response to recent calls for a renewed anthropological engagement with abortion, as there is a sore need for ethnographic data that articulates the effects of restricted access to abortion across multiple intersections of social axes such as race, ethnicity, class, migratory status, and region (Andaya and Mishtal 2016). The experiences of people seeking abortion are not homogenous. Rather, one's experience is determined by the various ways in which they are marked by interlocking systems of oppression and influence (Crenshaw 1991). In this light, an anthropological approach is used to serve the aims of reproductive justice by acknowledging the ways that women of racial and ethnic minorities are differentially impacted by the culture, including the protocols and processes of the healthcare institution as it is found within an abortion clinic. In a time when discourse on abortion is dominated by a tide of conservative politics that threatens to restrain access at the most determinant level, that of policy, let us not forget that legal policy is only one of many necessary aspects of abortion access, particularly among women of lower privilege. Thus, may this thesis illuminate barriers and facilitators to abortion access that emerge from the clinical context, a locus amenable to advocacy efforts, financial support, policy, and the goodwill of clinical leaders yearning to bridge long-standing gaps in healthcare.

This study took place at a free-standing, non-profit, abortion clinic in a large, metropolitan city in the Southeastern United States. The clinic offers reproductive health services to primarily low-income women of color, a demographic that comprises the majority of the abortion seekers in the United States (Jerman et al. 2016). Abortion is the main service provided by the clinic, accounting for over 84% of patient cases in 2020. Given the limited availability of abortion clinics throughout the Southeast (Jones et al. 2019), the clinic sees a diverse array of patients from surrounding states, including but not limited to Alabama, Georgia, South Carolina, Florida, and Tennessee.

I was employed at the clinic from Fall of 2019 to Winter of 2022, occupying various roles that exposed me to multiple facets of the clinical experience, from establishing appointments by phone, to checking in patients the day of their appointment, to educating patients about abortion, to translating pertinent information between clinicians and Spanish and French speaking patients. During the Fall and Winter of 2021, I collected surveys and conducted in-depth interviews with patients and staff members in an attempt to better understand the obstacles, facilitators, perceptions, and experiences of abortion access that I had long observed and participated in throughout my employment at the clinic. Thus, my analysis centers the experiences of both patients and staff members as they are affected by or participate in the processes that either enhance or restrain access to abortion.

This thesis begins with a brief history of biomedicine and its relationship with women's health. Next, I cover the scholarship of barriers and facilitators of abortion emerging from the clinical context. I use the concepts such as structural violence and biopower to conceptualize how the clinic enhances and restrains abortion access. After a detailed discussion of my study design, I provide a description of the field site and of the status of abortion clinics within the

Unites States, particularly the South. From there, I expand on my ethnographic analysis through chapters dedicated to the logistical, cognitive, and structural conundrums that are exacerbated and mitigated by the clinic. The thesis ends with policy and research recommendations for abortion clinics, advocacy organizations, public health professionals, and any other interested institutions invested in increasing access to abortion.

2 CONCEPTUALIZING CLINICAL BARRIERS

2.1 The History of the Clinic: Biopower and The Biomedical Institution

Here, I contextualize the modern-day abortion clinic through a brief history of the biomedical establishment as it relates to women throughout history. The modern institution of healthcare is conceptualized as a product of Western culture which is grounded in the values of science, white supremacy, patriarchy, and capitalism. Thus, the medical industry is sculpted and constrained by such values and operates as both a passive and an active vehicle for their perpetuation. Since its most incipient stages, the medical industry has acted as a medium for the Western patriarchy to surveil and control the medicalized female body, sustaining and compounding notions of hierarchy against women of various social axes via the supplantation of female medical models of health, the technological surveillance of female reproduction, and the manipulation of reproduction within female bodies of color. Michel Foucault's concept of biopower is useful within this analysis. Biopower, defined as the regulation of human life at both an individual and group level (Foucault 1990), is typically administered by the state. Yet here I argue that biopower is also managed by the sociocultural institution of the biomedical industry due to its history and continued performance as a handmaiden of patriarchal interests.

2.1.1 The Transfer of Women's Bodies to the Biomedical Institution

Modern biomedicine emerged in the late 19th century, radically shifting existing paradigms of health. In the late 19th century, the field of medicine in Western hegemonic cultures was transformed by an emerging understanding of biological processes. Physicians transitioned away from Hippocratic theories of medicine and increasingly relied on scientific understandings of biomedical phenomena in their treatment of medical problems (Shah 2016: 143). Throughout this process, a hierarchy of medical models was consolidated, giving Western

biomedicine a perceived authoritative knowledge over alternative models, be they folk models from non-white cultures or medical models belonging to women, such as midwifery. Biological determinism was privileged within this model, creating a paradigm shift in the field of medicine that marginalized more holistic and interdisciplinary models of health (Shah 2016: 160).

Biomedicine reduced complex problems to the smallest and simplest components, extracting health phenomena from their highly influential sociocultural factors (Shah 2016: 162).

Despite the profound public health benefits of these new biomedical paradigms (CDC 1999), the paradigm shift is not without its problems. Disease and illness are more than physical phenomena. Rather, they are sculpted by a host of social and cultural matters which are still often unacknowledged in the field (El-Hassan et al. 2002; Hoke and McDade 2015; Shah 2016: 162). This concept is well-illustrated by Arthur Kleinman's distinction between disease and illness in which Kleinman establishes the concept of 'disease' as the physiological aberration observed within the body, and which serves as the unit of interest to the physician. Illness, on the other hand, is defined as that which encompasses the full social, behavioral, cultural, and all-around life-altering ramifications of the disease, or the ways in which a patient experiences a disease in their daily lived experience (1989).

Not only did biomedicine gain an authoritative foothold within the hierarchy of medical models, but it also gained hegemony across contemporary western culture, existing as an omnipresent force in the lives of most, if not all, modern individuals within the west and most western-influenced regions. In effect, the biomedical institution has since become an authoritative institution around which western individuals and society find and create meaning about their existence. Despite the many positive influences of biomedicine across the world, it has flourished at the expense of alternative, holistic health models, extracting the biological from

its sociocultural context and thus ‘medicalizing’ matters of human importance (Barker 2009: 11). The medicalization of social experiences has impacted humanity at various levels, including the ways in which the biomedical institution responded to and interacted with women and the female body.

Under biomedicine, the female body was marginalized and extracted from a woman-centered approach to women’s health. Among the various medical models that encompass the history of medicine across various cultures, midwifery has existed as a female-oriented model in many societies in which women were the primary proprietors of intimate knowledge about the bodies, health conditions, and birthing practices of women (Green 2008) In essence, women’s health was supported through midwifery, an art learned and inherited through oral tradition and consisting of a myriad of practices including herbal remedies, ritualistic birthing practices, and reproductive management (Schiebinger 2007: 121; Thompson and Varney Burst 2016).

Throughout the 18th and 19th centuries, male physicians within Western societies created the field of obstetrics, a branch within the medical establishment that specialized in problems related to women’s health and anatomy. Pre-existing patriarchal models in which the male body was perceived as normative, while the female body was rendered an aberration (Barker 2009: 12), sculpted the field of obstetrics. Instead of supplementing the pre-existing models of midwifery, obstetric physicians sought to distance themselves from what they perceived to be unprofessional and unscientific aspects of the art (Schiebinger 2007: 233; Thompson and Varney Burst 2016: 23). Women’s bodies were thus medicalized, separated from their historic treatment through midwifery, and placed under the care of all-male, text-educated physicians. Simultaneously, oral traditions of midwifery were diminished as midwives were excluded from the more profitable ends of their profession. Thus, even though an obstetrical institution was

being erected that would seemingly place women within an egalitarian establishment that acknowledged their health needs, the institution was nevertheless founded on male-centric ideology that marginalized feminine bodies, thought, and knowledge systems. The field of obstetrics allowed the female body to be transferred to the surveillance of male-oriented and state-adjacent institutions, fulfilling a necessary step to biopower over women by conferring the administration of women's bodies to an institution managed by men.

2.1.2 Conferring Precision over the Management of Women's Bodies

Medical technologies facilitated the increasing surveillance and manipulation of the female body. In the early 20th century, as the medical field evolved to develop new technologies, their implementation created both positive and negative consequences for women's place within the western, Eurocentric patriarchy. Historically, influential institutions have utilized pathways into the intimate worlds of women to exert influence and control over the female body, which may be linked to the state's desire for monopoly over human life (Galtung 1990: 299). For example, in late 14th century Europe, midwives, who were formerly autonomous in their practice, were incorporated as agents of the state to report all pregnancies to governing authorities, transforming midwifery into an intermediary with which to surveil women's reproduction.

In an attempt to ensure a strong and thriving state population, governing bodies mandated that midwives cease the use of abortifacients, a strong facet of midwifery that has not fully translated to modern day obstetrics (Schiebinger 2007: 237). Thus, the surveillance of women's bodies is nothing new, but historically women have been able to find loopholes within patriarchal governance in order to exert reproductive autonomy. In times preceding 20th century biomedicine, women could exert agency due to the general lack of male knowledge concerning

female reproduction; under the influence of the Hippocratic medical theory which preceded biomedicine, women were encouraged to evacuate blood on a regular basis in order to maintain humoral balance (Marcotte 2016; Schiebinger 2007: 226). This medical model, combined with a lack of male understanding of the intimacies surrounding pregnancy, allowed women to sequester intimate bodily knowledge that allowed them to maintain an unrecognized level of reproductive freedom (Schiebinger 2007: 118).

Women experiencing pregnancy symptoms could easily feign delayed menstruation while approaching male physicians, the gatekeepers to emmenagogues. In other words, women could feign irregular menses when they suspected an unwanted pregnancy, granting them access to medications that both stimulated menses and acted as abortifacients. As long as men misunderstood unwanted pregnancy to be an irregular menstrual cycle, women could covertly access abortion. All of this changed dramatically with the introduction of technologies such as the stethoscope and ultrasound, both of which established a gateway through which men in power gained ever-more invasive understandings of female anatomy, thus rendering female bodies under a larger, and harsher microscope of surveillance within the field of male-led obstetrics (Zechmeister 2001). Now that pregnancy could not be mistaken as irregular menstruation, patriarchal pro-life ideologies had a firmer control over female reproduction via the institution of medicine. Patriarchal culture was now able to more precisely enact forms of biopower that ensured the proliferation of life, despite the desires of the woman.

Kristin Barker speaks indirectly to the concept of biopower as she asserts that “Medicalization can...grant the institution of medicine undue authority over our bodies and lives, thereby limiting individual autonomy and functioning as a form of social control” (2009: 11). This concept is well-illustrated by the advent of ultrasound technology, which has been used

to further consolidate control and surveillance over women's bodies through the medicalization of pregnancy. As is the case with most, if not all, biomedical technologies, ultrasounds offer a source of empowerment and liberation in the lives of women around the world. The ability to understand granular aspects of one's pregnancy is a source of unprecedented knowledge that allows women to make detailed, informed decisions about their sexual and reproductive health. Yet, the ultrasound has also exacerbated the patriarchal surveillance of female bodies through its ability to be a 'window into the womb' (Zechmeister 2001: 391). With the ability to see a growing fetus inside a woman's body, a fixation of fetal personhood was amplified, leaving women as the secondary and subordinated individual within the context of their own pregnancies. Biomedical science, in its fascination with the fetus, thus tends to treat the mother as the environment in which the fetus grows (Zechmeister 2001: 391), without prioritizing the absolute dependence of that fetus in relationship to the mother, and thus marginalizing the woman within an act rendered impossible without her. The visual nature of ultrasound technology also marginalizes the woman's voice, feelings, and opinions in favor of the image seen on the screen (Zechmeister 2001: 392). Similar to the biological determinism of the biomedical field as a whole, ultrasound technology renders the fetus as a completely asocial entity (Franklin 1991: 489), extracted from the sociocultural influences of the woman on which it depends. This perception further medicalizes the female body and the female experience, turning it into an object of the medical gaze which can influence ideas of women held by surrounding cultural institutions. In sum, with the advent of ultrasound technology, not only have women's bodies become more easily surveilled, but in addition, paradigms such as fetal personhood were generated to justify the regulation of women's lives.

2.1.3 Exploiting the Bodies of Women of Color for the Benefit of the Institution

The medical establishment as it is conceptualized in Western societies has consistently exploited the bodies of women of color for the advancement of European patriarchal culture, beginning in large part with the colonial era. From the days of early colonization, physicians were solicited to use existing medical technology and knowledge of women's reproduction to assist plantations in promoting the reproduction of slaves (Taylor 2020: 508). Acts of resistance on the part of enslaved women, such as infanticide or abortion (Schiebinger 2007: 107, 146), led to severe punishments with the assistance of surgeons who were used as an agent to register all pregnancies of female slaves (Schiebinger 2007: 148). The use of medical technologies on enslaved women's bodies benefitted both slave owners and physicians. Physicians took advantage of the vulnerability of enslaved women to carry out experimental medical procedures, often without anesthesia, for the advancement of the gynecological industry (Sartin 2004: 500; Taylor 2020: 508). Through the unethical use of bodies of women of color, men such as John Sims, known as the 'father of gynecology,' established medical legacies for themselves that are lauded to this day. Sims produced groundbreaking medical knowledge regarding female bodies which progressed the field of obstetrics in the 19th century and elevated his reputation as an unrivaled physician for his time. Furthermore, the knowledge reaped from the exploitation of enslaved women was used for the benefit of white, upper-class women who were deemed as far more deserving of anesthesia and informed care (Sartin 2004: 503). As a result, the exploitation of female bodies of color benefitted not only white men and their institutions, but white, upper-class women as well. As the Western hegemony embodied ideas of progress throughout the eras of colonization and beyond, the medical establishment became a critical demonstration of advancement, built in large part on the horrors inflicted onto the bodies of women of color.

During the era of eugenics in the early 20th century, in which White patriarchal identity was perceived to be inherently superior, numerous policies were instituted to ensure white supremacy within the US. Involuntary sterilization was enforced to restrict the birth of children of color under the guise of ‘social wellness.’ Within a seventeen-year range in the early 20th century, a total of thirty bills were passed across eighteen states which authorized compulsory sterilization (Taylor 2020: 509). Thus, physicians were used as a tool for white ideology, assisting in the systemic suppression of non-white women. Yet again, the hegemonic culture used medical means to manipulate the reproductive nature of women of color for the use and benefit of the majority, and at the absolute expense of the wellness, survival, and independence of women of color. Thus, the medical establishment has been utilized to fulfill the desires of dominant, white-centered institutions, demonstrating how women of color have been more vulnerable to the performances of biopower.

2.1.4 The Continued Management of the Bodies of Women of Color

The sordid history of the medical establishment in relation to women of color is not resigned to the past, but rather, it remains embedded within the structures of the contemporary medical institution. The history of direct violence of the medical institution helped to erect forms of structural violence in which the large-scale social forces of the medical institution travel down an institutional continuum to be embodied within an individual as harm, injury, disease, or death (Farmer 1996: 261; Scheper-Hughes and Bourgois 2004: 21). One facet of this structural violence is demonstrated by the prevalence of maternal mortality, particularly among women of color. Within the United States, 700 women die each year of problems linked to childbirth (Taylor 2020: 510), with nearly the highest rates occurring among Black women in the Southeast (America’s Health Rankings 2019; National Center for Health Statistics 2021). These deaths are

preventable, invoking John Galtung's definition of violence as the infliction of any avoidable insult to a human's basic needs (1990). Furthermore, Black women receive cesareans at significantly higher rates than white women, a concerning fact considering the ways in which cesareans complicate and compound future risks of maternal mortality and morbidities in individuals (Taylor 2020: 512). Such statistics are not caused by preexisting socioeconomic forces within populations of color, but rather they are the direct result of systemic racism; Black women, regardless of their adjacent social axes, receive consistently subpar medical care unless their physician was also a black woman (Taylor 2020: 512). In 2020, amidst heightened political animosity towards Latinx immigrants, alleged cases of forced sterilization amongst women of color in Georgia immigrant detention centers served as yet another example of the use of the medical industry to control female bodies of color (Dickerson 2020). Such profound evidence points to the continuation of racism within the medical institution, marking it as a locus of large-scale structural violence through which biopower continues to operate.

2.1.5 In Conclusion

Through the field of obstetrics, the appropriation of medical technologies, and the mechanics of structural violence, biopower, or the regulation of human life at both the individual and community level, is continuously exercised over women, particularly women of color. The structures of power exerted via the medical establishment have been both literally and figuratively embedded onto the bodies of women in ways that are difficult to extract given the cultural dominance and authority of biomedicine. What is taken for granted as the objective arbiter of health is seldom scrutinized as a mechanism in which power is inscribed onto marginalized bodies. Given that the abortion clinic is a product of the biomedical industry and given that abortion seekers are largely represented by women of color, it is critical to understand

the ways in which the abortion clinic may have inherited multiple aspects of biopower and structural violence that remain to be fully contested. Thus, I seek in part to critique the structures, protocols, and processes of the abortion clinic and the ways that women of color are continuously marginalized via the multiple, and mundane structures that are often taken for granted, and from which the reproductive lives of women are shaped and ordered (Das and Kleinman 2000). In a similar vein, I seek to understand the ways in which abortion clinics deviate from the normalized structures of biomedicine to enhance abortion access.

2.2 The Contemporary Abortion Clinic: Barriers to Abortion

2.2.1 Gatekeepers of Abortion

A primary barrier to abortion access arises when clinics are structured as the authority and gatekeeper of the service. Though a surgical abortion warrants that a patient obtains the service within a clinic, a medical abortion does not. The medical abortion, a series of pills, requires no intervention by a doctor, save the act of writing a prescription. Thus, any medical abortion that requires travel to a clinic results in a litany of barriers to access. Naturally, the logistical concerns of travel, transportation, childcare, and time requested off work result in barriers and delays that could be avoided with a telehealth appointment (Aiken et al. 2020; Kerestes et al. 2021). Through a telehealth appointment, patients can meet virtually with providers to obtain a prescription for the pills which can sometimes be sent directly to the patient's home. Considering the dominance of logistical barriers cited among abortion seekers (Baum et al. 2016; Jerman et al. 2017; Ostrach and Cheyney 2014), a lack of telemedical abortions presents serious constraints to access. In this light, the perception of the physical abortion clinic as the exclusive distributor of abortion serves to potentially delay or impede access for medical abortions.

Furthermore, abortion stigma often amplifies the magnitude of logistical barriers when one must rely on their social network for resources such as transportation or childcare. Women have spoken largely of the importance of discrete access to abortion, and of the difficulties in doing so when the hurdles of travel require resources from their social network (Aiken et al. 2020; Kerestes et al. 2021; Shellenberg and Tsui 2012). Thus, abortion access is hindered when the logistical resources necessary to acquire the procedure necessitate abortion disclosure. To this end, abortion access is constrained for those individuals for whom a potential discredited status is unacceptable (Goffman 1963). For women who must travel more than 100 miles to access an abortion clinic, such conundrums are compounded, creating a higher frequency of circumstances in which women must choose between involving unwanted people in their journey towards abortion access, or maintaining an unwanted pregnancy due to fear of a discredited status (Baum et al. 2016; Jerman et al. 2017). In fact, among 45 US interviewees who were able to acquire telemedical abortions, 13% stated that they would have continued their pregnancy if telehealth were not available to them (Kerestes et al. 2021). Thus, the mere need to travel to an abortion clinic incurs a variety of barriers to access, many of which are unnecessary due to the nature of the medical abortion. Yet, society's over-reliance on the physical clinic as the rightful bestower of abortion results in a continuation of unjustified barriers.

2.2.2 Marginalized among a Fragmented Network

Abortion clinics present difficulties to access due to their positionality among a fragmented referral network. Due to the politicized nature of abortion, the service is not conceptualized by the American healthcare system as an inherent part of a woman's sexual and reproductive healthcare. As such, abortion is not guaranteed as a service by most primary care or OBGYN clinics (Grossman et al. 2019). Thus, most abortions are offered at free-standing clinics

which are marginalized among the broader network of healthcare providers (Jones et al. 2019). Such marginalization both directly and indirectly interrupts access to abortion. Oftentimes, a woman seeking abortion finds herself navigating a network of clinical institutions that are unhelpful in pointing her to an appropriate abortion clinic (Kavanaugh et al. 2019). This is considerable given that in a study conducted in South Carolina, at least half of women presenting with an unwanted pregnancy visited a healthcare provider in the interim between discovering their pregnancy and accessing an abortion (Margo et al. 2016). Nevertheless, a myriad of factors results in the abortion clinic being obscured by the larger referral network, a phenomenon that constrains access to abortion.

