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Stratified Access On The Border: Examining Experiences Of Reproductive Care

Maralyn Doering
University of Texas at El Paso

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STRATIFIED ACCESS ON THE BORDER: EXAMINING EXPERIENCES OF
REPRODUCTIVE CARE

MARALYN DOERING

Master's Program in Sociology

APPROVED:

Carina Heckert, Ph.D., Chair

Ophra Leyser-Whalen, Ph.D.

Amy Reed-Sandoval, Ph.D.

Stephen L. Crites, Jr., Ph.D.
Dean of the Graduate School

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STRATIFIED ACCESS ON THE BORDER: EXAMINING EXPERIENCES OF
REPRODUCTIVE CARE

by

MARALYN DOERING, B.A.

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Introduction

Patient care experiences shape and affect the way that patients perceive and contextualize health care (Koenig 2011). Prior care experiences can change how patients choose to receive care in the future. In Texas, reproductive health care research has primarily focused on troubling trends in reproductive health care outcomes. This can be noted by the high cervical cancer rate (CDC 2019), the high unintended pregnancy rate (Kost 2015), and the limited access to reproductive care, particularly preventative care (Hopkins et al. 2015). The focus of this research has been on structural barriers, such as funding cuts (White et al. 2012), barriers to medical insurance (Melo 2018), and clinic closures (Gerdtts et al. 2016). While there has been work conducted on patient experiences of care, my work bridges this previous research with work on stratified access to reproductive care by demonstrating how aspects of care experiences, such as doctor-patient interactions, interpretations of negative care experiences, and negative results of care, are another dimension that can lead to limited reproductive care in an area where structural barriers have received more attention.

For this research, I conducted formal, semi-structured interviews with 12 participants of reproductive age in El Paso, Texas in order to analyze their experiences of seeking and receiving reproductive care. I analyzed their responses through the frame of stratified access to explore how patient care experiences created stratified access to reproductive care. Through the examination of stratified access through experiences of care emerged three subthemes: negative doctor-patient interactions, care as biopolitical control, and the iatrogenic effects of care. Through this examination of patient care experiences, I show how these subthemes combine with outside forces to stratify care. The framework of stratified access, which focuses on an individual's ability to access health care and the quality of health care that they receive based on

outsider perceptions of their perceived identities, allows for this analysis (Melo 2018). My research expands on conceptualizations of stratified access by exploring how experiences of care shape patients' responses to care and decisions related to seeking care in the future. By analyzing these experiences and interactions, I examine how a negative care experience, as well as negative results from a care experience, could lead to changes in future utilization of and access to care. This discussion of patient experiences allows for broader analysis of the range of factors that shape access to reproductive care in underserved medical locations (HRSA 2019).

Stratification and Stratified Access

I use the lens of stratified access to analyze individuals' abilities to access care. The concept of stratification originated with Davis and Moore (1945), who described societies as stratified based on talents and skills held by individuals. The more "useful" a talent or skill was deemed, the higher one's status became when they held that talent or skill (Davis and Moore 1945). Tumin (1953) argues that stratification is based on power. Individuals in power are the ones who create stratification. Fischer and colleagues (1996) state that societies create stratification by creating barriers that lead to inequality.

The concept of stratification is important in relation to health care access because stratification determines "worthiness" of individuals to receive care. For example, Mulligan and Castañeda (2018, 11) describe how "stratified citizenship" enables immigration status to determine access to health insurance through Medicaid and subsidies under the Affordable Care Act (ACA). Individuals who are undocumented or who are permanent residents and have not resided in the U.S. for at least five years are deemed ineligible. Melo (2018) discusses stratification through the lenses of stratified citizenship and stratified access. She does this by analyzing how immigration status along with other factors such as income level, age, and primary language spoken of individuals in the Rio Grande Valley of Texas affects access to dialysis. Those who are perceived by care providers as possessing the correct qualities that make them worthy of accessing care do so; those who do not receive subpar care. Andaya (2018, 115) analyzes stratification in prenatal care amongst Medicaid recipients in New York City. Given that New York enables women to access Medicaid during pregnancy regardless of immigration status, lack of health coverage is not always a problem, but rather perceived citizenship status creates stratification in other ways. By discussing immigrant women who qualify for prenatal

care and Medicaid coverage due to their pregnancy, Andaya highlights a temporary period in which these individuals stratified access to health care shifts. While the care these patients received was good quality, and their providers were genuinely concerned for their health, their placement in a system overloaded with patients created a negative perception amongst patients. Long waits for Medicaid and doctors left patients feeling dismissed and underserved. These issues of stratification fall under the greater umbrella of stratified reproduction, which Colen (1995, 78) argues is the way that reproductive work gets unevenly constructed and executed based on social hierarchies. Stratification and stratified reproduction then shape how providers interact with patients based on the patient's perceived social status.