First, healthcare providers are often unfamiliar with abortion providers. A recent survey of 674 providers showed that 53% did not know how or to whom to make abortion referrals (Anderson et al. 2022). Even for providers who may be familiar with local clinics, many may be morally opposed to offering a referral, bolstered in their moral conviction by a federal clause that allows providers to refuse abortion referrals (U.S. Department of Health and Human Services 2021). Furthermore, a dense network of anti-abortion institutions known as Crisis Pregnancy Centers (CPC) act to disrupt the referral network between women and abortion clinics. CPCs are clinics erected by antiabortion communities with the intention of influencing women's decision to abort a pregnancy. They do so by advertising free ultrasounds in various locations, and by claiming to support any decision that a woman chooses regarding her pregnancy. Yet, once women are within clinic walls, staff members rely on manipulative tactics to persuade women to continue with an unwanted pregnancy (National Abortion Federation, 2006). In South Carolina for instance, where CPCs outnumber abortion clinics 30:3, abortion seekers encounter CPCs that refused to offer abortion referrals (Margo et al. 2016). Thus, abortion clinics have been

marginalized in a way that obfuscates them from the eyes of those who seek them, resulting in barriers and delays to access. The positionality of the abortion clinic among the wider network of healthcare providers is as an inherent barrier to access that can be traced back to wider macrostructures of politics and community-wide stigma.

2.2.3 The Social Encounter with the Clinic

Aspects of the clinical encounter within and around the abortion center are also responsible for barriers to access. Abortion clinics are often surrounded by ardent antichoice protester activity, which can lead women to reschedule or cancel their appointments (Ostrach and Cheyney 2014). Additionally, in the eyes of patients, protester activity can be conflated with the culture and values of the abortion clinic, leading women to be unsettled by their clinical experience (Kimport et al. 2012). Mexican immigrants have also reported missing their abortion appointments due to the perceived fear that the clinic may be affiliated with immigration authorities, a sentiment gleaned from ardent protester activity (Deeb-Sossa and Billings 2014). Anti-choice activity has necessitated that abortion clinics abide by strict safety protocols, such as maintaining locked doors through which patients must be buzzed in after confirming their identity. Such structures influence patients' perceptions of the clinical encounter, amplifying stereotypes of abortion clinics as unsafe and lonely places, and thus propagating psychological barriers of fear associated with accessing abortion (Kimport et al. 2012; Smith and Cameron 2019). Fear plays a pronounced role in one's consideration of abortion with women declaring a variety of concerns about abortion including safety, impact on fertility, associated level of pain, and general uncertainty of what an abortion entails (Goss 2004; Keefe Oates et al. 2020; Smith and Cameron 2019).

Women have also declared hesitations concerning abortion due to the social environment within abortion clinics. Encounters with staff members are extremely influential, and women have articulated fears and experiences of feeling judged by abortion providers (Aiken et al. 2018; Kimport et al. 2012; Margo et al. 2016). Negative encounters with staff influence one's considerations of abortion for future unwanted pregnancies, leading women to seek abortion outside of the clinic (Aiken et al. 2018). Recently arrived refugees, migrants, and immigrants have also reported barriers to access due to a discordance between the real and perceived cultural orientations of the clinic, and one's native cultural attributes. Mexican immigrants, for instance, have reported great difficulty communicating with staff members who do not speak Spanish. Yet, even when the same patients are able to interact with Spanish speaking staff, they report feeling stigmatized for their inability to speak English (Betancourt et al. 2013). In addition to the language barrier, refugees may experience difficulties approaching an institution that they perceive as less welcoming to their cultural attributes. For instance, among Somali women, those with more advanced forms of female genital cutting were known to be less willing to seek sexual and reproductive healthcare (Banke-Thomas et al. 2019). Thus, the social encounter with the abortion clinic, which is sculpted by antichoice activity, staff interactions, and the lack of cultural concordance with migrant communities, results in both psychological and practical barriers to access.

2.2.4 The Constraints and Supports of the Clinic

The modern American abortion clinic operates within a culture of commodified healthcare compounded by varying and intersecting currents of abortion stigma, both of which impact the interaction between the abortion clinic and the abortion seeker. It is no secret that abortion is both a politically and morally divisive subject in the United States. As of 2021, 26%

of US adults believe that abortion should be illegal in most cases, and an additional 13% believe it should be illegal in all cases (Pew Research Center 2021). Such sentiments are highly associated with one's political and religious identity, with 63% of Republicans opposing the legalization of abortion and 80% of Democrats supporting it. In terms of religious identity, White Evangelicals are prominently represented among anti-abortion communities, with 75% of all White Evangelicals opposing abortion. With respect to other dominant religions in the US, including White Protestant Non-Evangelicals, Black Protestants, and Catholics, the majority of individuals within such communities support the legalization of abortion (Pew Research Center 2021).

Such community-wide sentiments both influence and originate from larger macro-structures, particularly American politics, which have influenced the ways in which the US healthcare system funds abortion care. The Hyde Amendment, which prohibits federal funding from contributing to abortion services, results in a system of non-profit abortion clinics, such as the well-known franchise Planned Parenthood (Id. § 509, 107 Stat. at 1113). These centers attempt to bridge the gap of abortion care for low-income patients, particularly in Southeastern states, where legislators choose not to compensate for the Hyde Amendment by funding abortion with state-generated dollars. Thus, many abortion clinics exist among the lower half of a two-tiered healthcare system that lacks a robust channel of funding. Furthermore, the highly politicized approach to abortion has placed clinics under extreme scrutiny, resulting in the success of policies that impose unnecessary regulations on abortion clinics. Such policies, often called TRAP laws, have diminished the prevalence of abortion centers in several states, while asserting the surveillance under which such institutions must carefully operate (Guttmacher Institute 2020). Thus, the abortion clinic is arguably the least autonomous of all medical

institutions, and many of the barriers that emerge from its clinical context may be a direct or indirect result of larger political and economic processes that continue to unjustifiably constrain the accessibility of the abortion clinic.

The exceeding surveillance of abortion clinics, combined with their financial precarity, highly impacts the abortion clinic's accessibility. Despite, or perhaps, in spite of these conundrums, abortion clinics are supported by a cultural tide of feminism and human rights that grants them access to a broader network of support from privately funded donors such as the National Abortion Federation. Some of the funding offered by members of this wider network has been funneled through abortion clinics to supplement and cover the costs of abortion for many low-income patients. Thus, many abortion clinics, by way of their position within a wider network of reproductive rights organizations, directly assist women in overcoming one of the most determinant barriers to abortion access (Baum et al. 2016; Jerman et al. 2017; Upadhyay et al. 2022). Beyond financial assistance, moral support for abortion rights extends beyond national borders to include a larger transnational civil society comprised of international NGOs, national governments, and intergovernmental organizations such as the United Nations, all of which attempt to counteract the spatialization of conservative state entities that continue to constrain abortion access at the policy level (Ferguson and Gupta 2002). Unfortunately, the efforts of the wider transnational community have yet to counteract the intractable politicization of abortion in the US, which continues to be reinforced by advances in conservative abortion legislation. Thus, while abortion clinics are financially buttressed by currents of funding within the reproductive rights community, they are nevertheless directly beholden to the country's political and economic processes, resulting in a clinical encounter that generates barriers to access while disempowering the clinic's ability to resolve them.

3 CONTEXT AND STUDY DESIGN

3.1 Abortion Rates and Abortion Clinics in the Region

Using 2019 abortion surveillance data from the Center for Disease Control alongside data from the Guttmacher Institute's most recent Abortion Provider Census, I provide here an idea of the landscape of abortion clinics throughout the region as well as the demand for their access. In 2017, over 860,000 abortions were obtained in the United States among 1,587 facilities. Among those abortions, 5% were provided at a hospital or private physician office while 95% were provided at one of 808 abortion-providing clinics, including specialized abortion clinics, where 60% of total abortions were obtained (Jones et al. 2019). Specialized abortion clinics are defined as a facility where at least half of all patients receive abortions. Though the majority of abortions in the US are obtained at specialized abortion clinics, such clinics comprise only 16% of all facilities that provide abortion care (Jones et al. 2019).

In 2017, more than 34% of all abortions occurred in the US South (Jones et al. 2019). Both the Southern and Midwestern regions of the US are home to the poorest distribution of abortion facilities, with 54% and 51% of women, respectively, living in counties without an abortion clinic. These numbers are considerably different from that of the Western and Northeastern US, where only 15% and 21% of women, respectively, reside in counties without abortion clinics. The poor distribution of abortion clinics is more intensified among particular Southern states, such as Mississippi, West Virginia, and Kentucky where 91%, 90%, and 82% of women reside in counties with no abortion clinic. In fact, each of those three states hosts only one abortion-providing clinic (Jones et al. 2019).

3.2 Study Site

The study took place at an abortion clinic in a large, metropolitan city in the US Southeast. The clinic, which I will anonymize with the pseudonym *Choice Clinic*, has served the community for decades and is one of the more highly trafficked abortion centers in the region. While the clinic offers a variety of gynecological services, abortion constitutes the majority of its services rendered, and in 2019, the clinic provided abortions for nearly 3,500 individuals. Choice Clinic offers medical abortions as well as surgical abortions until the legal gestational limit, thus drawing abortion-seekers from a variety of surrounding counties and states where abortion clinics remain sparse and where existing clinics offer only a limited variety of abortion services. Choice Center's commitment to high-quality, compassionate abortion services stems from its overarching dedication to the values of reproductive justice.

In order to better understand the core values of Choice Clinic, I elaborate here on the concept of reproductive justice. Reproductive justice is both a framework and a movement that centers reproductive rights within a general human rights framework (Price 2020; Ross and Solinger 2017). It is entirely separate from the more mainstream 'pro-choice' movement and distinguishes itself by extending beyond the narrow pursuit of the right to choose abortion. Instead, reproductive justice embraces intersectionality, privileging the voices and experiences of women of color across various social axes, and who have been traditionally marginalized from mainstream 'pro-choice' dialogue (Price 2020; Ross and Solinger 2017). By privileging the voices of women of color, the Reproductive Justice movement acknowledges that oftentimes, women of color may not have the same access to the variety of choices in their reproductive outcomes as many White women (Price 2020; Ross and Solinger 2017). Additionally, the movement anchors itself in a social justice framework, acknowledging the need for a

community-based approach to reproductive rights as well as the acknowledgement of oppression experienced by many women of color which impedes their access to liberty (Price 2020).

In response to the ‘choice’ to determine one’s reproductive trajectory, the movement recognizes that choice is only as available as the resources that one can or cannot access within their community (Ross and Solinger 2017). An intersectional lens necessitates the goal of facilitating access to a broad source of community resources that support reproductive health, including housing, education, a living wage, and high-quality health care (Ross and Solinger 2017). The ultimate global forces of white supremacy, colonialism, and capitalism require consistent and incisive critique within the movement, given that such concepts have drastically structured, constrained, and dictated nearly all facets of the lives of women of color (Ross and Solinger 2017). Such concepts have trickled down to various mid-level forces that shape access to reproductive health such as community-level resource availability, individual distrust of the medical establishment, and individual and household health and wellness. Since access is predicated on an elimination, or at least near minimization, of barriers, the present study is aligned with Choice Clinic’s core value of reproductive justice as it seeks to understand the various ways in which the clinic can expand abortion access among the community.

3.3 Methodology

3.3.1 Qualitative Methods

I conducted this study at Choice Clinic (hereinafter referred to as Choice) during my employment there from Fall of 2019 until Winter of 2022. The study privileged exploratory, ethnographic methods as they are best poised to define social problems and provide ongoing feedback to practitioners (Johnson and Hrushka 2014: 114; LeCompte and Schensul 2010). More specifically, the qualitative portion of the study consisted of participant observation (Musante

2014), informal interviews, and open-ended, semi-structured, in-depth interviews (Levy and Hollan 2014).

For the participant observation piece, I served in the capacity of a health educator who met with patients one-on-one the day of their procedure to ensure full informed consent, answer patient questions, inform patients about post-abortion care, and take relevant notes on their medical history. The role also included checking patients in for their appointment the day of their procedure; answering phone calls from potential patients to respond to questions, provide referrals, and establish appointments; screening patients for financial assistance; and translating between Spanish-speaking and/or French-speaking patients and various clinical staff. The role maximized my exposure to relevant data by allowing me a broad range of social movement among various groups and subgroups of patients and staff; by allowing me access to pertinent information that patients disclose to staff members as they navigate abortion access and the clinical encounter (i.e. a patient expresses a barrier to abortion access over the phone in order to inquire about resources necessary to overcome the barrier); and by allowing me to participate in the ways in which various aspects of clinical bureaucracy can both enhance and constrain abortion access (Johnson et al. 2006: 118). I worked in this role for approximately 12 to 20 hours per week during which I took systematic daily jottings and field notes concerning my observations and interactions (Bernard 2011). The jottings consisted of on-the-spot, cursory notes, mostly comprised of trigger words to jog my memory once I reviewed the notes later that day or week (Bernard 2011: 309).

I also conducted in-depth interviews with eight patients and five staff members (Levy and Hollan 2014), including one staff member from a local community clinic serving primarily refugees. These numbers were chosen in accordance with literature on the number of interviews

needed to reach theoretical saturation (Guest et al. 2006: 73). I utilized a combination of convenience and purposive sampling (Guest 2014: 223) to interview patients that reflected the demographics of abortion seekers in the US Southwest in terms of race, age, socioeconomic status, gestation at abortion, procedure type, and distance to clinic. I also used purposive sampling to conduct interviews with four Choice staff members that perform the roles of phone operator, health educator, and/or patient check-in. Out of all employees at the clinic, these staff members are best poised to hearing patient narratives, concerns, and questions regarding the pre-abortion process. Thus, they are best acquainted with the potential barriers that patients face when trying to access abortion care at Choice. Mid-way through the study, I noticed a consistent difficulty in abortion access for refugee, immigrant, and migrant populations (RIM). This observation, combined with a knowledge of the structural vulnerability of RIM communities (Chen and Hulsbrink 2019), led me to seek insight from a doctor of maternal and child health at a local clinic that serves primarily refugee women in the area. A detailed interview schedule for patients was prepared in both English and Spanish, and a similar interview schedule for staff members was prepared in English. The interview schedule for patients elicited the narrative of the patient from the time she discovered her pregnancy to the time she completed the abortion, as well as the patient's perception of her abortion experience at Choice. The interview schedule for staff members included questions regarding anecdotes of patients that experienced barriers to abortion, staff perceptions of general barriers to abortion, and ways that the clinic both enhances and constrains access.

3.3.2 Quantitative Methods

I also designed, distributed, and collected patient surveys on abortion barriers during the Fall and Winter of 2021. Preliminary participant observation and relevant literature informed the

contents of the survey instrument which included close-ended questions about the most difficult aspects of accessing the procedure as well as demographic data such as race, ethnicity, income, household size, age, gestation, and zip code. I used convenience sampling to recruit survey participants. The survey was made available during patients' ample wait time in the lobby. The final question of the survey inquired if the patient would be willing to be interviewed over the phone at a later time and date for a monetary incentive of \$20 which would be emailed to participants after the completion of the interview. Thus, the survey served as a recruitment tool for patient interviewees. Surveys were collected from 119 patients and the results were used to add strength to the study by way of triangulation with participant observation, patient interviews, and staff interviews. This study was approved by the supervising university's Institutional Review Board.

3.3.3 Analysis

Interviews were audio-recorded with the permission of the interviewees and transcribed in the weeks following the interview. Data from all interviews, field notes, and surveys were cleaned for personal identifiers before analysis began. Due to the sensitivity of the subject, all data were stored within the researcher's personal, password-protected computer and were regularly uploaded to an external password protected hard drive. All field notes and interview transcripts were analyzed in NVIVO using a mixture of repetition (Ryan and Bernard 2003: 89) and 'cutting and sorting' (Ryan and Bernard 2003: 94) to find the most salient barriers to abortion among the entire corpus of data. I used a code sheet of themes from the existing literature as well as codes derived from iterative grounded theory analysis (Wutich et al. 2014: 506). I built categories of codes including, but not limited to: internal and external barriers (i.e. moral conflict, language barrier), severity of the barrier (i.e. gestation at abortion), patient

characteristics (i.e. traveling from out of state, ethnicity, age), and explanations for overcoming barriers (i.e. ability to rely on one's social network). I also analyzed the differences between provider and patient perception of barriers. Once the most salient barriers were identified, I reanalyzed the data in NVIVO, using the technique of 'cutting and sorting' to identify the most salient ways that the clinic influences each barrier.

The survey data were cleaned and uploaded into Microsoft Excel to compare the independent variables of demography and patient characteristics against the dependent variables of expressed barriers. The data were organized to include binary categorical variables for each barrier (1 = experienced, 0 = did not experience) as well as a continuous variable of the total barriers experienced by each participant. Descriptive statistics were extracted to show the frequency of each barrier among the sample. I also used SPSS to measure any potential associations between variables such as gestation, ethnicity, age, and socioeconomic status against barriers experienced. Descriptive statistics as well as associations from SPSS were triangulated against the most salient themes found in NVIVO. Data from patient interviews, staff interviews, patient surveys, and field notes allowed for the triangulation of key themes across diverse data sources, as well as an analysis of the reasons for differences across the various sources, thus strengthening the validity and reliability of the findings (LeCompte and Schensul 2010: 31).

3.3.4 Participants

3.3.4.1 Survey Participants

A total of 119 patients completed the survey at the clinic. A description of the survey participant sample is available in Table 1. In terms of race and ethnicity, the majority of participants were women of color, with 51.3% of participants identifying as Black, 19.3% as White, 18.5% as Latina, 4% as Asian or Pacific Islander, and 1.7% as Multiracial. Additionally,

11 of the 119 surveys were completed by Spanish Speakers, as surveys were made available in both English and Spanish. In terms of age, most survey participants were in their 20s, with 28.6% within the 27 – 30-year age bracket, 25.2% within the 23 – 26-year age bracket, and 24.4% within the 18 – 22-year age bracket. Overall, the average age of participants was 27 years. To assess socioeconomic status, participants were asked about their monthly income and household size, including number of children. The largest proportion of participants lived at or below the federal poverty level (FPL) (21.8%). In addition, 18.5% lived between 100% to 200% of the FPL, 18.5% lived between 200% and 300% FPL, and 11.8% lived at over 300% FPL. Most of the participants were employed (63.9%), yet a significant percentage was not (21.8%).

In terms of religion and/or spiritual beliefs, the largest percentage of patients stated that they did not follow a religious or spiritual practice (45.4%). Additionally, 25.2% of participants identified as a follower of Christianity, 6.7% as a follower of Catholicism, 4.2% identified as Spiritual, one participant identified as Muslim (0.8%), and one identified as Hindu (0.8%). In terms of gestation at the time of their abortion, most patients were in their early first trimester within 5 – 8 weeks gestation (52.9%); 18.5% were in the late first trimester at 9 – 12 weeks gestation; 10.9% were in the beginning of their second trimester at 13 – 15 weeks; 6.7% were in the mid-second trimester at 16 – 18 weeks; and 4.2%, or 5 patients, were in their late second trimester, at 19 – 21 weeks.

Most survey participants received the surgical procedure (70.6%) as opposed to the medical abortion (20.2%). A large proportion of patients receiving the surgical option did so due to the inability to receive a medical abortion past 11 weeks of gestation. Out of all patients eligible for the medical procedure (67.2% of the total sample), 60% chose the surgical procedure rather than the medical abortion (28.7%). In terms of travel, most patients lived within 60 miles

of the clinic (64.7%), 14.3% lived between 60 – 120 miles from the clinic, 10.9% lived between 120 miles and 400 miles from the clinic, and 2 patients (1.7%) traveled over 400 miles to receive their abortion, including one patient traveling from Texas due to The Texas Heartbeat Act that was implemented in September of 2021, and which effectively eliminated abortion for Texas residents past six weeks of gestation (Texas S. Doc SB8). In terms of relationship status, most participants were single (56.3%). Additionally, 22.7% of participants were partnered, 10.1% were married, 2.5% were engaged, 2.5% were actively dating, and 1.7% were divorced. In regard to number of children, most participants had no children (41.2%), 21.8% had one child, 14.3% had two children, 11.8% had three children, one participant had four children (0.8%), two participants had five children (1.7%), and one participant had six children (0.8%).

Table 1 - Survey Participants - Attributes and Demographic Characteristics (n =119)

Characteristic	n	%
Ethnicity	112	
Black	61	51.3 %
White	23	19.3 %
Latinx	22	18.5 %
Asian/Pacific Islander	4	3.4 %
Multiracial	2	1.7 %
Survey Language	119	
English	108	90.8%
Spanish	11	9.2%
Age	118	
18 - 22	29	24.4 %
23 - 26	30	25.2 %
27 - 30	34	28.6 %
31 - 35	11	9.2 %
36 - 40	10	8.4 %
40+	4	3.4 %
Religion	101	
None	54	45.4 %

Christian	30	25.2 %
Catholic	8	6.7 %
Spiritual	5	4.2 %
Hindu	1	0.8 %
Islam	1	0.8 %
Unspecified	2	1.7 %
Gestation	111	
5 – 8 wks.	63	52.9 %
9 – 12 wks.	22	18.5 %
13 – 15 wks.	13	10.9 %
16 – 18 wks.	8	6.7 %
19 – 21 wks.	5	4.2 %
Type of Abortion	108	
Surgical	84	70.6 %
Medical	24	20.2 %
Distance Traveled	109	
0 – 60 m.	77	64.7%
60 – 120 m.	17	14.3 %
120 – 400 m.	13	10.9 %
400 m. +	2	1.7%
Socioeconomic Status	84	
At or below FPL	26	21.8 %
100 – 200% FPL	22	18.5 %
200 – 300% FPL	22	18.5 %
300 – 600% FPL	9	7.6 %
Over 600% FPL	5	4.2 %
Relationship Status	114	
Single	67	56.3 %
Partnered	27	22.7 %
Married	12	10.1 %
Engaged	3	2.5%
Dating	3	2.5 %
Divorced	2	1.7 %
Number of Children	110	
0	49	41.2 %
1	26	21.8 %
2	17	14.3%
3	14	11.8%
4	1	0.8%
5	2	1.7%

6	1	0.8%
Employment Status	102	
Employed	76	63.9%
Unemployed	26	21.8%
	<i>M</i>	<i>SD</i>
Age (years)	27.21	6.33
Gestation (weeks)	9.48	4.1
Distance Traveled (miles)	65.23	112.24

3.3.4.2 Patient Interviewees

A description of the eight patient interviewees is available in Table 2. Pseudonyms were created for all interviewees. In terms of race and ethnicity, seven participants were Black women, and one was a Latina woman. Patient interviewees ranged in age from 18 years to 31 years, and their gestation at the time of their abortion ranged from seven weeks to 21 weeks. The distance traveled by each patient ranged from 13 miles to 178 miles. Five of the eight women identified as either Christian or Catholic, three women received the medical abortion as opposed to the surgical procedure, and half of the women lived at or below the federal poverty level.

Table 2 - Patient Interview Participants

Pseudonym	Ethnicity	Age	Religion	Gestation (weeks)	Abortion Type	Socio-economic Status	Miles Traveled
Ariana	Black	24	None	14	Surgical	0-100% FPL	17m.
Taylor	Black	23	N/A	20	Surgical	0-100% FPL	69m.
Silvia	Latina	18	Catholic	9	Medical	0-100% FPL	24m.
Amber	Black	31	Christian	9	Medical	100–200% FPL	178m.
Jade	Black	18	Christian	7	Medical	200–300% FPL	22m.

Tanesha	Black	26	Did not specify	21	Surgical	0-100% FPL	24m.
Ashley	Black	24	Christian	9	Surgical	100–200% FPL	30m.
Kiara	Black	27	Christian	12	Surgical	400–500% FPL	13m.

3.4 Strengths and Limitations

This study reflects numerous strengths and limitations. With respect to strengths, the study is unique in that, to the best of my knowledge, it is the only recent ethnographic study of abortion barriers that centers the abortion clinic as the primary unit of analysis¹. To this end, the study queries the structures and systems of the clinic to support system-changing praxis for a highly obscured yet highly frequented institution (Singer 1995). Given the difficulties of performing research concerning such a profoundly stigmatized subject, this study was made possible due to my employment at the clinic. My position as a clinical staff member allowed me to privilege participant observation as core arm of data collection to reveal the unique or ‘hidden’ experiences taken for granted by clinicians and patients (LeCompte and Schensul 2010). Additionally, my employment allowed me to foster relationships of trust, respect, and camaraderie through which I gained an understanding of the importance of the human beings that define the clinical encounter. Though the term abortion clinic may often conjure images of efficient architecture, medical devices, and biomedical expertise, it is rather the social system of the clinic that defines the healthcare encounter, and it is the human beings serving as phone staff

¹ To the best of my knowledge, the only published ethnography of an abortion clinic is that of Donald W. Ball’s 1967 article titled *An Abortion Clinic Ethnography*. During an era in which abortion was illegal throughout the US, Ball’s study centered on an underground abortion clinic in Southern California that catered to an upper and middle-class clientele. Thus, his study was performed under a substantially different context than the study I present here.

or front office admission that shape and define the clinical experiences through which patients experience abortion care. In fact, my own experience as an abortion patient in 2014 prompted me to maintain a keen observation of the primary interactions between a patient and the clinic which remain absent from popular and scholarly discussions of abortion access, but that remain branded in my memory eight years after the fact.

An additional strength to this study is the ways in which it centers women of color across a variety of social axes. Women of color comprise the majority of abortion seekers in the United States (Guttmacher Institute 2019; Kaiser Family Fund 2019). Additionally, 16% of abortion seekers in the US were born outside of the United States. The majority of Choice patients, survey participants and patient interviewees were Black women, and as such their voices, perspectives, and clinical experiences serve as the foundation of data for this study. Furthermore, my capacity as a Spanish and French speaker enabled countless interactions with migrants, refugees, and immigrants, whose healthcare access is enormously determined by potential language barriers (Banke-Thomas et al. 2019; Betancourt et al. 2013). I also began my employment at Choice with years of experience working with refugee and immigrant communities, which primed me to stay alert for the inclusion of such populations, whose structural vulnerability can often lead to exclusion from critical resources (Chen and Hulsbrink 2019). Thus, this study is unique in its ability to center a variety of ethnic and racial minorities, populations that continues to experience substantial health disparities throughout the United States (Institute of Medicine 2003).

Despite these strengths, there are a variety of limitations that must be considered upon interpreting this study's results. First, though the unit of analysis is the abortion clinic, the case study represents one of many abortion clinics, all of which vary in their capacities, structures, protocols, and patient population. Thus, the abortion clinic is part of a heterogenous subset of

institutions, and Choice Clinic represents one of many expressions of that subset. Though many aspects of the study and its recommendations may be applicable to other clinics, they must be interpreted in context. Another limitation to this study relates to the inherent selection bias of participants. The vast majority of patient participants represent those who were ultimately successful in accessing abortion, while those who experienced the most extreme barriers were left unseen. Thus, a crucial population of abortion seekers is neglected from this study, warranting future research that includes the experiences of those who were unable to access the procedure due to clinical influences.

Yet another limitation to this study is related to my own positionality as a researcher, employee, patient, and abortion advocate. First, my anthropological lens has not escaped the influence of biomedicine's salience within Western culture. As such, I have long taken for granted the normalization of the clinical encounter, and I experienced great difficulty in finding a vantage point through which to view the clinic as a cultural institution amenable to reform. This view was perhaps intensified by my prolonged employment at the clinic, which further desensitized me to the particularities of the abortion encounter. In addition, though employment at the clinic was a significant strength to the study, it may also have affected patients' transparency within informal and in-depth interviews. My ability to build trust and rapport with patients was extremely limited as staff often spent a matter of minutes in one-on-one interactions with patients. Thus, patient transparency may have been influenced by my positionality as a staff member as well as the difficulties of speaking intimately of a stigmatized procedure with an unfamiliar person.

Furthermore, my personal stance on abortion may have limited some of my observations. As an advocate of reproductive justice with no ethical qualms concerning abortion, I may have

often failed to consider the magnitude and variety of abortion-related ideologies that impact one's experience with abortion. As the study demonstrates, cognitive barriers to abortion are substantial, yet remain obscured by clinical processes. Granular aspects of patients' internalized experiences of abortion may be better illuminated through future studies with a research team that incorporates researchers from a wide variety of moral and ethical stances on abortion. Though difficult to imagine, such variation may add much needed understanding to abortion access, as cognitive models of abortion among abortion seekers remain highly variable. Finally, patients' perspectives of my own ethnicity may have determined their level of transparency and involvement with the study. As a biracial woman of Vietnamese and White background, I represent a substantially small minority of abortion seekers in the US. Thus, my ethnic positionality with patients at Choice most likely impacted the degree of rapport that I was able to gain with patients.

A final constraint to this study is its inevitable impact by the COVID-19 pandemic. Though Choice Clinic did not halt its operations during the pandemic, the volume of patients nevertheless decreased by approximately 23% from 2019 to 2020. Thus, it is highly likely that some core populations of abortion-seekers were overlooked from this study. For example, I presume that individuals with immuno-compromised dispositions may have avoided public spaces such as the clinic. Additionally, I presume that some essential workers may have found themselves overburdened by employer demands, and thus less capable of requesting the time away from work necessary to obtain the procedure. Furthermore, the pandemic resulted in temporary staff shortages at the clinic, which exacerbated the conditions of an already understaffed clinic. As a final note, the pandemic may have been a primary factor in one's decision to obtain an abortion, resulting in a possible distortion in the existing pattern of abortion

seekers. Nevertheless, the pandemic is not an abnormal phenomenon, and its inevitable inclusion in the timeline of this study is representative of the various sudden, unpredictable, and devastating changes that so often define the human experience. In light of the myriad, strengths and weaknesses of this study, I transition now into my ethnography of the abortion clinic.

4 COGNITIVE BARRIERS

4.1 Legitimization of the Clinic

It's 7:20am, my coffee is half-consumed, and the sun is barely peeking over the horizon. As I approach the clinic, I contemplate whether or not to turn off my radio completely, or increase its volume to a full blast – a decision influenced by whether or not my nervous system is grounded enough to accept the screams of the protesters as a thing to be observed, or a thing to spike my cortisol. Unlike my coworker Sasha, who ritually and defiantly blasts the song, 'I don't give a Fuck about Nunnedet Shit,' while driving past the protesters, today I decide to subject my ears to their nasal toned declarations, half-hoping to hear something new and unusual. As I turn into the clinic, I see a baby sitting in a highchair that is positioned to face the cars entering the clinic parking lot. In front of the baby is Shane, a white middle-aged male wearing a red baseball cap and holding a megaphone. He leans towards my car, brandishing a stack of pamphlets while his buddy holds up a sign of a bloody fetus that says 'I can't breathe', a twisted nod to the recent George Floyd murder. "Ma'am, have mercy on these babies, ma'am. Stop participating in this demon child sacrifice!" I find myself unable to budge, stuck behind a patient car who rolls down their window and takes a pamphlet, likely simply trying to figure out where to park. "Stop participating in this Black genocide, ma'am!" I lean my head against the head rest, curse under my breath, and stare blankly into the brake lights of the car ahead of me. In the meantime, Shane, who knows my car all too well by now, pushes his boundaries by stepping into the parking lot to follow my car with the lens of the camera that he wears strapped to his chest. Finally, just before my nerves spring out of my body – perhaps finishing my coffee would have helped - the patient car is guided away by a security guard, and I drive past quickly, quickly enough to do damage if Shane were to find his foot too close to my front wheel. I find a space in the employee parking

lot in the back of the building, out of protester sight. Tomorrow I'll blast "Nunnedet Shit" instead.

Choice Clinic, like many free-standing abortion clinics, is habitually surrounded by protester, anti-choice activity. Though not surprising, especially in the US South which is home to the country's largest demographic of White Evangelicals and Republicans (Pew Research Center n.d.), their presence is enormously influential to the way that clinics legitimize themselves to abortion seekers. Considering the historic and continued stigma of abortion, clinics make concerted efforts to legitimize their presence through targeted imagery and rhetoric that attempts to counteract the stigma of abortion as dangerous and deviant (Ball 1967). Yet, the myriad antichoice strategies, including consistent protests at abortion clinics, leaves clinics with limited ability to transcend the overwhelming pollution of antichoice rhetoric, imagery, and propaganda. Abortion stigma and protester activity thus runs the risk of perpetuating the image of abortion clinics as cold, lonely, unwelcoming places, especially considering that many patients are unaware or confused about why protestors are permitted near abortion clinics (Kimport et al. 2012). Amber, a patient interviewee, made sure to assert several times during the interview that the clinic should do everything it can to address the protesters:

"I just think that that's [protester activity] bad... So not only do you get harassed driving in here, you got to park, get out your car, hear it all the way as you walk up the hill. That's just too much...Like I said, I'm a strong person. But that made me cry...I mean they are essentially harassing people, and I can see how a lot of people could change their mind hearing all that."

Jade, another interviewee, also shared her experience with me upon taking an Uber to the clinic and back to receive the medical abortion:

“It really could have been more traumatic if I did not have thick skin....They got me on the way out, not when I went in. When I left the clinic, I got in the car with the Uber driver, right? Then she said, ‘It’s a good thing that they’re there, that they’re outside, protesting for it.’ I’m like, ‘Oh, okay.’ Then, we get to the end where you turn out of the facility, and she stopped to talk to a protestor while I’m in the back seat...I’m melting. I’m thinking, ‘what is she saying to these folks. Hopefully she’s not going to give me a bad rating’. Yeah... Zero stars, would not recommend her. She grabbed some fliers and she tried to hand them to me, and I’m like, ‘No, ma’am. No thank you.’ I’m thinking, ‘It’s too late. What are you doing? Like, the process has already started.’ Then the guy, he leans into her window, the driver’s window, and he’s talking to me at this point. He’s saying something like ‘Ma’am, are you going to keep your baby?’” I said, ‘Sir, respectfully.’...all I gotta say is thank God for headphones. I just popped those in for the rest of the trip.”

During my first several months at Choice, I often felt similar to Amber. Surely there was *something* that the clinic could do about protesters. Yet, confronting protesters was often a fruitless pursuit. Freedom of speech gives protesters the legal right to be present at the outskirts of abortion clinics, and though protesters often pushed legal boundaries by stepping onto the clinic’s property, by the time law enforcement was informed, protesters simply returned to their original posts. Furthermore, the decision to bring police officers onto the premises simply exacerbated the stereotype of the clinic as a site of controversy. Thus, protester activity flourished and was often charged with rhetoric and imagery that consisted of shaming, blaming, and manipulating women and men into reconsidering their decision to abort. The most vocal and ardent protesters were often the same rotation of middle-aged white men. During the timespan in which patients found parking, talked with security guards, walked up a steep hill to enter the

back of the clinic, and waited in line to enter the clinic, protesters took advantage of open ears in an uncharted territory. Below is just a small sample of their regular dialogue:

“I bet the guy who killed George Floyd was prochoice...You talk about BLM, BLM, BLM. But they’re in there killing beautiful Black babies...You ask why the world is so messed up, why people are protesting at the capitol. It’s cause of the murder of innocent children!...I don’t see anyone here that looks poor. You’re here today because of your sin...a child has to die so you can have a sex life...Sir, be a true man today and save your baby. A true man loves and protects their baby...They don’t care about you, they only want the money...I know a woman who had an abortion and she still has nightmares and hears babies crying. Two weeks later she tells me she’s on drugs and is going to need rehab... You’ll have to live with that on your conscious...”

Protesters used a variety of rhetorical tactics to manipulate women and men into reconsidering their decision to abort. Often these tactics consisted of co-opting existing cultural and political paradigms to support an argument against abortion. For instance, after the birth of the Black Lives Matter movement, protesters attempted to graft the values of anti-racism into anti-choice rhetoric to frame abortion as an anti-Black genocide. By doing so, they framed the abortion clinic as a perpetrator of systemic racism that benefitted from the income of Black individuals. Thus, protester activity served to reinforce harmful perceptions of the abortion clinic to patients and their loved ones, influencing patients first impressions with their abortion encounter.

In addition to protester activity, the ability of abortion clinics to legitimize their credibility to abortion seekers is also affected by the extreme prevalence of Crisis Pregnancy Centers, particularly in the Southeast, where they can outnumber abortion clinics 30:3 (Margo et

al. 2016). Crisis Pregnancy Centers are anti-choice centers that pose as neutral clinics. They advertise free ultrasounds and claim to support any decision that a woman chooses regarding her pregnancy. Yet, once women are within the CPC, anti-choice employees rely on manipulative tactics to influence a woman to maintain the pregnancy (National Abortion Federation 2006). Out of eight patient interviewees, four interacted with a CPC before receiving their abortion. Silvia spoke of the bias and misinformation that she experienced at a CPC in the weeks preceding her abortion appointment:

“They kept on pushing towards adoption or parenting. And then when they did the ultrasound, they had actually told me I was around 10 weeks. So, they were like, at this point you probably won't be able to do medical abortion. I was kind of shocked at that because then that told me I have to consider the other option which I didn't want.”

Silvia was at nine weeks gestation when she received the abortion pill at Choice a week after her trip to the CPC. The CPC's inaccurate ultrasound measurement, whether intentional or not, risked leaving her with the impression of being ineligible for her desired abortion option. Kiara, another patient interviewee, spoke of the ways in which CPCs work to delay or impede abortion access:

“So initially, I was looking up free everything. And so I came across them [CPC] on their website. So, I went there and they were very nicely discrete with me and so I had to go there by myself. They didn't let anyone else in with you...They were Black as well...Once we went on to the ultrasound, it was too much for me, honestly, when they were like, look at the baby being really active. They made a bunch of comments like that when they knew the route that I wanted to go... it started making me upset because I'm like, can you please stop telling me these things about the baby, because it's going to hurt my feelings if I'm being honest because this [abortion]

is something I want to do...And they gave me a pamphlet, and said to do my own research to find a clinic. I'm just like, I researched you all to do the research for me. They were supposed to have a clinic connected to them that you go to right after for your decision...Also they stayed in contact with you...I didn't want to keep seeing text messages about like, 'Hey, how you doing? This is nurse so and so, can I talk to you?' I'm thinking, just let me respond or reach out on my own, because it [the abortion] was already a hard decision for me... ”

CPC's attract patients such as Kiara by advertising a free ultrasound as well as a referral to an abortion clinic. After ensuring she was alone, and after hearing Kiara explicitly state that she was seeking an abortion, the clinic continued to imbue meaning and bias into her pregnancy, a phenomenon that was emotionally disconcerting to Kiara. Kiara, like many other interview participants, expressed how her 'thick skin' and strong disposition left her much more resilient to the effects of antichoice actors, and worried that those with more malleable dispositions would likely be more influenced to reconsider their decision. Thus, CPCs directly delay abortions by intercepting women in their search for pregnancy termination, relying on persuasive rhetoric to influence a woman's opinion about her pregnancy, and withholding referrals for local abortion clinics. Furthermore, they succeed in propagating stereotypes of abortion clinics as judgmental institutions. CPCs are not often recognized as antichoice entities by patients. Rather, patients perceive them as part of the wider web of healthcare institutions. At times, they are even considered to be directly related to abortion clinics (Margo et al. 2016). For example, in my patient interview with Ashley, she talked with surprise about how her consultation with Planned Parenthood seemed to sway her away from abortion. After further investigation, including a quick Google search during the interview, she finally concluded that the clinic was not a Planned Parenthood, but rather a place called Options Now. Previous to our interaction, Ashley was

convinced that her biased encounter took place within a well-known abortion clinic, and one that places considerable effort into curating a pro-choice and non-judgmental stance. Thus, Crisis Pregnancy Centers succeed in disrupting the legitimization of abortion clinics by co-opting names that are associated with pro-choice ideologies, such as ‘Options Now.’ By doing so, they obfuscate the distinction between prochoice abortion clinics and antichoice pregnancy centers. Not only does this succeed in directly delaying abortions, but perhaps more importantly, it succeeds in reiterating the stigma of abortion clinics as judgmental and unsupportive institutions.

In consideration of the ways in which anti-choice activity affects community perceptions of the abortion clinic, let us consider how these perceptions trickle down to affect the clinical institution itself. In what ways does the strategized stigma of anti-abortion actors sculpt and determine the ways in which direct service providers and other staff of the clinical institution interact with abortion seekers? Additionally, what other macro-structures, besides abortion stigma, are responsible for sculpting the clinical encounter?

4.2 Fearing Abortion

It’s mid-morning at the clinic and I head towards the waiting room to call for a Señora Gomez to complete health education. I always find it refreshing to talk with a Spanish-speaker. It broke up the monotony. Health education, like many aspects, of the job, required tedious repetition of the same information: ‘What’s your pregnancy history? Would you like to speak about birth control options today? Be sure to avoid taking Aspirin after the procedure’. An identical collection of words, questions, and phrases, repeated to one patient after another as they worked their way through a larger chain of events leading to the procedure. As much as I loved speaking to patients one-on-one in health education, after about the sixth patient, the routine started to feel much too scripted. There was little opportunity to break rank and ease into a

tangential conversation with a patient regarding simple human matters like where they went to school or what their favorite hobby was. Human conversations took too much time, and there were simply too many patients in a day's schedule.