While past research on stratified access to reproductive health care demonstrates how individuals face barriers to health care, particularly in relation to the ACA, this work does not center doctor-patient interactions. In her work on medical racism, Dána-Ain Davis (2019, 46-51) contextualizes the historical significance of doctor's authority in creating and treating medical issues amongst communities of color, and thus demonstrates how these historical issues are still reproduced today in doctor-patient interactions. With her focus on premature birth and its medicalization, Davis demonstrates how racial bias becomes embedded in the way that patients receive care. This has been achieved by creating a medical discourse in which premature birth and low birth weight become "black issues", and thus other health concerns become minimized and dismissed as a normal occurrence for blacks. The creation of prematurity and low-birth weight as black issues allow for blame to be placed on patients. When patients fail to prevent premature birth, they are blamed for being unable to do so. Their behavior is judged and monitored, and when it does not meet expectations, it creates a standard by which doctors can dismiss them as undeserving of quality care.

The acceptance of created discourses as discussed by Davis relies on the acceptance of information carried by doctors as expert knowledge. Expert knowledge addresses the authority given to the ideas, thoughts, and words of individuals perceived as experts (Foucault 2015). In *The Birth of the Clinic* (2003), Foucault discusses how patients' experiences of care become dehumanized through the clinical gaze. Foucault writes that prior to the 1800s doctors and patients had more personal interactions, but that the advent of medicalization that grew through the 19th and 20th centuries brought about a change in medical interactions. Patients were no longer seen as individuals, but rather as an extension of their illness, a thing to be treated and cured. Doctors derive the authority in their interactions with patients based on their identities as experts, creating stratification in the doctor-patient relationship. While stratified citizenship and stratified access attempt to form a comprehensive framework for addressing how individuals fall through coverage gaps and how they are streamlined into subpar care, these frameworks fail to address how care providers create stratified access through doctor-patient interactions and relationship building. Waitzkin (1979) highlights issues of class and gender in doctor-patient interactions, but stops short of showing how these interactions can serve to stratify access. Issues such as how stratified access can be shaped by the geographical and socioeconomic context of the location it takes place in do not figure in his analysis. Relationship building and doctor-patient interactions create an experience base for patients to reference in determining quality of care, as well as whether to continue accessing care.

Location and Methods

This study was conducted in the El Paso, TX region. El Paso is nestled between the southeastern corner of the state of New Mexico, with the city of Las Cruces nearby, and the northeastern portion of the state of Chihuahua, Mexico, with city of Ciudad Juarez directly across the international border from El Paso. The city of El Paso has an estimated population of 683,080, while the county has a population estimate of 837,918 (U.S. Census Bureau 2018). U.S. Census Bureau data identifies El Paso as a majority minority city, with the Hispanic/Latino population comprising 82.2% of the population. According to Census Bureau findings, 26.2% of the population do not have health insurance, and 20.9% of the population live in poverty. This high uninsured and high poverty rate, as well as a refusal by the state to expand Medicaid coverage and under the ACA, means that a large portion of the individuals who live in the El Paso area rely on the Healthy Texas Women program to receive reproductive care (Sommers et al. 2015). This program subsidizes reproductive and some preventative care, such as diabetes care, for eligible low-income women in the state. They list the following as services that they provide: pregnancy testing, screening for postpartum depression, pelvic examinations, STD testing and treatment, contraceptives, breast and cervical cancer screenings, as well as some preventative care (Texas Health and Human Services n.d.). I operationalized reproductive care based on this list of services.

For this project, I conducted formal, semi-structured interviews with 12 individuals between the ages of 18 to 34 who had received reproductive care in the El Paso area between January 2017 and July 2018. These interviews occurred after IRB submission and approval. Eleven of the participants were cisgender women, and one participant was non-binary. The average age of participants was 28.5 years of age. All participants had some level of college

education. Ten of the participants identified as Latinx or Hispanic, while two of the participants identified as white. Eleven out of the 12 participants had health insurance at the time when they had received care. Nine of the interviews were conducted in person, and 3 interviews were conducted over the phone. Interview times ranged from 13 to 54 minutes in length. Interviews were recorded with verbal consent from participants. Pseudonyms were created for participants and were used while discussing their experiences here.