I open the door to the lobby and peer over the small crowd of patients. The scene is a marbled mix of activity. Some women are swaddled in blankets and hoodies, heads propped against the wall, eyes closed, and knees pulled up to their chest. Others sit upright and rest their gaze on one of two TVs at either corner of the room. Yet another group of women are chatting amongst themselves, their faces morphing from smiles, to shock, to disbelief as one of them relays a personal narrative.

“Señora Gomez,” I call.

A woman rises out of her seat and heads towards the door. She wears a grey, zip-up hoodie with bedazzled trimming, and light blue jeans. Her hair is pulled back into a bun, revealing high cheekbones below attentive eyes. She was one of many resting her gaze on the TV.

“Como está?” I ask as she pauses in front of me at the doorway.

“Bien.” – she responds, with a head nod and a half smile. Her energy is kind, albeit stiff.

I lead us to one of two main offices where I and my co-worker's health educate. It is miniscule, windowless, and accented with grape-purple walls. I sit at the desk, which faces one of the non-graped walls, and Ms. Gomez sits at one of two chairs next to the desk, our bodies somewhat adjacent to one-another. There is a plastic divider between her and me, recently installed as a Covid precaution, and reflecting a glare that hides Ms. Gomez's face, forcing me to lean awkwardly to the side. I smile with my eyes, or try to, and ask her again how she is doing. She answers with a quick, ‘Bien, bien.’ I always wonder where a simple ‘How are you?’ can lead

in these interactions. Some patients use it as an invitation to discharge a whirlpool of thoughts and emotions. But more often, others, like Sra. Gomez, treat the question as a simple formality. I open her file, a new one, and we proceed with the normal routine. I ask about her health history – allergies - none, pregnancy history – four children, history of medical procedures - none. I ask if she is interested in contraception, and she replies with a brief yet firm shake of the head. She sits erectly in the seat, hands folded into her lap, ready to provide short and direct answers. I take notes in the file, attempting not to forget any pertinent information for the medical team, while trying not to assume too much by Ms. Gomez’s silence. Maybe she is nervous, maybe she is tired. Maybe she is confused about why an Asian woman is speaking Spanish to her. Who really knows? I am reminded of a conversation I had earlier with my coworker, Alex, when we discovered, upon many minutes of chit chat, that health education must be a strange experience for patients. How aware are they of the purpose of this small interaction? How much does that uncertainty affect how comfortable they are revealing any questions, concerns, doubts, or even sentiments of relief? I am also reminded of a conversation with my coworker, Bianca, who has a distaste for the invasive nature of health education. In her words, “I mean especially considering the history of medicine for Black women, I’m not trying to be nosy. I’m just trying to keep it to a minimum.”

After gathering her medical history, I close the file and get ready to familiarize her with what to expect in the next couple of hours leading up to the procedure. I start by asking how much she knows about abortion. The question had become a way to assess the level of detail to inject into the explanation, as well as an assessment of which abortion myths I might need to dispel during our brief encounter.

“OK, Señora Gomez. *Que sabe Ud. sobre el procedimiento, sobre el aborto?*” [What do you know about the procedure, about abortion?]

She looks me in the eye, and contrary to her pattern of prompt responses, she hesitates. The energy in the room shifts and more light than usual reflects off her eyes. Before the tears break surface tension, I question whether I should give her privacy by looking away, as a silent stare can be so intimate. Before I have time to decide, she speaks in quivered tones:

“Tengo miedo. De verdad tengo miedo de que algo me pase. Y no quiero dejar a mis niños sin madre. ¿Que cree Ud? ¿Lo hago, o no lo hago? No sé.” [I’m scared. Honestly, I’m scared that something will happen to me. And I don’t want to leave my kids without a mom. What do you think? Do I do it, or do I not? I don’t know.]

Ms. Gomez, like many patients, expressed a considerable fear of abortion. Among 119 survey participants, 29% indicated that fear of the procedure was a barrier to getting to their appointment, making it the most highly cited barrier out of 13 close-ended options. Women with whom I interacted primarily expressed concerns regarding abortion’s perceived impact on fertility, the risk of death from anesthesia, and the perceived invasiveness of abortion. One patient laughed nervously when admitting that, when thinking about the procedure, all she could picture were “a bunch of knives.” Months into my employment at the clinic, I had discovered a pattern among patients that I interacted with during health education. The health education step consisted of a conversation with the patient the day of their procedure about their medical history and what to expect before, during, and after the procedure. Often, after I explained the process of a surgical abortion, patients exclaimed relief at what paled in comparison to the process that they imagined an abortion to be. Patient comments during health education included phrases such as:

“Wait, so you’re not gonna cut me?” “My sister said you might take an ovary out, so that’s not true, right?” “Wow. I’m only asleep ten minutes? I thought it was going to be hours.”

The frequency of these encounters conditioned me to learn more about the nuances of the procedure in order to disabuse patients of the wide array of misinformation and uncertainty that they harbored. The term ‘health education’ had therefore taken on an enhanced meaning. The clinical encounter was now an opportunity to formally educate patients on a topic that is rarely, if ever, spoken about, much less taught about, in any other context. Accurate and objective education on abortion naturally alleviates a women’s anxiety about the procedure. Though the procedure has been touted by anti-choice groups as both psychologically and physically harmful (Cannold 2002) abortion is a short and simple procedure that is over 14 times safer than childbirth, and that shows no association with psychological damage (National Academies of Sciences 2018; Raymond and Grimes 2012).

In addition to neutralizing a patient’s fear of the procedure, health education also serves as a potential mechanism for community education among the local population at large. Each patient that passes through the clinic is a community member with the potential for disseminating accurate, comprehensive education concerning the realities of a poorly branded service. Considering the ubiquity of abortion receipt, the collective and long-term effect of this encounter may assist in neutralizing community wide stigma. Yet, the encounter must be approached with critical reflexivity. Health education, or what some abortion clinics may title as ‘counseling,’ is an encounter between staff and patients that is not lacking in power dynamics (Vincent 2012). As such, counseling is an intervention in which the rhetoric and biases of staff members can easily infiltrate a patient’s perspective of her deservingness to have an abortion, as well as of the broader understandings of the process itself (Vincent 2012). With appropriate staff training, the

health education encounter can enhance the clinic's potential as a site of dispatch for accurate abortion education with the aim of stifling community fears and stigma concerning abortion, both of which influence abortion access. Though the health education encounter may work to indirectly stifle community fears and misconceptions of abortion, it does not directly resolve the barrier of fear that inhibits a woman from arriving to her appointment. For that, a more immediate approach would have to be implemented during encounters with women over the phone.

4.3 Mitigating and Enhancing Fears

The lessons I learned in health education came to influence my telephone conversations with women. When a woman called to ask questions or make an appointment, it was not typical to explain the details of what an abortion entailed. It was somewhat graphic, and beyond that, there was typically a litany of other bases to cover – cost, driver requirements, anesthesia requirements, how long to expect to be at the clinic, what to bring, what to leave in your car. The list was long, tedious, and often, I simply did not want to overwhelm women with more information than was necessary. Yet, the prevalence of fear and misinformation evidenced by my health education interactions was convincing enough to start interjecting appropriate expectations of abortion during phone encounters. Instead of a strict list of 'dos and don'ts,' I started weaving in the dos and don'ts to a larger conversation tailored to a woman's perception and expectation of the procedure. My co-worker, Lynn, spoke to me about the importance of the phone encounter, and of a human-centered approach to phone conversations with women:

“See, when I talk to the women over the phone, I go through everything I need to go through, but it's not so structured...I'm not just listing things off like on a bullet list, like I hear some people do. That's just too stiff. There's no humanity in it...I also let them know, 'the

anesthesia that they are going to give you, I've had it. It's very good. You'll be okay.' Because there are many women that say, 'I don't know if I want to go to sleep.' I say, 'Well, it's general anesthesia, but you will not be asleep for hours. You'll only be asleep for 10 or 15 minutes. I've had it.' And they always relax."

Phone conversations were pivotal to facilitating abortion access. The mental hurdles of the abortion process loom large and are likely influenced by anti-choice propaganda of the procedure, alongside the silence concerning the realities of abortion by the medical community. Phone conversations were an opportunity to disabuse myths of abortion, demystify the procedure, and legitimize abortion as a safe, simple, and common treatment. Furthermore, a human-centered approach by which staff members employ empathy, conversation, and personal narrative can serve as a mechanism for building rapport between individuals and representatives of the abortion clinic, thus helping to legitimize the clinic as a trustworthy provider. Not only does the phone encounter directly mitigate barriers of fear for women desiring to abort a current pregnancy, it is also a mechanism for direct community education. As my coworker, Alex, states, phone conversations are influential not only for future patients of the clinic, but also for disseminating information among the local community:

"I've realized now how many people call into our clinic just for information, not even for an appointment...So many people just don't have information. And so many have a hard time doing adequate or accurate research in ways that we don't think about because most everyone we know is good at it, right?"

Community members contact abortion clinics for reasons that extend beyond making an abortion appointment. Thus, abortion clinics, and specifically the staff members that answer phone calls, act as health educators to the broader community. Individuals often called to ask

questions about a variety of topics including general sex education, information on the abortion procedure, information on women's sexual health, and information regarding community resources such as OBGYN clinics. The phone interaction was particularly important for interacting with hard-to-reach community members such as members of the local im/migrant community. Choice is involved in community outreach to local Latinx community members. Yet, my coworker, Julieta, expressed to me the difficulty of community outreach with individuals, such as Latina mothers, who may often be sheltered from Choice's outreach and marketing efforts:

“The thing is, most of the women [immigrants] who need to hear about these resources are not at the places where we do outreach. Some of them are simply at home. So, I feel like there has to be some other way, whether it's through social media or some way where you could say, ‘Hey, let's be a part of this conversation. Let me know what resources are out there.’ But because it's healthcare and because it's also abortion, that's where it may be challenging, because as I've experienced over the phone, most of them don't even want to give you their name cause they feel uncomfortable.”

The phone encounter at an abortion clinic acts as an important mechanism to educate the community on abortion access and other matters of sexual healthcare. Given that abortion seekers are often uncomfortable disclosing their consideration of abortion to members of their social network (Kerestes et al. 2022), and given the strategized stigma of abortion by antichoice actors who disseminate inaccurate propaganda on abortion (Cannold 2002), the abortion clinic may often be the only objective source of abortion information for community members. This phenomenon amplifies the relevance of abortion clinic phone employees as abortion facilitators and advocates. Such individuals are not merely employees that establish appointments. Rather,

they are health educators that can dispatch accurate abortion information to the community via the phone encounter. As implied by Julieta's words, this is particularly true for individuals who are harder to reach through in-person community outreach activities. The phone encounter thus impacts abortion access by shaping larger community perceptions of abortion while also directly addressing a woman's concerns about the procedure that she is considering. The tone, rhetoric, and biases of staff members are thus imperative to wider efforts of community outreach which serve to indirectly increase abortion access. Yet, such conversations must be informed by proper training and reflexivity, for just as the phone encounter can counteract anxieties, it can also generate them.

Rachel sat adjacent to me during health education. She was young, perhaps in her early twenties, with long braided hair and a crimson t-shirt embroidered with the words *Alabama State*. While I introduced myself as the health educator, Rachel's gaze darted around the small office, avoiding my eyes before finally resting on her twirling thumbs. As I proceeded with my normal routine, I suddenly became aware of my bouncing left leg. My body was mirroring Rachel's, whose right heel silently jackhammered into the floor beneath it. After I finished explaining the procedure, I asked if she had any remaining questions. For the first time, Rachel lifted her gaze to meet mine:

“Do people ever...not wake up from the anesthesia?” she asked.

I answered an all too familiar question. “No, no. It's completely safe. I have never, ever witnessed that happening. You're in really good hands, and you'll actually only be asleep for about 15 minutes.”

Rachel's leg continued to bounce, as she spoke. “I've never been asleep for anything...and I'm terrified. I actually didn't even want to do this procedure. I wanted to do the

pill instead, but the lady over the phone said it would be horrible. But I don't know about this, I really might have a panic attack about this whole anesthesia thing.”

Like countless other patients I interacted with, Rachel was prohibitively hesitant about general anesthesia. She had originally wanted to complete an abortion using the medical route, but her phone encounter with a staff member had introduced fear of the medical abortion. I witnessed this a handful of times at the clinic. Patients would admit during health education that they opted against the medical abortion after a disconcerting phone conversation with a staff member. The findings were predictable; it was common among myself and my staff members to grimace at the thought of the medical abortion. The pill worked by inducing cramps sufficient enough to expel the pregnancy, a phenomenon that often brought significant amounts of pain to patients. Yet, not all patients suffered through a medical abortion. And furthermore, not all patients considered pain as a priority for accessing an abortion. In fact, some patients specifically chose the medical abortion due to their fears of the surgical process. Amber, a patient interviewee, provides an example of this point:

“I've had miscarriages before. So that's just the way that I looked at the abortion to help me cope. It's like I was just having another miscarriage basically... Because I don't know if I have the stomach to actually go through with the surgical. If I had to have it, like if I was past the weeks allowed for the pill, then my boyfriend and I probably would've had to have another conversation as to if we were going to keep this baby or not. Because I don't think I can do it...I realized some of the risks of the surgical where they [the CPC] was like, 'Oh, you could have a hole in your uterus or something.' And I was like, 'Nah, I don't want to do that.' I like to do the least invasive stuff anyway.”

Due to her previous experience with miscarriage, and due to the influence of CPC propaganda concerning surgical abortion, Amber saw the medical abortion as her only feasible option. In fact, if she had been ineligible for the medical abortion, Amber admits that she may have reconsidered her decision to abort. Thus, the medical abortion fulfills a critical function in the minds of abortion seekers who are fearful of surgical processes. In this light, the influence of staff members' bias against the medical abortion can act to delegitimize what some women see as their only viable option for abortion. By stigmatizing the medical procedure, I and my coworkers intended to curate a more comfortable abortion experience for the patient. Yet, by doing so, did we actually risk constraining access to abortion?

As my coworker, Lynn, once told me, the phone staff is the 'heartbeat of the clinic.' Though they may often be among the least compensated in terms of hourly wage, phone staff are the ultimate gatekeepers of abortion by ensuring that patients are scheduled and prepared for their appointments. This act of preparation extends beyond a conversation about the logistical necessities of gaining an abortion. Rather, it can also include an element of counseling by which the staff member can legitimize abortion receipt in the eyes of a woman who is likely harboring fears of the procedure. Legitimization is an important act for abortion clinics who are continuously counteracting a deluge of misinformation about the procedure, including ideas of abortion as dangerous and anti-feminist (Ball 1967; Cannold 2002). As perhaps the only ambassadors of abortion in a woman's life, phone staff play an indispensable role in mitigating the psychological hurdles that can constrain access to abortion. As such, the interaction between phone staff and women seeking abortion must be informed by a continuous level of critical reflexivity by which staff members can minimize their biases concerning abortion, while prioritizing an individual's specific questions, concerns, and barriers to access.

In addition to exchanges held over the phone and during health education, other aspects of the clinical encounter can also intensify and mitigate the psychological barriers of fear and stigma. Despite biomedicine's tendency to prioritize the biological and physiological phenomena of a patient's illness experience (Lock and Nguyen 2018), patients themselves prioritize the social experience found in the clinical encounter. Survey participants were asked to give their first impressions of the clinic, and among 106 respondents, the most highly cited responses spoke of the staff members with whom patients interacted. Words such as *friendly*, *welcoming*, and *caring* were used to describe various staff members ranging from security guards to front office admissions, to health providers such as lab technicians. Kiara, a patient that I interviewed, spoke to me more specifically about her impressions of the clinical staff from the vantage point of a Black woman in the US Southeast:

"And if I'm being completely honest, having a Black staff and then other people of minority, that was helpful for me just because I know a lot of talk out there is about the Black maternity death rate and everything. So, with people passing away, it's just like...it's scary. But having like a team of mixed people and people that look like me...I felt very much supported especially because I didn't bring anybody with me that I knew."

The human beings that fill the roles of abortion providers play an indispensable function in mitigating the fears and hesitations that women bring with them to the abortion encounter. This is particularly true for Black women and other women of color for two primary reasons. First, women of color constitute the majority of those who acquire abortions, with Black and Hispanic women comprising 38% and 21% of the nation's abortion recipients, respectively speaking. These numbers are even more pronounced in the Southeast, with Black women in Alabama, Georgia, and Mississippi constituting 62%, 65%, and 74% of abortion recipients (KFF

2019). Secondly, women of color continue to suffer a form of structural racism from the biomedical institution in the form of maternal deaths, which are three times greater among Black women than White women (CDC 2021). The abortion clinic thus resides among interlocking currents of community stigma, including the stigma of abortion itself, as well as the racialized stigma of obstetrical biomedicine. Kiara's comment illuminates the impact of having not only a diverse staff, but a staff body that is comprised of majority Black women. Thus, it is not the mere presence of Black women and other women of color that was significant to Kiara's perception of the clinic. Rather, it was the phenomenon of having 'a Black staff,' or a staff comprised primarily of Black women. This visual dynamic helps to legitimize the abortion clinic as one that transcends historic patterns of White privilege engraved onto Black bodies, thus facilitating abortion access to those who most often seek it.

4.4 Moral Negotiation

It was Carolina's second visit to the clinic. Weeks before, I first talked to her over the phone on a day when I had decided to call back the 'no call no shows' of the week. She was one of the many women who had missed their appointment one Saturday. Over the phone, she told me that she was unable to make it to the appointment because of the cost and because she did not know anybody who could be her driver, as no one knew about her desire to have an abortion. After connecting her to a source of volunteer drivers, and after screening her for financial assistance, she made her first appearance at our clinic. On the day of her appointment, I had not seen her, as she was one of many faces in the crowd, but I recalled seeing her name on the list of appointments. Hours later, I found out that she had cancelled the appointment, walking out once she saw the ultrasound. She was at twelve weeks gestation, and the image appeared to have influenced her, perhaps a final determinant of a morally difficult decision.

Since that day, Carolina had apparently changed her mind, and now, seven weeks later, she was sitting across from me in the exam room. She had her dark hair pulled back into a bun, and she wore a pink t-shirt, tights, and white worn sneakers. The t-shirt was loose, yet tight enough to show a swollen abdomen under which she rested her hands, palms to belly and fingers laced. She looked at me with a nervous smile and reddened eyes. The sterile white walls played foil to the emotions radiating from her chest.

“No sé qué hacer. Si lo hago, nunca me voy a perdonar. Pero estoy con problemas con mi pareja que le cae mal a mi hija. No se llevan bien, y además, él toma. Lo quiero dejar pero no podría con este bebé...Dios, dime que hacer.” [I don’t know what to do. If I do this, I’ll never forgive myself. But I have problems with my partner who my daughter doesn’t like. They don’t get along, and plus, he drinks. I want to leave him but I wouldn’t be able to with this baby. ...God, tell me what to do.]

Carolina was in a process of moral negotiation for which she had no evident solution. Although she was morally opposed to abortion, she also feared that the pregnancy would harm her nine-year-old daughter. Her current partner was an alcoholic whom her daughter feared, and who attempted to isolate Carolina from her daughter with jealous commentary when the two were together. According to Carolina, maintaining the pregnancy would have necessitated staying with her partner for financial support. Though Carolina was morally opposed to abortion, she was also morally opposed to creating a difficult life for her daughter. Carolina spoke to me about her situation, expressing appreciation for a lending ear. Due to abortion stigma, she did not dare talk with her family about her temptation to abort. After providing the details of her predicament, she asked for my opinion. *“¿Qué opina Ud.? ¿Qué debería hacer?”* [What do you think? What should I do?]. I told her that I could not make that decision for her, and nor should I.

Yet, I recognized the tone of her plea. Carolina was living with a social illness for which her social network could provide no relief. The magnitude of such social predicaments often leads people to seek advice, counsel, and consolation from family and close friends. Yet, in Carolina's case, the stigma of abortion hindered her ability to seek the counsel of loved ones. I walked Carolina out of the building that day. After hours of internal debate, she decided against having the abortion. Yet as we walked through the hallway, she maintained a look of concern, asking me if she was making the right choice. Her decision did not mitigate her uncertainty. For Carolina, the process of moral negotiation was impacted by her inability to receive counsel, whether from her social network, or from her clinic.

Among the eight patients that I interviewed, six women expressed similar processes of moral negotiation. Abortion was a concept dissonant to their moral compass, and it remained that way even after their personal experience with it. Yet, in the cases of these women, moral codes must often be negotiated when the maintenance of one moral code causes one to break a higher oath. Amber offers an example of this process:

"I personally don't believe in what I just did. But it was a circumstance that came up, so I went through with it. I thought about how it would affect not only me, but also the dad. So, I was trying to be fair about it instead of just being like, 'Well, I don't care what you have to go through or whatever. I'm just going to keep the baby.' I tried to take him into consideration, and I did that for him...he already has kids, so he probably would never get to see his kids again that he already has a bond with that and that he loves because his ex was acting jealous and threatening to restrict his time with his kids over the idea of him having another kid."

Amber's commitment to her partner overrode her decision to maintain the pregnancy given that the two events were mutually exclusive. Amber and other interviewees spoke about

the difficulty of coming to terms with their decision, a sentiment that I found surprising given how little I witnessed these stories within the clinic. Apart from Carolina's case, it was somewhat rare to see evidence of a patient's moral sentiments during the clinical process. In fact, the barrier of morality did not appear among any of the interviews that I conducted with my coworkers. What could explain the discrepancy between the centrality of a woman's moral negotiation of abortion and the lack of staff member perceptions concerning that process?

4.5 Moral Iatrogenesis

The biomedical industry has been founded on a process of biological reductionism by which an individual's state of health is defined by the internal, physiological manifestations of a disease (Lock and Nguyen 2018). As Arthur Kleinman articulates, this makes for a distinction between disease and illness, where disease can be perceived as the harmful physiological aberration in which the doctor takes interest, and where illness is perceived as the social experience incurred by the disease, and the primary focus of the patient (1989). Thus, biomedicine takes primary interest in the physiological expression of disease while disregarding its social manifestations. This phenomenon permeates all aspects of biomedicine and can thus be located in the structures and processes of the abortion clinic. In the context of abortion, the clinic is exclusively interested in the removal of embryonic or fetal tissue in order to terminate a developing pregnancy, and it accomplishes this task within a context that excludes the social and cognitive experiences that accompany pregnancy termination, including processes of moral negotiation. Thus, a patient's experience within the clinic is determined by a process whose definition of a successful abortion may differ from that of the patient.

Not only is the social experience of an abortion excluded from the clinical process, but if it does emerge within clinic walls, it can be pathologized as an event that hinders the success of

an abortion (Singer 1995). Rita, a woman at the clinic experiencing a fetal anomaly, provides an example of this:

“I came here because the other clinic was so horribly rude to me. I was emotional when they were trying to insert the laminarias [dilators], and I just needed some time to calm down. But they made me feel bad for being scared. They were yelling at me. So. I left...I don’t even want to do this, but I have to.”

Rita’s grief over the abortion of a wanted pregnancy was medicalized by a clinic as a barrier to efficient abortion receipt, thus pathologizing her emotional experience of abortion. This encounter was disturbing enough for her to seek abortion elsewhere. Medicalization of patient emotions is prevalent in biomedicine (Singer 1995), and may be particularly problematic in the context of abortion, an event that is often accompanied by a diverse range of sentiments, ideas of acceptability, and cognitive models. In particular, the ultrasound encounter within an abortion clinic is a locus of concern. Ultrasound technology has been co-opted by anti-choice movements to amplify notions of fetal personhood which have led to the successful implementation of legislation such as the Texas Heartbeat Act (Texas S. Doc SB8; Zechmeister 2001). Despite the politicized history of fetal personhood, such notions have been internalized by many individuals who find profound meaning through the ultrasound encounter. In contrast, the clinical atmosphere can condition staff members to prioritize the medical aims of the ultrasound over the cognitive experiences of the woman. An ultrasound technician at the clinic once mentioned this to me:

“At the end of the day, I know the doctor is looking at this sheet and wanting to see numbers, numbers, numbers. So that’s what I got in my head.”

This approach contrasted sharply with the patient ultrasound encounter. For instance, patient interviewee, Kiara, said the following:

“Everyone at the clinic was really supportive, although I did wish I could have heard the heartbeat again during the ultrasound. I asked for the picture of the ultrasound but it was so busy there that I never got it. I guess I got lucky cause I already had a picture from the Health for Her clinic [CPC], but that’s the only thing I’d give for feedback. Cause some people do want that and that’s you know, they’re right to have that... And I will say that, and maybe it’s just me, but after the whole thing [the abortion], I didn’t want to be around children for a minute when it first happened. Like a tear would just drop even just being around my niece...I didn’t even want to watch certain shows with kids and babies in them...I’m actually at a good place now all around... having like the ultrasound picture has been good. Whenever I get sad, I talk to it as well, if I’m being completely honest.”

Women such as Kiara approached the ultrasound encounter with meaningful expectation. Kiara admitted in our interview that she continues to talk with what she perceives to be her unborn child via the ultrasound photo that she received from Health for Her, a Crisis Pregnancy Center. The act of receiving the abortion did not extract the meaning from what she believes to be her first child, yet clinical processes did marginalize the cognitive experience of her abortion. The internal experience of a pregnancy termination can thus be medicalized in ways that are unique to the abortion clinic atmosphere. Part of this phenomenon is found in the aforementioned history of biomedicine which tends to medicalize patients’ social illness experience, while other aspects of this phenomenon might be found in the constraints of the abortion clinic itself, a marginalized institution serving an underserved population of women. This context has led to a high demand of abortion that is spread over a low supply of providers, guiding abortion clinics to

establish a procedural flow in which as many patients can be seen in a day as possible. Contrary to a typical OBGYN visit, in which patients may be seen individually among a patient caseload of perhaps 11 to 20 patients spread throughout the day's schedule, some abortion clinics such as Choice often see large groups of women, perhaps 30 to 50, who arrive within a small window of time and who are somewhat simultaneously processed through what I conceptualized as a production line system. Thus, given the constraints of abortion clinics, their structures may yield a process with even less margin of error than most medical encounters, a circumstance that can create more opportunity for the pathologizing of highly variable sentiment and meaning that women may experience when terminating a pregnancy. Though not all women experience profound meaning in the abortion encounter, and though the magnitude and texture of the meaning-making experience is highly diverse, meaning-making is nevertheless highly prevalent within the abortion encounter, and the intensified processes of the abortion clinic are particularly primed to invisibilize and/or pathologize those experiences.

Thus, the abortion clinic acts as a site that can obscure a unique form of cognitive sequelae, or what I define as moral iatrogenesis. Iatrogenesis can be defined as any adverse condition resulting from treatment from the healthcare institution (Varley and Varma 2021). The term has also been elaborated to include social and cultural iatrogenesis, which speaks to the ways in which healthcare professionals medicalize aspects of the lived experience in ways that can dissolve traditional manners of dealing with and making sense of death, suffering, and sickness (Illich 1974). Here, I define moral iatrogenesis as the cognitive discordance that can occur when one's process of moral negotiation remains incomplete even after the physical completion of a morally imbued medical procedure. This concept must be well-contextualized so as not to place unfair blame on the abortion clinic and perpetuate anti-choice propaganda of the

clinic as a harmful institution (Cannold 2002). Thus, it must be understood that the moral iatrogenesis that can yield from the abortion encounter is a phenomenon that is amplified, and often times generated, by larger macro-processes such as community-wide, anti-choice strategies. Contemporary religious and political institutions have intensified ethical incitements of fetal personhood to delegitimize abortion at all stages (Zechmeister 2001), thus providing the material by which communities construct their moral codes. Furthermore, as stated previously, anti-abortion propaganda has marginalized the abortion clinic, leaving it with minimal support to adequately serve a large population of abortion seekers, and thus leaving clinics with processes that obscure cognitive processes such as moral negotiation. Thus, the moral iatrogenesis that can result from the highly medicalized processes of abortion clinics is a phenomenon that is in large part fabricated by the strategized stigma of antichoice actors. The abortion clinic is thus a site in which moral iatrogenesis occurs due to the intersection of the established processes of biomedicine alongside the strategized stigma of abortion by anti-choice communities. Given the resource constraints of the abortion clinic, and given the established biomedical processes inherited by the clinic, it is rarely capable of acknowledging and outsourcing emotional support for the moral negotiation that is unique to its patient population.

4.6 Moral Consolation via Communal Exchange

Despite the clinical paradigms which can invisibilize and/or pathologize a patient's cognitive processes, there are nevertheless some unique aspects of the abortion clinic that can assist women in their moral negotiation of an abortion. Ariana, an interviewee who had great difficulty coming to terms with her decision to abort, found consolation among the other women that she met in the waiting room:

“When I was waiting for my procedure, there were a whole bunch of other young women in the same waiting room. And we were just all talking about our experiences and how we felt about abortion, how many abortions we had and our kids and everything and how their partners felt about it. So that's what I think made it more easier to go through...Because other women were going through it too and they didn't see it as murder.”

The waiting room of an abortion clinic can be grounds for a restorative process through which women find moral validation through interactions with other abortion seekers. At Choice, women often spent hours drifting in and out of the waiting room as they completed the many steps required to obtain an abortion. Here, I conceptualize the abortion clinic as a site for the gathering of a community that is otherwise rendered invisible by abortion stigma. Within the clinic, abortion seekers find a rare opportunity to both share and be exposed to stories of abortion that may be largely absent among their social networks. As Ariana articulates, this community encounter can facilitate the process of moral negotiation through a felt solidarity with women who hold more neutral views of abortion. The exchange of abortion stories is demonstrated to reduce ideas that abortion is morally wrong and socially unacceptable (Cockrill and Biggs 2018), and the abortion clinic is a unique site of potential for such an exchange. Therefore, although patients' cognitive experiences may be obscured by an overstressed clinical process, the abortion clinic is nevertheless capable of facilitating moral negotiation through its capacity as a site of intensified community engagement.

In addition to a platform for communal exchange, the abortion clinic is also a platform for contemplation where patients find ample space and time to reflect without the direct influence of significant others, family members, or close friends. Taylor, a patient that I interviewed, was unaware of her pregnancy until 18 weeks of gestation. Once she announced her

unplanned pregnancy to her parents, they immediately kicked her out of the house and discontinued their financial support. Furthermore, once she contacted her ex-boyfriend about the pregnancy, he adamantly denied involvement. Within a matter of days, Taylor's life circumstances were completely overturned, leaving her dejected, overwhelmed, and furious. During the two weeks leading up to her abortion, her mental processes were overwhelmed by the logistical and psychological magnitude of her circumstances, leaving her with limited opportunity to reflect on her perceived moral predicament. In response to my question of "Did you ever have any uncertainty about the abortion in the two weeks between finding out about your pregnancy and coming to the clinic?", Taylor responded:

"No, it wasn't until I started going through everything at the clinic, because like I said, before, it was more so rage that I felt. I was getting rejected by my-ex, and I didn't understand why. I couldn't make sense of any of it. So it was more so when I got to the clinic and finally got a free mind, I was like, 'I'm really doing this.' And then I had to decide whether I was doing this for me or for other people."

Taylor's experience demonstrates how the abortion clinic encounter can operate as a space of minimal distraction during which women may have an enhanced opportunity to negotiate the meaning behind receiving an abortion. This may be unique to the abortion clinic encounter considering the ways in which the stigma of unplanned pregnancy can negatively transform one's social circumstances to distract from processes of moral negotiation. Carolina, whom I mentioned much earlier, admitted to having a similar experience. At one point in our conversation she stated, in Spanish, that there was too much time for her to think in the waiting room, making her doubt her decision. If Carolina had been able to speak among a group of

Spanish speakers who shared their abortion stories, could she have found the affirmation needed to proceed with the abortion?

Among survey participants in their second trimester, ‘feeling that abortion might be wrong’ was the fourth most highly cited barrier out of 13 options, tied evenly with the barriers of cost and travel. The moral negotiation of abortion is a prevalent phenomenon among abortion seekers and should be distinguished from larger conversations of stigma. Though stigma and morality can inform one another, they are ultimately two separate phenomena. Stigma speaks to the community-level sentiments attached to abortion and the ways in which such negative sentiments can affect abortion access. Morality rather, speaks to one’s individual code of ethics and the ways in which that code influences one’s acceptance, access, and negotiation of abortion. Though the process of moral negotiation may often occur before a woman’s encounter with the abortion clinic, the process may not be complete once a woman arrives to the clinic. Within the waiting room, women may find mental space, encouragement, and moral support through the communal exchange of abortion stories. Thus, aspects of the abortion clinic encounter can support the process of moral negotiation. This can both facilitate abortion access for patients with residual psychological barriers, as well as leave patients with a transformative impression of abortion which they may transmit to the community at large.

5 LOGISTICAL BARRIERS

5.1 Financial Barriers

“What are the main challenges women face when trying to get an abortion?”

“Money. Oh, definitely money. It’s the financial challenges that are the toughest.”

Lynn, a Choice employee who has been working in the phone center for over four years, spoke from experience.

The struggle to pay for an abortion was a reoccurring theme among patients with whom I interacted. In fact, among survey participants, those in their second trimester were significantly more likely to be living at or below the federal poverty level than those in their first trimester ($p < 0.04$), suggesting an association between financial precarity and abortion delays. Yet, throughout my time at the clinic, financial concerns changed in magnitude depending on the type of patient expressing them. For instance, patients appearing for their appointment rarely mentioned the burden of cost, and were rather concerned with alternative aspects of the procedure such as any associated impact on fertility. This finding is not surprising, given that patients at the clinic represented a sample of individuals who had already surmounted the barriers of cost. In fact, among survey participants in their second trimester at the clinic, the burden of cost was only the sixth most cited barrier among eleven options, suggesting that a handful of other barriers may be perceived by patients as being more influential in delaying abortion.

In contrast to patients arriving for their appointment, women who were calling to establish appointments repeatedly expressed financial concerns. Throughout the US, the financial burden of abortion has been widely recognized by advocacy groups, encouraging them to establish formal streams of financial assistance. Funding sources are numerous and span from

national non-profits such as the National Abortion Federation (NAF), to regional organizations such as Access Reproductive Care (ARC), which supports women throughout the Southeast. Choice has established partnerships with at least four funding sources to increase abortion access to women who cannot otherwise afford the procedure. As a result, numerous patients at the clinic have at least some of their abortion costs covered by these funding streams. Yet, as the surveys suggest, and as numerous studies have confirmed, financial constraints continue to cause barriers to abortion access. Why is this? Participant observation and interviews with Choice patients revealed at least a partial answer to this question. Although financial assistance was readily available to women who were in need, assistance was often distributed inconsistently and in accordance with a woman's willingness or ability to self-advocate. My patient interviews with Ariana and Tanesha help demonstrate this phenomenon.

During the interview, Ariana spoke with a melodic cadence that indicated an aptitude for engaging conversations. As we spoke over the phone, I pictured a woman accentuating her story with calculated gestures and theatrical facial expressions. Her energy nourished our interview, during which she openly shared her experiences leading up to her abortion. Ariana had discovered her twin pregnancy at six weeks gestation. Several months prior, she had moved from New York to the Southeast to live with her partner who offered to financially support her as she established her roots in the new city. After joyously disclosing her pregnancy to him, Ariana's partner declared that he no longer wanted to be in a monogamous relationship with her. Unsettled by what he proposed as a one-sided polygamous romance, Ariana chose to end the relationship. Amidst a heart-wrenching break-up, Ariana contemplated an abortion. Though she was distraught at the thought of giving up her twins, she was also adamant that she did not want to bring children into a broken family. After becoming more comfortable with the idea of ending

the pregnancy, she asked her ex-partner to contribute to the cost, but he refused, disagreeing with her decision to terminate. With no local support, Ariana took refuge at a local women's shelter and spent weeks wondering if her ex-partner would change his mind and be the man that she needed him to be for a future family. As it became clearer that the relationship would never be reliable, and as Ariana came to terms with giving up her twins, she called Choice Clinic and explained her situation. The staff ensured that her costs were fully covered through the National Abortion Federation, and she obtained the abortion at 14 weeks gestation.

Tanesha, a single mother of three, spoke with me somewhat conservatively about her experience. Throughout the interview, her voice barely breached the threshold of audibility and her answers to my question were curt. I found myself probing much more frequently than I did with my other interviewees. As we interacted, I imagined a woman who was preoccupied with the many chores of motherhood and who perhaps had difficulty mentally suppressing the litany of responsibilities that awaited her after our phone call. Tanesha had discovered her unplanned pregnancy at six weeks gestation. Despite her moral opposition to abortion, she decided that she had little option but to terminate her pregnancy. The man involved refused to father a child and considered the issue to be 'not his problem.' After speaking with a staff member at our clinic by phone, Tanesha determined that she was unable to pay for the procedure, which was priced around 600 dollars. She had been unemployed for a few months, and though she could normally rely on the support of her aunt and mother, the shame of her unplanned pregnancy left her hesitant to ask them for financial support. Within a matter of weeks, Tanesha found employment as a direct care giver, and began working full-time while dealing with the pregnancy day by day, a priority competing with the many tasks of mothering three young children. Weeks later, her moral sentiments around abortion were amplified with the onset of fetal movement, or what

Tanesha would describe as a ‘child in her belly’. She continued to work, saving week by week for a procedure that felt more upsetting as time progressed. At 19 weeks gestation she was finally able to produce enough funds to cover the cost, yet now that she was further along in her pregnancy, she would have to have a Doppler sonogram to ensure that the placenta was not built into the scar tissue of her multiple c-sections. After obtaining the sonogram, she received the abortion a week later, at 20 weeks gestation. According to clinical protocols, the procedure also required that she find a driver to take her to the clinic and back, leading her to finally disclose her unwanted pregnancy to her mom, who despite her disappointment, agreed to drive her. At 20 weeks, the cost of the procedure had increased to nearly 1500 dollars. Though Tanesha had only 700 dollars to contribute, the rest of the costs were covered by sources of financial assistance that she accessed with the help of the clinic staff who wanted to ensure that Tanesha receive the procedure by the 22-week limit.

Many of the patients that I interviewed were similar to Ariana – gregarious, transparent, and eager to share their experiences. This pattern likely revealed the selection bias of convenience sampling by which volunteer interviewees may be more prone to a candid disposition. Among these more talkative interviewees, three out of four with low-income had successfully accessed financial funding, and more importantly, they had accessed it upon their first time contacting our clinic. Tanesha, the only soft-spoken interviewee, was also the only one who did not access financial assistance upon her first contact with us. Could it be that a certain type of patient is more prone to accessing financial assistance? Additional experiences and conversations at Choice provide support for this hypothesis.

5.1.1 Who is Accessing Funds?

After several months of working at Choice, I was trained to screen eligible women for financial assistance through the National Abortion Federation (NAF). The training had been long-awaited, and even once it was confirmed that I would be trained, it took several weeks for the training session to come to fruition. The clinic was busy, after all, and trainings often happened only when the clinic decided to shut down for half a day or so. Otherwise, there was much to do, many women to serve, and few hands to accomplish the tasks. The training was somewhat straight forward – we spoke of the most appropriate ways to screen eligible patients, how to fill out the appropriate forms, and how to ensure those forms arrived in the hands of NAF. I walked away from the training with one salient take-away – screen individuals who indicate difficulty paying for the procedure. Yet, a simple question remained unanswered: Does an individual’s financial precarity always result in their willingness or ability to indicate that? When establishing an appointment with a potential patient, staff members did not ask about financial status. Thus, any indication of financial need would be initiated on the part of the patient, or at times, by a staff member with the mental and emotional capacity to intuit financial need. In short, though there was a thorough screening process to determine eligibility for financial assistance, not all eligible individuals were guaranteed to be screened. This was due in part by the lack of a formal process to guide staff in actively detecting individuals that were in financial need. Rather, the onus was on the individual to express it.

This screening tactic rested on an assumption that women who were in financial need were able and willing to self-advocate, that staff members were intuitive enough to detect nuances in the conversation that indicated financial duress, and/or that those same staff members had the mental and emotional capacity to do so. For women such as Ariana, funding was easily

accessed due to her willingness to share the details of her abortion story, including her financial constraints. But for women such as Tanesha, who tended to share only what was asked of her, financial funding came only when circumstances were dire enough for staff members to feel compelled to intervene. In Tanesha's case, staff members finally intervened upon realizing that she would be ineligible for the procedure within a matter of two weeks. How might Tanesha's case have been different had she received financial assistance when she first contacted the clinic at six weeks gestation? And how might women in similar situations have been unable to surmount the additional barriers that emerged as the pregnancy developed?