I recruited participants using snowball sampling, beginning with individuals in my own social networks (Babbie 2013). These networks included cohort members in the sociology department, as well as friends and members of reproductive rights organizations of which I was member. I then used initial participants to identify additional individuals who would be interested in participation. Given my sampling strategy led to participants whose interests and views were often similar to my own, issues of bias may arise. However, my sample demonstrates what previous literature argues: that despite perceived ideas of what creates access to health care, these signifiers of care do not actually mean that individuals can access quality health care (Mulligan and Castañeda 2018). Therefore, it is important to tell stories of participants who disrupt narratives of quality health care access.

I used an interview guide (see Appendix A) with open-ended questions to provide a general format for the interviews, but patient responses and experiences guided probes. I used open-ended questions in order to encourage respondents to give far more detailed answers than I could have achieved with a survey (Weiss 1994). Besides some general demographic questions, the questions I asked participants related to the following: first reproductive care experience, latest reproductive care experience, health insurance, where they sought care, how they found the places where they sought care, and perceptions of their care seeking experiences. This is due to

the fact that these questions were originally meant to explore whether participants had experienced difficulty accessing reproductive care after restrictive abortion legislations went into effect in Texas. While conducting interviews, it became apparent that participants' interactions with providers had shaped their care experiences more so than policy changes. I then transcribed and hand coded the interviews in order to analyze them using themes related to my selected theoretical frameworks, with a focus on patient care experiences. Hand coding involved creating a codebook based on a list of themes developed through inductive reasoning while analyzing the data. The codes were identified and organized via a color coding system. Coding surrounding patient care experiences centered on their interactions with providers and how negative experiences shaped future care because participants made it clear that interactions and experiences shaped future care and decisions.

Stratified Access Through Experiences of Reproductive Care

The main theme that emerged from interviews with participants was the stratification of reproductive care itself. Reproductive healthcare is considered a specialized field that concentrates specifically on women. This means that individuals who are seeking this type of care may have to go to a specialized provider depending on what they need. Furthermore, some aspects of reproductive care have a negative connotation to them, such as abortion (Kumar et al. 2009). This creates policing surrounding this type of care, which means individuals may have a harder time accessing this type of care (Fuentes et al. 2016; Gerds et al. 2016). Three subthemes emerged from the theme of stratified access through experiences of care. The first theme discussed, negative doctor-patient interactions, shows how doctor-patient interactions are internalized by patients. This internalization then shapes future care decisions and care seeking behaviors. Care as biopolitical control highlights how care experiences contribute to biopolitical control, bringing interactions into larger discussions that traditionally focus on structural issues. Lastly, the section focusing on the iatrogenic effects of care demonstrates how individuals who have the ability to receive quality care through health insurance may face more interventions that lead to negative health consequences.

Negative Doctor-Patient Interactions

Doctor-patient relationships play an important part in how care is disseminated amongst different patients. Literature often discusses doctors as if they lack agency when it comes to providing patient treatment (Davis 2019). In his discussion of micropolitics, Waitzkin (1979) demonstrates that this is not the case; doctors have more agency than they are credited with, and they make decisions about patients' health based on their beliefs as well as interpretations of their patients. Waitzkin demonstrates how this takes place on an interactional level, based on experiences between doctors and patients.

In this study, participants noted that experiences with doctors served as a vehicle to predict future experience. Roxanne was a 34-year-old participant of Mexican descent. At the time of our interview, she was divorced and worked at a call center. Roxanne's first experiences with reproductive care began with her first pregnancy at the age of 20. Prior to this, she states that discussions of reproductive issues with her mother were limited, as her family was "really conservative Christian." Roxanne states that she was on state provided Medicaid for pregnant women at the time, and that she found her doctor by Googling doctors who took Medicaid. Roxanne had a miscarriage, and she describes her doctor's reaction as "cold." When she became pregnant again, she switched providers due to her doctor's reaction. She states that she enjoyed her interactions with her second doctor, but that his case load was too heavy for him to be able to continuously see her. He referred her to a nurse practitioner, and when the nurse practitioner closed her practice a few years later, she ended up going to a clinic run by a medical school located in the city. While receiving care at the clinic, Roxanne had a negative experience with the provider there. After the birth of her daughter, Roxanne's doctor had suggested that she have an intrauterine device (IUD) implanted. Roxanne had a negative reaction to the IUD and she wanted it removed. She said:

I remember asking if I could take out my IUD, because I felt like, my body was already rejecting it, because after I had her [daughter], I had the IUD in place. And I remember having pushback like 'No, you don't want to do that. No, well that's not because of that,' like 'You're gonna keep it' basically. So I got really aggravated, trying, for years, trying to get rid of my IUD. There was no doctor that would really make it easy, right? It was like 'Oh, yeah, sure' or 'No, you don't want to do that.'