At one point in the study, I decided to do something out of the ordinary. For months, I had noticed a pattern. Anywhere from one-third to one-fourth of the patients who were scheduled for abortions simply did not show up to their appointments. Often, we would not know why, as the women often did not contact us to cancel or reschedule, and as it was not clinical protocol to follow-up with them. These cases engrained large question marks into my mind, and in search for answers, I decided to volunteer a handful of days to call the many women comprising this particular population. The results were varied. The majority of my attempts ended in voicemails or even alerts that the number was no longer in service. I assumed many women were working. I assumed many had perhaps been unable to pay their phone bills. I also assumed that, in an era of incessant spammers, many likely screened their calls. Among those who did answer, some had gone to another clinic with more convenient hours, some had decided to maintain their pregnancy, and some were struggling to find the money to pay for the abortion. Of the latter group of women, nearly all of them had already been offered a clinical discount for Medicaid members, and almost all of them had been screened for funding from NAF, which contributed to a portion of the abortion cost. Nevertheless, they continued to struggle. One of the women, who

was at 17 weeks gestation, was eager to be rescheduled for the following Saturday, but once I rescreened her for financial assistance through NAF, her portion of the payment increased to \$550 since she would be 18 weeks gestation by the time of her appointment. In a disappointed voice, she expressed hesitancy at being able to produce the amount before the weekend. Yet she, like the rest of this sample of women, had yet to be connected to alternative forms of funding. Thus, I connected her to ARC, letting her know that if, despite their assistance, she was left with a payment that she still could not afford, she could call us to be screened for yet another form of assistance, WWRAP, which conferred financial support to one patient per day, per clinic.

As my coworker, Luisa, stated to me in an interview, 'Even when there are different resources for women to pay for a procedure, not everyone knows that.' Not only were many women unaware of financial assistance, but many were also unaware of the multiple streams of assistance at their disposal. The distribution of funding was not a streamlined process, and access to funding largely depended on the actions, inactions, biases, and constraints of clinical staff who acted as the bridge between patients and funding sources. Thus, the screening process for financial aid often appeared to favor a certain type of patient. Either those who were familiar with the existence of one or more financial funds, those who were open and trusting enough to continually share their developing stories, thus allowing staff members the opportunity to detect evolving instances of need, or those who simply knew how to advocate for themselves and ask the right questions. The ability or willingness to conform to these expectations is not universal, particularly among refugee, immigrant, and migrant populations. My coworker Julieta spoke to me about this point:

“They're [immigrants] unaware of funding that is available, or even the volunteer services that at times we get for patients. So, I feel like they're the ones that are mostly in need, but because they don't know how to ask, it makes it hard.”

Individuals are unable to ask for that which they do not know exists. In the context of financial assistance, refugees and im/migrants are more likely to be unaware of the social benefits provided by their host community. Furthermore, the perception of social supports may be heavily influenced by one’s migrant positionality, about which Julieta also spoke:

“I find out certain things and I reach out to them, and they're like, ‘Oh, I didn't know.’ And for some of them it’s because they don't know that we have these services here, or they feel that because they're not an American citizen or they're undocumented, that they don't qualify. Or one of the common things is, ‘So, I have to pay this back. I don't have this money.’”

Thus, in addition to one’s ability to self-advocate, access to financial assistance is affected by the high variability in awareness of financial assistance as well as the variability in one’s perceived eligibility for funding. These phenomena complicate what is perceived by funders to be a straightforward process of funding distribution.

5.1.2 Who is Distributing Funds?

Financial assistance is thus differentially accessible to women based on a screening process that favors a certain type of struggling patient - one that is transparent, one that is comfortable revealing their need, and one that is likely familiar with the general concept of assistance that exists for patients despite their immigration status. Yet, just as financial funding is differentially accessed in accordance with certain attributes of the patient, it is also differentially accessed in accordance with the attributes, capacities, and behaviors of the distributor. To distribute funding, staff members are tasked with passively detecting women with financial

barriers. This can result in high variability among the tactics of individual staff members, some of whom may only screen a patient once they express financial precarity, and some who may take extra efforts to probe patients into disclosing more information about their finances. Thus, financial assistance is also distributed differentially based on the characteristics of the staff member interacting with the patient over the phone, a phenomenon that leaves room for various sources of bias. Julieta, as she stated above, often made an effort to reach out to patients that may be experiencing financial difficulty. In this sense, Julieta transcended the typical patterns of the abortion clinic by initiating conversations with scheduled women before their appointment to ensure that a patient who was suspected to be with financial difficulties was screened for financial assistance. Under typical circumstances, staff members had little capacity to do the same, and only interacted with patients based on a standard pattern of communication – talk with a patient when they first call the clinic to establish an appointment, leave the patient a message the day before the appointment as a courtesy reminder, and interact with the patient the day of their appointment. By breaking with this pattern, Julieta demonstrates how some staff members feel more empowered to act as a helpful provider to assist women in surmounting barriers to access. My coworker, Alex, on the other hand, spoke to me about the difficulties of supporting patients as a disempowered staff member:

“There are ways that I feel empowered to be helpful. And then ways that I’m like, I can’t even offer to be extra helpful because there will be no avenues for me to do that.... Sometimes it also feels like I don’t know what it’s going to look like for a patient to have to apply for this funding. It feels like there’re gaps in information. I like complete information. I like a full picture.”

Despite Alex's desire to assist patients in surmounting the many barriers to abortion access, she often felt stunted in her ability to do so due to a lack of knowledge and training of the larger network of social services available to patients. Unlike Julieta, who had worked at the clinic for over five years, and who had gained an intimate awareness of the many relevant community resources, Alex was one of the newer employees, and had yet to be familiar with the full resource network. Thus, the differential capacities of staff members impact their ability to be helpful, equitable resource distributors.

Clinical staff members, particularly those who interacted with women over the phone, are figurative links to a broader network of social services, including financial assistance. It is the staff member on the phone who acts as the gatekeeper to a wealth of services of which patients were often unaware. Thus, the staff members in the phone center and the front admissions, both of which answered incoming calls, were not simply people who made appointments; they were also the primary actors for ensuring that women were connected to the various supports that existed to assist women in surmounting various barriers to abortion, including that of cost. In this light, non-medical staff members at the clinic fulfill a crucial aspect of reproductive justice. The reproductive justice movement recognizes that true reproductive choice is only as available as the resources that one can or cannot access within their community. To this end, an intersectional lens necessitates the goal of facilitating accesses to a broad source of community resources that support reproductive health, be it funding, housing, or education (Ross and Solinger 2017). Within this framework, staff members fulfill the aims of reproductive justice in their capacity to distribute community resources to patients and community members with whom they correspond by phone. Yet, my experiences at the clinic revealed that staff members often varied in their ability to equitably connect women to streams of financial assistance. The reasons for staff

members diverse behavior are better understood through an exploration of their day-to-day experiences and the ways in which they are empowered and disempowered to be helpful agents of reproductive justice.

5.1.3 The Staff

“What brought you here? What led you to working at the clinic?” I asked my colleagues.

“Reproductive justice has always been important to me. So, when I found out that the clinic was hiring, I was like “Honestly, I would love that. I would be really interested in any way that I can work there...This is a thing that I knew I cared about, but I also didn't know how to work in that field, and then all of a sudden there was an opportunity to work in it...I have a strong research background and I care about the way that information gets disseminated. Before this I was actually a teacher. I also have a sociology and psychology background - it matters to me why people do and don't and can and can't have access to certain things. I like the education part of the job, the social justice aspect, and how it all goes together with reproductive justice.

– Alex, Health educator and Phone staff.

“I've been in the reproductive justice movement and human rights movement for a while... in college I also got a minor in women and gender studies. Also, I used to work for a shelter. It was a safe house for women who experienced domestic violence. And yeah, that is how I got very appalled, and I decided I wanted to work helping women.”

– Luisa. Health Educator, Front Office Admissions, Translator, and Phone staff.

The staff members at Choice represent a community of individuals with a diverse set of life experiences. Though the medical staff, such as nurses and lab technicians, naturally yield from various healthcare institutions, the front office staff, or the staff members responsible for non-medical aspects of clinical operations, had a variety of experiences working with the public.

Some had worked for public schools, some for community organizations, some for non-profits, and some from major retailers, to name a few occupational sectors. The backgrounds of front office employees tended to have two similarities— serving the public, and believing in the values of reproductive justice. Reproductive justice is both a framework and a movement that centers reproductive rights within a more general human rights framework. It privileges intersectionality and seeks to amplify the voices and experiences of women of color who have been traditionally marginalized among mainstream ‘pro-choice dialogue’ (Price 2020: 345; Ross and Solinger 2017).

I too, was attracted to Choice because of my interest in human rights. Previous to my role at the clinic, I had worked at a variety of community organizations serving refugees, migrants, and individuals leaving incarceration. My time working within those organizations revealed the many disparities within our society that are often invisibilized by mainstream propaganda and dialogue. I first discovered Choice during an online search for part-time work. I was attracted to this agency not merely because it was an abortion clinic, but because the clinic was grounded in the values of human rights, a value made noticeable by their dedication to advocacy, community outreach, and capacity building.

I vividly remember my first day on the job. I entered the front office admissions at 8:00am, my stomach fluttering like a neurotic moth. Everything was new – the hue of the paint on the walls, the antiquated-looking font in the database system, the melody of the blended voices of my new coworkers. I had never worked at a clinic before, much less an abortion clinic, and my mind took on the stance of a young toddler absorbing every minute detail of the exotic world around me. As I shadowed my supervisor, I relished each patient story – a woman at 14 weeks gestation who traveled all the way from Alabama. Fascinating! A teenager at 20 weeks

gestation who originally thought she was but eight weeks pregnant. I wonder why! A young woman who carried a textbook to study while she waited. Good thinking! Each patient was a galaxy of stories and experiences that fueled my motivation for working there, and though I knew I would only ever see a miniscule segment of their personhood, I was nevertheless intrigued by the many walks of humanity that represent a population that is so neglected and scorned by such a substantial segment of the broader community.

About six months later, I experienced a mental and emotional shift as an employee. Until that point, I often felt a sense of contentment and curiosity upon walking into the clinic. My heart had been open to interacting with patients and understanding how best to meet their needs, make them comfortable, and provide quality health education regarding abortion and contraception. Yet, after six months I started to notice that my sense of curiosity and contentment had dissipated, only to be replaced with a sense of duty amidst a backdrop of anxiety and anhedonia. My relationship with the clinic had evolved as I became adjusted to the quotidian pattern of clinical operations. Each shift started before sunrise, with a fierce greeting from protesters who diligently reminded us of the hellfire that awaited us after death. Though I believe nothing that they proclaim, and though I often tried to laugh at their aspersions, their actions were nevertheless a daily reminder of the growing tide of anti-choice activity that is gaining such cultural and legislative traction in our society. In what other field is one surrounded nearly every day by those who vilify their work and sense of humanity? Looking back, I had no conscious coping mechanism for their provocations, but subconsciously, there was an element of emotional disengagement that accompanied my arrival to the clinic. It was a simple matter of mental protection. Yet, what risks could such persistent emotional disengagement incur?

After a breakfast of stinging retributions, the shift began abruptly, and over the following two hours, anywhere from 30 to 50 patients were to be checked-in among two to three staff members. Patient dispositions were diverse, with some individuals expressing fatigue, some morning sickness, some neutrality, some gratitude, some fear, and some despair. I quickly greeted each individual at my window before launching into an explanation of the thick file of paperwork to be completed. Check in was tiresome, and the feat often provoked in me the same trembling energy that I experienced as a waitress in a high-volume restaurant during an understaffed Saturday night. In those moments, simple patient inquiries became nuisances, threats, wrenches in the gears of this precariously tuned clinical process. For the first few months at the clinic, my emotional discernment was unimpaired. Thus, for instance, senses were heightened each time I had to explain the state's Advance Directive for Healthcare, or a living will that clinics must legally offer to patients in the event of an emergency resulting from the procedure. My stomach would turn at the idea of introducing even more anxiety to patients who were already fearful of a mysterious procedure, and I would take the extra time to explain the safety of the procedure as well as the legal reasoning behind the will. By month six or so, my stomach stopped reacting, and my explanations waned. The conversation was simply a part of the spiel, and an exchange that must take place quickly despite a patient's reactions. After all, each patient was only at the beginning of a long line of steps leading to their exit from the clinic: check-in, complete paperwork, receive lab work, complete the ultrasound, complete their payment, meet for health education, undergo preoperative care, receive the abortion, be monitored in aftercare. The day was only beginning.

Prior to working at the clinic, I had often felt that a strong sense of empathy was an asset in situations like this. When working within the realm of human rights, it was often useful to

maintain a high level of emotional intelligence in order to earn trust, gain an understanding of one's perspective, and then use that information to better serve the community. Yet, at the clinic, empathy was often an inconvenient quality. There was a lot to feel at the clinic. Patients were not always in a disheartened state of mind, but many were, and some had heart wrenching stories attached to their unplanned pregnancy. I say this not to frame abortion seekers as individuals in a state of crisis, but rather to accentuate the realities of offering abortion care within such prominent levels of community wide stigma. Abortion seekers are not women in crisis, but rather women addressing the cognitive dissonance incurred from the need to acquire a treatment that can render her the target of moral outrage, even by her own mind.

The sheer quantity and variety of these sentiments amidst a backdrop of clinical urgency made for a social atmosphere primed to pathologize empathy. And though leadership was often understanding of these dynamics, and encouraged us to prioritize the experience of patients over the rush of the clinical atmosphere, it was never quite that simple. Our responsibility to provide timely abortion was often at odds with creating the time and space to humanize our interactions with patients. Interactions thus often felt more like a transaction, an exchange to gather the data necessary to ensure abortion receipt to all of the day's patients. This reality is largely due to the lack of state support for abortion care alongside increasing restrictive abortion legislation. These macro processes have produced large disparities of abortion clinics throughout the United States, particularly throughout the South, where many states lack an abortion-providing clinic in 95% or more of counties (Guttmacher Institute 2017). Thus, existing abortion clinics are charged with caring for high quantities of patients with limited resources. The community-wide stigma of abortion therefore trickles into the abortion encounter to create a dynamic in which staff members must habituate to the daily occurrence of serving large quantities of patients with a

high variability of emotional dispositions. Within this context, empathy can act as a mental liability to the staff member who lives at the nexus of both patient and institutional expectations.

Healthcare access within the US is already criticized for minimizing the social experience of illness, as well as minimizing the human interaction between provider and patient (Lock and Nguyen 2018). In the context of abortion receipt, these phenomena are exacerbated, allowing little room for one-on-one engagement with patients who may be experiencing heightened fears, uncertainties, and mistrusts of a stigmatized procedure. Thus, leading with empathy at the abortion clinic often seemed to open the door for conversations and concerns for which there was little time and opportunity to address given the need to ensure abortion access to the day's patient cohort. The empathy of abortion providers is thus pathologized for similar, yet more intensified reasons that the social experience of illness is pathologized by the general biomedical institution.

My coworker Julieta speaks to one of the consequences of this phenomenon:

"It gets to the point where we become programmed like we're a robot. And sometimes it's almost like everything just becomes second nature. You've just got that habit. And that's why sometimes, I think we need to have those conversations about why we do what we do ...because you're so much into it that all of a sudden, you just become heartless. You become cold, there's nothing new to you no more. And I've also seen some staff members that are not all that compassionate or caring, and sometimes they can make the patient like not feeling all that cared about, especially after they just made a tough decision. So, I think sometimes it can be hard in healthcare, because you want to just be like, 'No, I'm just here to offer this procedure. The patient seems okay. So, be it - next.'"

Julieta speaks to the consequences of a clinical paradigm that programs staff members to act as a 'cog in the wheel' of a larger, more urgent clinical process. This process is comprised of

an established set of steps, such as ultrasound and health education, in which staff members are positioned to repeat the same interaction as efficiently as possible. The process often resembled that of a production line in which factory workers are placed at specific posts and tasked with a granular aspect of product preparation. This atmosphere adds a level of analysis to Emily Martin's exploration of the ways in which women's reproduction is framed by metaphors of production. Though Martin speaks of the ways in which market principles are used to conceptualize birth as an act of production (2001), my observations speak to the ways in which market processes are implemented during a woman's efforts to control reproduction. Thus, in nearly all aspects of reproduction, the female body is 'productified.' As laborers of the clinical process, staff members are thus habituated to quickly performing the same set of repetitive steps with 30 – 50 patients per shift, a phenomenon that both pathologizes empathy while also dehumanizing patients. As my coworker Alex so astutely proclaimed to me one day, "I wonder what we are teaching women with the way we approach them as a clinic. What do they subconsciously internalize about themselves from this interaction?"

The pathologizing of empathy resulted in frustrations from staff members who had originally approached the job due to a highly empathic and justice-oriented nature. While talking with coworkers during lunch one day, my coworker Penny declared the following, after which a number of us agreed:

"Sometimes it just feels as if the clinic is totally separate from the mission of the organization as a whole. It's like the two aren't aligned at all, and that's so frustrating."

Penny was referring to the disparity between the values of reproductive justice that have been declared by Choice, and the internal ecosystem of the clinic. Despite the honorable intentions of the organization, the production line structures of the clinic were nearly

impermeable to the aspects of reproductive justice which necessitate investing the time, training, empathy, and dialogue to empower health care workers to most equitably serve such a highly intersectional community. Ultimately, the assembly line structure reflected the realities of an under supported establishment serving an underserved community, and one that must often prioritize the quantity of service delivery over its quality. This results in the marginalization of the more social elements of employees' jobs, such as health education, unbiased counseling for morally conflicted patients, resource distribution, and cultural competence. It also marginalizes the emotional impact that abortion care can incur on the staff member who must regularly navigate unpredictable social encounters amidst the institution's demand for productivity. To this end, the social attributes of staff members' jobs were frequently invisibilized and neglected, and training was often non-existent due to the need for staff to dedicate time and energy to maintain the precarious assembly line structure.

Furthermore, this dynamic left staff members with little opportunity to discharge their creativity, passions, and desire to contribute more greatly to reproductive justice. As a result, the attributes that led many staff members to choose employment at the clinic were often the same assets that were pathologized by clinical processes. The abortion clinic is thus in a unique position in which the stigma and restrictive legislation of abortion, alongside the clinic's inherited biomedical paradigms and procedures, results in a clinical ecosystem that can lead to high levels of staff burn out, a lack of capacity building of staff as community educators and resource distributors, and ultimately, lower levels of abortion access. Thus, staff members' inability to be equitable distributors of financial assistance was indirectly determined by macro-processes such as policy, legislation, and community stigma, all of which structured the abortion clinics intensified processes and ecosystem.

5.2 Drivers

It's 7:45am and I had just sat down. Next to me, Annie and Sasha were already checking in patients. After glancing at the appointment list, which somehow seemed longer than it was at 5:00pm yesterday, I take a couple of deep breaths to prepare for a busy check-in. Halfway through the second breath I overhear Annie apologizing to a patient.

"I'm sorry ma'am but you must have a driver for this procedure. We were very clear about that over the phone with you. Without a driver we won't be able to see you today."

The patient, a young woman, perhaps in her mid-twenties, stares blankly back at Annie. She starts to shake her head as she pleads, "Please this is my only day off. I Ubered here and I can just Uber back."

Sasha responds without skipping a beat: "No ma'am. We must have someone reliable that will sign off for you. I'm sorry."

The woman jumps out of her chair and heads towards the doors. The torso of her white t-shirt grips her swollen stomach, which I guess to be no less than 19 weeks pregnant, three weeks away from the legal abortion limit. She marches, understandably embittered, out of the glass doors. Sometimes my coworker Annie would follow women out of the clinic, in hopes of finding a solution that would still allow them to obtain the abortion that day. But at a busy hour like this one, outliers were sacrificed for the maintenance of a clinical process that was just beginning to absorb over 40 patients.

This was a common occurrence. Patients frequently arrived at the clinic without a driver, a clinic requirement for those receiving general anesthesia. General anesthesia was required for a second trimester abortion, and strongly preferred by most in their first trimester. The driver requirement is based on a recommendation from the American Society of Anesthesiologists

(ASA), which states that post-operative patients that have received general anesthesia should refrain from driving and should furthermore be released to a responsible adult who can monitor any negative side effects from both the procedure and the anesthesia (2018). In accordance with this recommendation, the clinic maintained a strict escort requirement by which the patient had to bring a companion that arrived with them upon check-in. The companion would then sign a form agreeing to transport the patient home after the procedure, which would often not be complete until six to eight hours after check-in.

Women repeatedly voiced concerns about bringing a driver with them to the clinic. Reasons for their hesitation ranged. Some were unable to find a loved one or acquaintance that was available to sacrifice a day from their normal routine. More than once I answered the phone to a patient needing to reschedule because of a sudden change in their driver's work schedule. The privilege of a flexible work schedule may be correlated with one's socioeconomic status, and the socioeconomic status of one's social network. Jobs paying a lower hourly wage also tend to be jobs with less schedule flexibility (Lambert et al. 2012). Surveys at the clinic suggest how this reality affects low-income abortion seekers; patients at or below the federal poverty level had a significantly more difficult time finding a driver ($p < 0.02$). In other circumstances, women were unable to find a driver due to a non-local social network. I recall a patient that pleaded for flexibility with the driver rule since she and her family were new to the area and had yet to establish a local social network. I also recall a woman who bought her brother a plane ticket from Texas so that he could serve as her driver.

In other circumstances, women were hesitant to rely on their social network to fulfill the requirement due to the stigma around both abortion and unplanned pregnancy. Jade, a patient that I interviewed, spoke about her fear of disappointing her father with the disclosure of an

unplanned pregnancy. “He has just done so much to help me get into a good university and get me on a good path – I just felt like telling him about this pregnancy would upset him. Like all his hard work would be flushed down the toilet,” she shared. Jade, who would have had to rely on her family for the escort requirement, chose to Uber to the clinic. Thankfully, she was early enough in her pregnancy to obtain the medical abortion, which does not require that a patient bring a driver.

In addition to the stigma of unplanned pregnancy, the stigma of abortion is an influential factor when considering a driver. Surveys among 119 patients at the clinic showed that women who did not know someone who had an abortion were significantly more likely to experience difficulties finding a driver ($p < 0.01$). This supports other studies that articulate women’s hesitancy to disclose their abortion to those who they would need to rely on to surmount logistical barriers (Baum et al. 2016). In some of the most heart-breaking circumstances, women were unable to get an abortion after their driver suddenly changed their mind in a moment of perceived moral magnanimity. I recall a patient from out-of-state whose sister had agreed to drive her, but who, days before the appointment, retracted her offer claiming that her sister would not be forgiven by God if she obtained the abortion. The patient was forced to contemplate a medical abortion, something that she was hesitant about given her health history, and a consideration that led her to cancel the appointment, even after a four-hour drive to our clinic.

Among survey patients in their second trimester ($n=26$), difficulty finding a driver was the most highly cited barrier. The driver rule was an obvious barrier to abortion, leading me and my coworkers to wonder the extent to which the escort policy was necessary. The driver rule was obviously justified when inhibiting a patient from driving themselves home after a procedure, but

to what extent was it necessary to prohibit a patient from relying on Uber or other forms of transportation when leaving the clinic? The sheer number of patients rescheduling, being turned away, and simply being unable to find a driver did not seem to justify a hypothetical instance where a patient might be unable to Uber home safely. In fact, patients did not step out of the building until about an hour after the procedure, when most anesthetic effects had already worn off and after patients had already been monitored for potential procedural complications. Therefore, was such medical paternalism justified in this scenario? A recent study by Mark et al. analyzes the necessity of escort services after an abortion and concludes by disrupting the medical narrative that escort services provide better outcomes for surgical patients (2022). Mark and colleagues highlight that the ASA recommendation that patients be released to a responsible adult is not evidence-based and is furthermore challenged by recent studies that show no improved outcomes between patients that have been released to rideshare services versus patients that have been released to a friend or loved one (2022).

Thus, if escort services provide little known benefit to patients, but rather incur barriers to access, then is the requirement justified? A concrete answer may require critical reflection between direct service staff members and clinical executives, who often determine such clinical protocols. I and my coworkers who worked to check-in patients had myriad examples of patients being unable to fulfill the driver requirement, but we often wondered if the frequency and texture of these stories ever reached the ears of those in charge. In fact, we often wondered why regular discussions between staff members and clinical directors were not already established to inform clinical decisions. Front office clinical workers provide the ethnographic evidence by which clinical protocols can be determined. So why was such pertinent data not collected by those determining the protocols? Did the clinical and organizational director have a strong justification

for this driver requirement, one that could outweigh the continuous instances of denied or delayed abortion? Did the executives simply have a different perspective, one of trying to maintain operations at a clinic under increased anti-choice scrutiny, and thus one that could not afford a potential lawsuit from an unfortunate circumstance? My co-worker Alex spoke to me about this tension:

“There's a way in which it feels like we do things based on sort of the lowest common denominator. So, for the most difficult patients, we're like, 'No, we can't make that kind of exception. They're going to have to figure this out on their own.' But there is the horrible tension where we are a non-profit and we get to be different than a typical clinic, so we don't have to be like that. Yet, we are more scrutinized than anyone. So, we also don't get any of the leeway that other medical facilities do.”

Alex spoke about the tension within abortion clinics when trying to serve a broad range of patients on a case-by-case basis. Clinical processes often result in favoring those patients who can most easily conform to clinical protocols, such as the escort rule, while patients who express the most difficulty with conforming to clinical protocols are expected to rely on their own resource network to surmount barriers to access. Abortion clinics are in a unique position given that the stigma and under availability of abortion exacerbates and generates barriers to access. Yet, given the politicized nature of abortion, clinics may also feel unable to risk flexibility with some protocols due to a heightened sense of liability generated from their surveillance by anti-choice actors. Yet again, macro structures of stigma and policy trickled down to the abortion clinic encounter to intensify aspects of mainstream biomedicine. In this case, the litigious aspects of American biomedicine are intensified within the highly surveilled abortion clinic, leaving providers hesitant to incur medico-legal liabilities. While the litigious nature of biomedicine does

not justify unnecessary protocols, the abortion clinic is nevertheless in an extra-ordinary circumstance where potential legal repercussions are not merely detrimental to the business, but to the already underserved population of abortion seekers. As Alex observed,

“I guess I have hope that... and maybe it's misplaced because we are in the South. But I have hope that, what if we aren't always scrutinized so harshly? What if we are able to offer more things or be more flexible and not be afraid that the liability is going to crush us every time? What if we do it mindfully, and in a good way? I don't know. We don't have to always be afraid of how shitty abortion clinics have been treated. Yet also, I don't have a good awareness of that.”

Alex's stance resonates with many of my and my other coworkers' conflicting sentiments. If reproductive justice encourages us to ensure healthcare access for all, then to what extent should clinicians actively push against the very clinical restrictions that impede access to abortion seekers? Despite the intensified liability under which abortion clinics operate, can protocols and systems be mindfully adjusted so as to realign longstanding clinical paradigms to fit the values of the movement? What aspects of reproductive justice can be operationalized within the clinical environment so as to reimagine the clinic as an exemplar of the movement?

My coworkers were a deep source of inspiration in my own revisioning of the clinical ecosystem. Despite the fatigue, burn out, and emotional numbing that often accompanied the job, my coworkers were grounded in the values of justice and eager to see system reform. Yet, they were placed in a system in which their ideas had little traction. During small moments of rest, we often spoke about what was going well within the clinic, and what could change. Yet, those conversations remained among us, floating laterally among staff workers engaged in day to day interactions, but unable to rise vertically to influence executive decisions. Had we more

opportunity to critically debate the necessity of protocols with clinical directors, perhaps protocols could have been adjusted, or perhaps not. But at the very least, my coworkers were vessels of inspiration for systemic reform. The myriad day-to-day experiences of abortion care empowered them with the data needed to inform system-challenging praxis (Singer 1995). Thus, clinical staff members have the potential to be powerful agents for operationalizing the values of reproductive justice through clinical reform.

6 STRUCTURAL BARRIERS

6.1 Structural Neglect

It's around 9:00am, prime time for checking in patients. A woman sits in the seat across from my window as I explain the stack of paperwork that she will have to fill out. It's important to explain it. It's confusing, cumbersome, and patients often make mistakes, skipping an important signature here and there, or forgetting to fill out pertinent information on their health history. As I explain the paperwork, I find myself competing with the voices of my coworkers as they perform the same task with other patients. Our voices fill the 5ft by 10ft space, bouncing off the thick plastic windows to create a disjointed cacophony of medical jargon punctuated by an occasional ring of the phone or flush of the toilet. As I explain the paperwork, my eyes catch a glimpse of the locked glass doors separating the lobby from the vestibule of patients waiting to be buzzed in. Three couples are in the vestibule while another two or three are outside of the building waiting to offer the security guard their ID. Behind them are a collection of cars gliding to a stop. I take a moment to accept the ever-increasing deluge of patients while continuing to explain the paperwork. The spiel was subconsciously engrained by now, allowing me the somewhat impressive ability of drifting into ancillary streams of thought. As I hand the patient her file of paperwork, I cue into the cacophony, and notice that Sasha is having a somewhat unusual conversation with a patient.

“No, no, no. We can't do walk-ins. You'll have to call us for an appointment,” – she says as she raises her hand to her ear, gesturing a telephone. The wall between Sasha's window and mine blocks my view of the patient.

My interest is piqued. For one, patients without an appointment are not allowed into the building during abortion days, as a matter of safety protocol. How did this patient make it past

security? I am also alerted that this is probably a non-English speaker. Why else would Sasha feel the need to gesture a telephone? I signal to Sasha that I can talk to them, assuming that the patient is a Spanish speaker, and Sasha asks the patient what language she speaks. French. Though it was a somewhat common occurrence to see Spanish-speaking patients, it was rare to see French-speaking patients, despite the large, local francophone refugee community. Sasha directs the patient to my window, along with the man accompanying her. She is tall, Black, and elegantly dressed, an image that stands out considering the casual garb of sweatpants and t-shirts worn by most patients. She wears a headwrap that matches her dress, which is patterned in squares of bright yellow encased in royal blue.

“Bonjour madame. Comment est-ce que je peux vous aider ? Vous n’avez pas encore un rendez-vous ?” [Good morning, m’am. How can I help you? You don’t have an appointment yet?]

“Non. J’en ai besoin.” [No, I need one.] – she calmly responds.

I prepare myself to schedule an appointment for her, but I hesitate. Appointments take a while. There is just so much to explain – don’t eat after midnight, bring a driver, keep your belongings in the car the day of the visit to the clinic. Moreover, the exchange is entirely in French, a language I can manage, but one that does not yet glide off the tongue. I consider all of this with the backdrop of patients peering through the glass doors, patiently waiting to be seen. I shake out of my hesitation and ask for her ID to begin entering her information, aware that this is an important moment. The odds are slim that I will be around to answer the call when and if she called back to schedule. And the odds are none that another coworker would be able to communicate with her in French; we were already struggling to find Spanish-speaking employees, let alone French Speakers. I remain unsurprised that she walked in for an

appointment instead of calling. Mostly likely she did call, but in vain. Even among Spanish speakers, for whom we had some interpreters, I had often noticed a pattern of them approaching the clinic in person to inquire about appointments. As clinical protocol required, I often had to instruct them to call us instead, letting them know that we were in the middle of a busy shift and that we would be sure to get them on the schedule once they called. I often felt a pang of guilt as I spoke those words, knowing how often the Spanish line remained unanswered. Elena and I, the only two Spanish speakers at the time, tried our best, but our language skills were in high demand between check-in, health education, medical translation, and the phones. And often, the phones came last.

I take my time to explain the process to her, having to repeat myself a few times, and asking her to do so as well. The cacophony continued, distorting my ability to understand any language, much less a language besides English, forcing me to lean my ears to the audio screen of the thick plastic pane separating us. As I listen to her, I squint my eyes as if that will somehow sharpen my senses. Her questions are few and the interaction is straight forward. Perhaps she's done this before. As we finish our interaction and as I declare an energetic 'Au revoir', I peer over at the vestibule. A blanket of guilt settles over me as I notice the five couples competing for vestibule space, in addition to the three couples waiting outside. I grimace at the thought of Dr. Bryant scolding the front office staff for not having enough patients processed once she arrived. Despite the sharpness of her retributions, I understood the complaint. Patients already waited long enough, and the weekend prior, delays in the clinical flow kept medical staff working until 8:00pm. Yet, if I had not ensured that this patient was scheduled, who would have, and when?

My ability to interact with the French-speaking woman represents an anomaly. The woman's entrance into the clinic is indicative of a rare oversight. Due to heightened security

protocols, individuals were not allowed within the clinic unless they had formerly established an appointment over the phone. Yet, phone operators were often unable to communicate with non-English speaking patients. Thus, the clinic elided correspondence with non-English speakers through a lack of mechanisms through which the clinic could communicate with refugee, immigrant, and migrant (RIM) individuals, whether over the phone, or in person. At the clinic, I repeatedly observed members of the RIM community that were unable to merely communicate with staff members, an obvious necessity for accessing healthcare. Thus, healthcare access for members of the (RIM) community necessitates a discussion of structural violence, which may be defined as the institutional structures that create avoidable insults to basic human needs (Galtung 1990). Though physical violence is easy to recognize, structural violence remains hidden in the normalized processes and bureaucracies of everyday life and is thus often taken for granted (Kleinman 2000). For refugee, immigrant, and migrant communities attempting to access abortion care, structural violence might be best conceptualized as *structural neglect*. Here, I define structural neglect² as the passive exclusion, or neglect, of marginalized individuals due to institutional structures that preclude their access to critical services. Structural neglect is incurred by acts of structural commission, such as the establishment of heightened security protocols, as well as acts of structural omission, such as a lack of interpretation services. In this light, RIM communities are systematically excluded from healthcare access due to a discordance between the structural orientations of the clinic, and the structural and cultural orientations of the RIM individual or community. Under the concept of structural neglect, what are often seen as ‘cultural

² The term ‘structural neglect’ has been used by the scholar Marinus van IJzendoorn to illuminate the ill effects of institutional care on orphaned children (2014). In his analysis, van IJzendoorn uses the concept to describe the ways in which institutions fail to respond to the basic needs of the children under their direct care. Though he uses the term within a different context, his use of the concept seeks similar aims as mine, which is to transfer the cause of neglect away from the individual and onto the institution.

barriers' (i.e. language barriers, a preference for walk-in appointments) are thus reconceptualized as the neglected responsibilities of the healthcare institution to ensure access to all communities, despite their cultural variance. My observations of structural neglect were corroborated by multiple coworkers, including Luisa, who spoke to me about her observations at the clinic with RIM individuals:

"We need to make sure that person will be seen. I've heard so many times, "I was calling, and nobody answer or when they answer, they answer in English. So, I couldn't talk to anyone in Spanish."

Luisa, a native Spanish speaker, often noticed the difficulties that Spanish speakers faced when attempting to interact with the clinic. The language barrier between RIM and the clinic manifested into a clinical ignorance of the comprehensive needs of this community. Thus, the inability for clinics to communicate with non-English speaking individuals resulted in a pattern of structural neglect against RIM communities. As a result, this phenomenon created a selection bias that favored abortion access for RIM individuals who were either more assimilated to US culture or who had obtained the resources needed to navigate US healthcare. For instance, many of the non-native patients with whom I interacted spoke English. Many others spoke Spanish, and could therefore communicate with one of our Spanish speaking staff members, when available. Those who were non-English or non-Spanish Speakers often leveraged another form of support that granted them access to the clinic, such as the assistance of an English-speaking friend or family member or the assistance of a local community agency. As a result, though the clinic served RIM individuals, it often only served those subjected to a relatively lesser degree of structural vulnerability (Chen and Hulsbrink 2019). The inherent selection bias of this form of structural neglect created a false sense of complacency among some staff members who

remained unaware of the variation in needs among RIM communities. My co-worker, Lynn, spoke to me about her impressions of the barriers experienced by RIM individuals:

“I really don't think they [non-native abortion seekers] have a difficult time at all... I'm trying to think if I have ever taken a financial assistance application from them. They have their money. You know what I'm saying? They know what's involved with it.”

Lynn's interactions with a particular subset of RIM individuals led her to over-generalize the experiences of RIM members who seek abortion. Lynn spoke only English, so any interaction that she had with a non-native individual would have necessitated that they speak some degree of English. Thus, Lynn was exposed to a subpopulation of RIM individuals with relatively less structural vulnerability, or more agency, than many of their non-English speaking counterparts.

Refugees, immigrants, and migrants represent a heterogenous set of communities that vary along the axes of ethnicity, economic status, education, culture, language, and many other factors. Thus, the term ‘RIM community’, though useful for some analytical purposes, jeopardizes homogenizing such a socio-linguistically diverse population. Clinicians evoke similar miscalculations when they speak generally about ‘refugees’, ‘migrants’, ‘non-natives’, or ‘foreigners.’ Such categories speak to a highly generalized aspect of one's identity, under which their intersectional experience to health access is obfuscated. In reality, the heterogenous nature of RIM communities results in a stratified reproduction, in which culturally assimilated RIM members are more enabled and encouraged in their reproductive capacities than other non-native groups (Shellee Colen 1995). At Choice, most of the RIM patients had a moderate level of English and/or a family member that was willing to assist them in their pursuit of abortion. Such

women represent only a segment of the RIM population and should not be mistaken to represent the many non-native women who remain excluded due to structural neglect.

6.2 Structural Competence

It was time to health educate, and I pulled a patient chart from the drop box outside my door. A red note on the bottom left corner of the chart stated in all caps ‘BURMESE SPEAKER. USE TRANSLATION SERVICE’. I remembered the patient from check-in; she had arrived with a family member, perhaps a spouse, who had dropped her off before heading back to work. I stood staring down at the chart, both curious and hesitant about the forthcoming interaction. I grimaced once again at the thought of generating a ripple in the clinical ‘flow,’ which would extend the already lengthy schedule, upsetting both the medical staff and the patients already anxious to be seen. The new telephonic translation service was a long-awaited feature at the clinic. I and other coworkers had often chatted about the need for interpreters, yet now that we were greeted with a solution, we came to view it as an awkward hurdle. It didn’t quite fit in with the clinical ecosystem. First, translation took a significant amount of time. A health education meeting that might take 15 minutes with your average English-speaker would easily take 45 minutes using the translation service. Secondly, the abortion views of the translator were a roll of the dice. Just a couple of weeks prior, a translator halted the conversation at a mid-point, refusing to be involved with an abortion process. Third, the application was used only in limited face-to-face situations; there was no mechanism to facilitate its use over a phone call, so its use was limited to interacting with patients at the clinic, or those who had already overcome the first of many language barriers in their pursuit of abortion.

The structures of the clinic were incapable of adequately incorporating the translation service, thus incurring another element of structural neglect. The implementation of such

technologies leads to a conversation on *structural competence*, or the antidote to structural neglect. Here, I define structural competence³ as the ability for an institution's structures, processes, or protocols to successfully and efficiently facilitate healthcare access. The concept of structural competence thus interrogates the structures of the clinic itself, acknowledging that such characteristics of the clinic represent salient structural determinants of health. In the example above, the intensified clinical processes precluded the comprehensive and consistent implementation of translation services, thus demonstrating a lack of structural competence, or an ability for the clinical structures to facilitate healthcare access to non-English speakers. Thus, in the context of abortion, the intensified clinical processes preclude an adequate form of structural competence.

To elaborate on the concept of structural competency, it is useful to provide an example of a clinic that prioritizes healthcare access to refugee, immigrant, and migrant communities. To achieve this, I interviewed Monet, a physician at a local community clinic that serves primarily refugees. Monet articulates the ways in which her clinic exemplifies a form of structural competency by integrating structures that facilitate healthcare access for refugees, immigrants, and migrants:

"We see over 50% refugees...There are over 60 languages and a hundred people groups in this part of town. And so, our clinic saw 27 languages last year. I think a lot of that was related to the amount of staff we have that spoke particular languages. So, I would say we see, probably primarily six of those language groups, based on the six languages that we have in-

³ In Jonathan M. Metzl and Helena Hansen's 2014 article, they introduced the concept of structural competence to describe how clinicians, policy makers, and other authority figures ought to recognize the structural forces that shape health inequalities. Their definition differs from my own in that Metzl and Hansen describe a clinician's outward focus on various societal structures that determine healthcare access. In contrast, my definition describes a clinician's inward focus on the ways in which their own institution's structures facilitate healthcare access.

house, but we also provide telephonic interpretation and so we have seen up to 27 languages in the clinic... One of our biggest priorities is that we want to be within walking distance. We're also on a bus line. We do also give priority to patients that walk up, because we know that a lot of them don't have the concept of an appointment. And so really leaving space and room for same day walkup appointments is really important for us."

The clinic at which Monet works is an exemplar for minimizing barriers between the clinical institution and the highly heterogenous RIM community within the area. Among other features, the clinic demonstrates structural competency by ensuring that it is accessible to those without a vehicle, that it maintains a multicultural staff, that it incorporates translation services throughout each step of service, that it advertises its services in multiple languages, and that it holds space for walk-in appointments. Thus, its structures and protocols are inclusive to the languages, healthcare expectations, and structural vulnerabilities of the various RIM subcommunities. By prioritizing structural competency, the clinic assumes the responsibility of challenging the existing structural paradigms of healthcare that incur structural neglect, thus increasing healthcare access to a highly intersectional population.

Structural competency is thus a fundamental tool in the repertoire of strategies to increase healthcare access to racial and ethnic minorities. The concept should be perceived as the necessary foundation for cultural competency. Cultural competency is a concept popular in contemporary healthcare settings, yet the concept has been critiqued by anthropologists for its common misuse (Castañeda 2010). A primary critique lies in an overreliance on cultural competency trainings, which can further the notion of the biomedical institution as a static, cultureless entity, while also obscuring the historical and structural determinants of health experienced by ethnic minorities (Castañeda 2010). Cultural competency is widely recognized in

contemporary healthcare as a means of more adequately addressing the health of migrant individuals. While helpful, its current implementation is not sufficient in deconstructing the structural barriers that impede healthcare access. To this end, although cultural competence is a useful concept for building cultural sensitivity among healthcare practitioners, it is insufficient for addressing matters of healthcare access by ethnic minorities. Rather, structural competence, in tandem with cultural competence, must be employed as a necessary mechanism for deconstructing the structural neglect that determines healthcare access for ethnic and racial minorities.