Roxanne explains that she had severe cramping and bleeding with her IUD, to the point that she considered it debilitating. While these symptoms are considered normal up to 6 months after the insertion (Planned Parenthood 2019), Roxanne experienced these symptoms for years.

Higgins and colleagues (2016) conducted focus groups and interviews with recipients of Long-Acting Reversible Contraceptive (LARC) care in Wisconsin. They found that their participants who were women of color reported having their wants related to LARC use ignored more frequently than white participants. They also note that providers often minimized patient experiences of negative side effects with LARC use, such as heavy bleeding, which is what Roxanne experienced in her attempts to have her IUD removed. Mann (2013) also noted that Community Health Care providers that serviced low income Latina youths pushed birth control and LARC on their patients as a means pushing for “responsible” sexuality. This push centered on normalized white, middle class ideals of responsibility and sexuality.

Foucault’s discussion of expert knowledge surrounds the authority given to the “knowledge” of individuals perceived as experts, such as doctors (Foucault 2015). Something important to note is the idea that pregnancy prevention and birth control result in better life outcomes (Sonfield 2013) is often used by providers as a push for LARCs on their patients. Whether doctors are well intentioned or not, their push for LARCs on populations that they deem as irresponsible is left unquestioned because of their authority as experts.

In Roxanne’s case, her doctor derived power from his position as an expert to conclude that she did not need to have her IUD removed, and that it would be irresponsible for her to do so. Any evidence that Roxanne provided that might show that her body was rejecting her IUD was dismissed by her providers. Furthermore, Roxanne felt that her doctor’s initial push for an IUD stemmed from his idea that as a young, low-income Latina mother on Medicaid, there was

no way that she would want more children. To Roxanne's doctor, the only "responsible" thing to do would be to have an IUD inserted. Roxanne's doctors' refusal to remove her IUD created stratified access for Roxanne by 1) Limiting the type of care that Roxanne was able to receive, and 2) Providing subpar care to Roxanne based on her social status.

Other patients, such as Hilda, an upper middle class former Mexican national and Jenny, a lower middle class Mexican-American, had birth control pushed on them despite their insistence against it as well. Hilda had gone to a doctor recommended by her mother to address severe cramping issues. She states that the doctor recommended birth control, which Hilda was opposed to. Hilda had bodily concerns about potential harm caused by birth control. Hilda notes that as a teenager she attended a school that had a large number of teen pregnancies. Hilda also notes the school she attended was primarily low-income and Hispanic, so Hilda felt that her attendance at this school, as well as her age and nationality, prompted her first provider to push birth control on her. Hilda did not feel that her second provider was recommending birth control for the same reasons. However, Hilda's concerns over the effects of birth control left her resistant to accepting a prescription for birth control:

And she's [the doctor] like, oh well the one thing I can recommend that's going to get rid of it is birth control. And I told her, no, I'd rather not. And she's like, 'why?' Because I don't want to put that in my body.

Despite Hilda's resistance to birth control, her doctor insisted this was the only method that would help alleviate Hilda's pain. Hilda had insisted that she felt that birth control was unnecessary for her, as she was not sexually active at the time, and she felt uncomfortable with its potential effects on her body. Hilda's doctor convinced her to take birth control by stating that the dosage would be low and that it could be further lowered after an initial trial. Hilda agreed

and decided to fill her prescription. However, when she went to pick it up, she was frustrated to realize that the birth control she had been prescribed had to be paid for out-of-pocket. To Hilda, this meant that her doctor had not only ignored her concerns about taking hormonal birth control, she had also deliberately prescribed something she would have to pay for. Hilda stated that she could afford to pay for the prescription, but questioned what would have happened if she had not been able to do so. Hilda also acknowledged that she knew that there were expanded options due to the ACA that would have been covered by her health insurance.