In a 2003 report by the Institute of Medicine, several explanations were offered to account for the health disparities among racial and ethnic minorities. The report remarked that levels of prejudice and bias in the clinical encounter were likely responsible for such inequities. The report also gave a list of recommendations, including greater support for professional interpretation services (Smedley et al. 2003). Choice, like many clinics, have tried to incorporate interpretation services to amplify access for the myriad cultural groups that comprise the American populace. The adoption of such translation services ‘checks the box’, so to speak, of cultural competency that clinics wish to integrate. Yet, the mere adoption of these services is not sufficient when the established processes of the clinic pathologize their implementation. Instead, translation services must be included within a larger effort to challenge the systems and processes that generate structural neglect. In this light, structural competency serves as the counteragent to structural neglect, as well as the necessary foundation to cultural competency.

6.3 Disrupting Reproductive Governance

The clinic in which Monet works is a primary care clinic. Within this domain, providers act as liaisons between patients and specialized clinics that are more apt to serve particular

matters of health that may arise in the primary care encounter, including reproductive and sexual healthcare. Thus, when a pregnant patient appears at the clinic, they are served and then directed to the appropriate healthcare facility with respect to their desired pregnancy outcome. Yet, like many of the organizations serving the local RIM population, Monet's clinic is patronized by a faith-based, Christian organization. Thus, the controversial nature of abortion within Christian culture trickles down to impact referral protocols, thus constraining the potential for the clinic to provide comprehensive pregnancy options for patients:

“As for our protocol, we give them a new patient prenatal packet. We give them prenatal vitamins, and then we refer them out immediately after their confirmation of pregnancy. And so they're to set up an appointment with an OBGYN, regardless if they're wanting to keep the pregnancy or not.”

When a pregnant patient appears at Monet's clinic, providers follow an established referral protocol that fails to incorporate the needs of patients who may wish to terminate their pregnancy. Abortion clinics are absent from the referral process, and instead the clinic directs patients to an OBGYN, which is taken for granted as the most appropriate referral for the woman. This process is problematic given that OBGYN's are not the primary provider for abortions. Thus, to optimize abortion access, a patient with an unwanted pregnancy would be best served through an immediate referral to an abortion clinic offered by their primary care provider. Yet, given the Christian-based values of Monet's clinic, abortion is omitted as a valid pregnancy outcome. Thus, the same patients who may be attracted to Monet's clinic due to its structural competency, are also less likely to be directed to an abortion clinic when presented with an unwanted pregnancy.

According to Monet, there are three community clinics in the area whose patient population consists of majority refugees and im/migrants. In addition to other aspects of structural competency, the three clinics are highly frequented by RIM members due to a combination of free or discounted services, Medicaid acceptance, and language support. Two of the three clinics are faith-based organizations (FBOs), including Monet's clinic, reflecting a high prevalence of FBOs that serve the RIM community in the area. The prominence of faith-based institutions is a common phenomenon among refugee communities. In fact, the history of refugee resettlement in the United States centers the activity of FBOs, who, since the early twentieth century have been highly involved in supporting refugee protection within the United States (Frazier 2021). The support of faith-based organizations is not to be denigrated, as they have acted as a core pillar for supporting the social welfare of some of the most vulnerable communities around the globe. Yet, given the pronounced stigma of abortion among Christian communities, and given these communities' prominence among refugee populations, their activity likely contributes to continuing health disparities among RIM individuals seeking comprehensive reproductive and sexual healthcare.

The prevalence of Christian organizations among RIM communities is indicative of US state neglect of healthcare and social support for migrant communities. As such, many RIM individuals in the United States experience the negative consequences of commodified healthcare, combined with insufficient state-funded social support for refugees, migrants, and immigrants, a phenomenon that compounds their structural vulnerability (Chen and Hulsbrink 2019). Thus, to compensate for the lack of state support, a lateral system of non-profits, NGOs, and faith-based organizations (FBOs) have emerged to bridge critical disparities among these communities, such as healthcare and housing. The consequences of this two-tiered system of

social support are many (Chen and Hulsbrink 2019) and include a spatialization of faith-based organizations among refugee communities. To this end, some RIM communities may find themselves dependent on networks with a high proportion of FBOs who provide critical services. Thus, in lieu of the state acting to spatialize governance over RIM communities, faith-based organizations and NGOs assume the role, allowing the organizations to exert both vertical and encompassing mechanisms of governance in the form of direct resettlement, free clinics, food banks, mental health services, and after school programs (Ferguson and Gupta 2002). Thus, the spatialization of FBOs among RIM communities positions some of the most structurally vulnerable communities as disproportionately dependent on a community in which abortion is ubiquitously slandered, unacknowledged, or obscured.

To this end, RIM communities are particularly vulnerable to the consequences of the abortion stigma that is so pervasive in contemporary Christian culture (Hanschmidt et al. 2016) and which excludes abortion as a legitimate pregnancy outcome. RIM individuals who are best served by structurally competent FBOs, are otherwise disproportionately shielded from abortion access. To further illustrate, the area of town in which many migrants reside, and in which Monet's clinic operates, lacks an abortion clinic. Thus, RIM individuals in the area considering pregnancy termination must access an abortion clinic through either Google, which necessitates English language competence, or a referral from a community clinic or organization, many of which are affiliated with some denomination of the Christian faith. The more assimilated members of RIM communities may find more success accessing abortion due to an ability to navigate Google, communicate with abortion providers, or rely on a more culturally assimilated social network. Meanwhile, RIM individuals with more increased levels of structural vulnerability are more often shielded from abortion access due to an increased dependency on

social support from faith-based organizations. Monet further demonstrated aspects of this as she continued to describe the referral process at her clinic:

“We work closely with an organization called Aspire [pseudonym], which is one of the prenatal birth support groups for refugees. And we tend to refer patients to places that they have had good experiences with. The majority of them are located nearby and provide interpretation and have women doctors. And so yeah, we rely a lot on Aspire because their volunteers are able to drive our patients there. So let's say, like yesterday I had an Arabic speaking mom. We referred her to an OBGYN, but she has consistent transportation. So, I probably wouldn't refer her to Aspire because she has support. But if it's a mom that has no support, needs transportation, speaks little English, they need an advocate with them at their doctor's appointment. Then I would refer them to Aspire as well.”

For pregnancy referrals, Monet and her colleagues rely on their partnership with Aspire, a local prenatal support group that is also faith-based. Though Aspire is not a clinic, they serve as a trusted point of referral for pregnant patients at Monet's clinic. Furthermore, Aspire acts as a direct social support for RIM patients with some of the lowest degrees of agency, such as those who lack transportation, partner support, or English. Thus, just as faith-based clinics tend to serve the more structurally vulnerable individuals among the general RIM community, faith-based clinics may also intensify this pattern by directing the most vulnerable of their patients to faith-based affiliates that can provide continued social support. Thus, a migrant's level of structural vulnerability may directly correlate with dependency on and/or influence from a Christian faith-based network. To this end, RIM individuals with the lowest degrees of structural agency are among those with the least access to abortion due to their entrenchment within a network in which abortion is traditionally elided.

The spatialization of FBOs over RIM communities results in a form of reproductive governance over increasingly vulnerable members of the RIM community. Reproductive governance is defined as “the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and population practices” (Morgan and Roberts 2012). The spatialization of FBOs among RIM communities allows a concentration of anti-choice ideologies to construct RIM access to comprehensive sexual and reproductive healthcare, particularly with respect to abortion care. It must be understood that not all FBOs are in opposition to abortion, and furthermore, not all individuals within such organizations may adhere to anti-choice ideologies of their faith community. Nevertheless, it remains to be seen if such hypothetical FBOs will break rank and make a concerted effort to transcend the abortion stigma that is so pervasive among Christian based communities. With respect to the abortion clinic, herein lies an opportunity. The abortion clinic represents one of many healthcare institutions with prominent forms of structural neglect in relation to RIM communities. By adopting adequate forms of structural competence, the abortion clinic can help to disrupt the reproductive governance that FBOs exert over RIM communities.

7 DISCUSSION

7.1 The Abortion Clinic as Reference Point of Ethnographic Analysis

This ethnography illuminates the ways in which the abortion clinic both enhances and constrains healthcare access. Often taken for granted, the biomedical institution as found in the abortion clinic has been the point of focus in order to make visible the processes, structures, and protocols that so often remain unexamined when querying matters of abortion access. By regarding the abortion clinic as my unit of analysis, this thesis centers the clinic as a structural determinant of health, and one that warrants careful consideration given its function as the ultimate gatekeeper of a highly politicized procedure. Using the lens of critical medical anthropology, I have positioned the clinic in its wider sociopolitical context in order to demonstrate how the clinic's capacity as an equitable distributor of abortion is largely shaped by pervasive anti-choice strategies as well as subsequent legislation that limits the clinic's agency and generates intensified clinical processes that incur barriers to access. Thus, the abortion clinic is a site in which macro sociopolitical structures, combined with the legacies of biomedicine, manifest to intensify, generate, and mitigate the myriad logistical, cognitive, and structural barriers to abortion.

With respect to cognitive barriers, the abortion clinic is capable of both enhancing and constraining the primary barriers of fear and moral negotiation. Fears regarding the procedure are prevalent and are primarily generated by the strategized stigma of anti-choice actors who directly interrupt individuals' perception of the clinic via protest rhetoric and Crisis Pregnancy Centers. Thus, the clinic is primarily tasked with the continual legitimization of both abortion and the abortion clinic. Staff members at the clinic serve as powerful legitimizers. They do so by mitigating fears through the mechanisms of one-on-one health education as well as phone

encounters with community members. As some of the only objective sources of information on abortion, staff members have the power to use patient and phone interactions as opportunities to neutralize fears of the procedure, dispel abortion myths, and equip individuals with accurate information of abortion. Thus, the abortion clinic acts as a site of community outreach to patients and callers through which accurate abortion information is dispatched. Additionally, adequate racial and ethnic representation among abortion providers is imperative for mitigating fears of abortion, especially considering the disproportionate rates of maternal mortality experienced by Black women.

In addition to the barrier of fear, patient interviewees and survey participants revealed the prominence of moral barriers to abortion which are redressed through a process of moral negotiation. Due to the constraints of the abortion clinic, clinical processes are established which invisibilize and at times pathologize a patient's moral negotiation of abortion, leaving potential for moral iatrogenesis, what I define as the cognitive discordance that can occur when one's process of moral negotiation remains incomplete even after the physical completion of a morally imbued medical procedure. Despite this quandary, the abortion clinic is nevertheless a site for moral consolation through the exchange of abortion stories among patients who spend a considerable amount of time coexisting in the waiting room. In this light, the abortion clinic is a singular site of community for abortion seekers who can be influenced by peers who hold more neutral perspectives of abortion. This phenomenon is considerable due to the invisibility of the abortion seeking community among the broader community, as well as the potential for the abortion encounter to be a platform for contemplation.

Regarding logistical barriers to abortion, cost is a salient and well-acknowledged obstacle. While abortion clinics function as active distributors of financial assistance, staff

members are often disempowered to act as equitable distributors of aid; the result is a bias that favors individuals who are able and willing to self-advocate as well as individuals who access aid through a more highly equipped staff member. This is a particular opportunity for growth under the paradigms of reproductive justice which acknowledges that an intersectional approach must involve facilitating access to a broad source of community resources. Thus, staff members are vital actors within the movement in their ability to equitably distribute the resources needed to acquire abortion, yet the clinical ecosystem of an abortion facility constrains their capacity to fulfill this role.

Macro-structures of policy and community-wide stigma result in a high demand for abortion that is shared among a limited number of abortion clinics, thus generating clinical processes that pathologize the practice of empathy. Furthermore, the clinical ecosystem obscures the social labor of the non-medical staff member, resulting in a lack of capacity building that would empower staff in their roles as resource distributors, educators, and liaisons. Additionally, escort policies are formidable barriers to abortion access due to the stigma of unplanned pregnancy, the stigma of abortion, and the lack of job flexibility for low-income households. The escort policy is not evidence-based, warranting a potential adjustment in its implementation. Yet, the increasing scrutinization of abortion clinics by anti-choice actors renders clinicians hesitant to incur medico-legal liability. Nevertheless, reproductive justice demands that such conversations be debated among staff members and clinical directors. After all, staff members serve as the ethnographic resource for data that can inform how reproductive justice can be better operationalized within the clinical environment.

Concerning structural barriers to abortion, the abortion clinic is particularly poised to restricting abortion access to refugee, immigrant, and migrant communities. The intensified

clinical processes of the abortion clinic, combined with established security protocols, exacerbate a form of structural violence that I specify as structural neglect, or the passive exclusion, or neglect, of marginalized individuals due to institutional structures that preclude their access to critical services. The concept of structural neglect helps to reconceptualize the idea of ‘cultural barriers’ by transferring responsibility for ‘cultural’ disparities to the institution instead of the individual.

The structural neglect of the clinic results in a selection bias that favors refugees, immigrants, and migrants with a lower degree of structural vulnerability, a phenomenon that can leave clinicians complacent with their perceived ability to serve the RIM community. As a counteragent to structural neglect, I have defined structural competence as the ability for an institution’s structures, processes, or protocols to successfully and efficiently facilitate healthcare access. This concept encourages an introspective stance among clinical institutions to interrogate the ways in which their structures, processes, and protocols can be reformed to optimize healthcare access. Several faith-based organizations (FBOs), who have historically served as social support pillars for migrant communities, demonstrate adequate forms of structural competence, thus remaining highly accessible to RIM communities, and thus serving as exemplars for reform. Despite their structural competence, the abortion stigma associated with Christian, faith-based organizations precludes abortion referrals for patients with unwanted pregnancies, resulting in a unique form of reproductive governance over the increasingly vulnerable RIM individuals who rely on such FBOs. This phenomenon thus presents an opportunity for the abortion clinic to reform its structures so as to disrupt the reproductive governance that FBOs passively exert over RIM populations.

7.2 Recommendations

In light of the findings of this thesis, I propose the following recommendations for abortion clinics as well as the many stakeholders interested in supporting the operationalization of reproductive justice within the clinical context.

- **Reconceptualizing the Role of Non-Medical Staff Members:** The recommendations below serve multiple functions, including the direct mitigation of abortion barriers, as well as the long-term mitigation of barriers via the implementation of reproductive justice within the clinical atmosphere.
 - Health Educators: To continually legitimize abortion and the abortion clinic, the clinic should be conceptualized as the most efficient and effective site for community education, particularly at highly trafficked clinics such as Choice. In order to accomplish this, the clinic must ensure that the social labor of non-medical staff members is acknowledged, honored, and empowered, rather than obscured by the biomedical paradigms of the clinic. Phone operators and health educators should be recognized as community educators and receive the appropriate training and resources to be effective in that role. Trainings should include: granular medical understandings of abortion, common myths of abortion, local anti-choice efforts to delegitimize abortion, informal pedagogy, and human-centered interactions.
 - Resource Distributors: Clinical directors should consider investing in capacity building for non-medical staff members, particularly phone operators. Phone operators do not merely create appointments. Rather, they serve to fulfill the additional aims of reproductive justice that facilitate abortion access, such as

acting as equitable distributors of vital community resources. Trainings and support should include: resource training, partnership building, collective action, bias recognition, emotional coping mechanisms.

- Resource for Reform: Staff members are the ethnographic resource for data that can inform system-challenging praxis within the clinic. Platforms of communication, such as team meetings and one-on-ones, should be established to foster critical dialogue between direct-service staff members and clinical directors and executives. Direct-service staff members retain a wealth of knowledge to inform the operationalization of reproductive justice within the clinical ecosystem.
- **Reimagining the Clinical Atmosphere**: The abortion clinic is more than a space in which abortion is obtained. Rather, it is a singular site of community for abortion seekers. As such, clinics should reimagine the spaces in which patients coexist in order to foster, but not enforce, communal exchange. Exchange can come in a variety of forms including live conversation with other patients, or anonymous conversation with past and future patients via journals or conversation boards. The waiting rooms of clinics can be reimaged with techniques such as: 1) inserting conversation pieces, such as art or poetry 2) utilizing comfortable furniture such as couches and bean bags to foster a sense of relaxation, 3) providing journals in which patients can anonymously share their thoughts and/or read the thoughts of former peers, 4) providing engaging education materials on abortion for patients to read while waiting, 5) providing healthy sources of distraction such as games, art, or books.

- **Prioritize structural competency tailored to refugee, immigrant, and migrant communities:** Abortion clinics should look to non-profits and FBOs serving RIM communities for concrete examples of structural competency. Examples include: 1) maintaining a highly multilingual and multicultural staff, 2) advertising services in multiple languages, 3) incorporating a mechanism to ensure communication with individuals who are more comfortable with in-person vs. phone correspondence (i.e.: an interested staff member is charged with following up with all attempted walk-ins), 4) offering services within walking distance or bus routes. Clinics should also seek to disrupt the reproductive governance of FBO culture among RIM communities through establishing partnerships with willing non-profits and FBOs, establishing a referral network with willing clinics and FBOs, and providing community outreach with the assistance of community partners that can act as cultural brokers between the clinic and RIM communities.
- **Lobbying to corporations:** abortion clinics are substantially constrained by seemingly intractable anti-abortion legislation. In a society in which corporations exert an increasing degree of governance over the population, advocates should concentrate efforts on establishing collective action with influential corporations (DeSalvo et al. 2017). This gives the clinic access to sorely needed finances and technologies. Additionally, the aims of abortion advocacy may be carried to higher political platforms by leveraging corporate influence.

8 CONCLUSION

Critical medical anthropology informs this ethnography on the ways in which the abortion clinic enhances and constrains access to abortion (Singer 1995). This study includes surveys, in-depth interviews, and intensive participant observation in my roles as researcher and as a staff member within a highly trafficked abortion clinic in the US Southeast. These methods allowed me to interrogate the interaction between macro-level structures such as policy, history, and stigma, and the micro-level experience of seeking, providing, and obtaining abortion (Singer 1995), thus offering concrete examples of the ways in which restrictive legislation manifests in the interaction between the abortion clinic and the abortion seeker. With respect to the ways in which the clinic intensifies barriers to abortion, data analysis demonstrates that the increased politicization of abortion manifests at the clinical level to 1) maintain unnecessary barriers of cost by rendering staff as disempowered to be equitable distributors of resources, 2) generate barriers of transportation through an increased sense of medico-liability that renders clinics hesitant to challenge existing escort protocols, 3) obscure the processes of moral negotiation that are unique to abortion and that are salient considerations to many abortion seekers, 4) burden the clinic with an increasing need to legitimize itself and dispel fears of abortion, 5) intensify forms of structural neglect, particularly towards refugees, immigrants, and migrants, and 6) provide limited opportunity for the clinic to disrupt the reproductive governance of faith-based ideologies over highly vulnerable refugee, immigrant, and migrant communities.

Despite these various barriers, the abortion clinic is also a critical site of opportunity for mitigating barriers to abortion. Key insights of the clinic's leverage points include 1) the salient role that staff members play in dispelling abortion fears and legitimizing the procedure, 2) the abortion clinic as a site of community where abortion stories can be exchanged to neutralize

stigma and moral quandaries, 3) the role of direct-service staff members as thought-leaders for operationalizing reproductive justice within the clinic, 4) the role of staff members as community educators and resource distributors, and 5) the clinic as an active disruptor of reproductive governance over refugees, immigrants, and migrants.

Among the rising tide of anti-abortion legislation throughout the United States, the abortion clinic provides paramount opportunity for the counter movements of feminism and reproductive justice. The abortion clinic is not merely a provider of abortion, but rather a potent leverage point for advocates who seek productive, concrete strategies in the fight for reproductive justice. Not only does the clinic act as a direct mitigator of abortion barriers, but just as importantly, it is a potential locus for social ferment, or a social space to explore new ways of addressing and responding to human needs (Scheper-Hughes 1990). Given that the population of abortion seekers in the US are largely comprised of women of color, the abortion clinic is a direct site of advocacy for such groups who are marginalized not only within the realm of reproductive care, but within the general field of healthcare. Yet, given the limited power and agency of the abortion clinic due to increasing anti-abortion legislation, the clinic is in dire need of support. May advocates, leaders, philanthropists, and clinicians increasingly invest in the abortion clinic as an indispensable instrument opportunity in the fight for human rights.

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