Jenny's concerns with birth control, particularly Depo-Provera injections, which she had been given, dealt with the cost of care as well as the potential for harm to her body. Jenny stated that she accepted Depo-Provera injections at first because she was told they would help with irregular periods and cramping. After receiving an initial injection, Jenny researched potential bodily effects. She stated that if she had been more informed prior to receiving them, she would not have accepted them. However, Jenny also stated that she knew she would not be receiving Depo-Provera injections for a long-period of time because they were expensive. This allowed Jenny to more readily accept the use of the Depo-Provera as a temporary symptom reliever.

In contrast, Lauren, a white college student, had a difficult time finding a provider who would insert an IUD for her. Lauren was told that it was difficult for doctors to insert IUDs into women who had never been pregnant. Lauren states that when she began dating a cisgender woman, she never discussed birth control with her providers. Although Lauren stressed that she felt her experiences with providers had been positive, she acknowledged that because she did not want to necessarily have a discussion with her providers, she potentially missed out on care:

I've not discussed my sexuality with my provider because it was just like... I was dating a man the first time. Um, but I did obviously talk about that because I was looking for an

IUD. Um, but after that, even though I was with women, I didn't really talk to my provider about that. Um, so I think that that definitely affects the kind of care I'm looking for, whether or not my provider knows that... But I guess I, if I can put it through my lens, like I said, I think it's just, uh, a little bit of a different conversation [sex with women]. So I mean, there is like stress, safe sex with women, but you don't have to worry about preventing pregnancy.

Lauren's care experience is affirmed by previous health care research that highlights lesbians' experiences seeking health care. This work discusses how providers often miss potential health concerns by being unaware of their patient's sexual orientation (Bjorkman and Malterud 2007; 2009).

Not all participants felt that their doctor-patient interactions were negative. Zelda, Hilda's older sister and a nurse, was attended to by the same provider that prescribed Hilda the out-of-pocket birth control. Zelda noted that she felt comfortable with this provider. Furthermore, Zelda felt that she was informed enough about what her care should look like in order to be an active participant in her care experiences. Zelda notes that when she went in to receive care, she was already taking birth control and already had decided opinions of what her care should look like.

Jenny also described her most recent reproductive care experience as a positive one. Jenny states that just after graduating from her graduate program, she had noticed a blemish on one of her breasts. Concerned, she went to the student health center at her university. She was told that it was probably just a small cyst, but was told to have it "checked out" just in case. Concerned because her graduate student insurance was about to run out, Jenny scrambled to find a provider who she could afford. The student health center directed her to a breast cancer clinic run the local medical school. Jenny states that her care experiences here were quick, prompt, and

affordable. Jenny stated that if she had had breast cancer, she would not have been able to wait the month long processing time for enrollment in the Healthy Texas Women Program to receive care. Jenny was grateful that the provider she ended up with was compassionate and affordable.

Participant's experiences with reproductive care included negative aspects that participants internalized. However, the focus of internalization was different for white and Latina patients. For Latina patients, internalization centered around their identities as Latinas. Patients tied a push for birth control from their doctors as a means of preventing pregnancy, which they felt was stigmatized amongst their demographic. For white patients, internalization of negative experiences was centered on other aspects of social status, such as sexual orientation. This internalization results from the difference in their experiences, such as Lauren's lack of access to birth control. Although their experiences varied, they still resulted in negative experiences and internalization of these experiences, which shaped future decisions regarding seeking care. Participants that had positive experiences felt that they had been listened to by their providers. They also felt that their providers had showed empathy and understanding, which they felt gave them say in their care (Koenig 2011).

Care Experiences as Biopolitical Control

As stated above, the experiences that patients have when it comes to building doctor-patient relationships and seeking care affect their future care choices. Negative experiences can have a long-term effect on whether patients will seek care in the future. This can be further affected by the ways interested groups attempt to exert control over reproductive decisions. In her retelling of her experience seeking and receiving an abortion seven years earlier at the age of 19, Natalie, a Latina call center worker, describes an experience that was negative prior to receiving care:

So my mom drove me over to the place and there were protesters, I remember, um, on the day and they were, uh, they would throw things at me. They spat at me. Umm, terrible, terrible experience. I, so I started crying outside and they were like ‘Come, come with us. We just want to counsel you and we want to do all this stuff for you.’ And I was like ‘You know what? I really would like it if you just like would leave me alone.’

Abortion protestors have become notorious in today’s media, with clips and images of them being shown as crusaders for the unborn. Ginsburg (1998) describes how the modern day abortion protestor originated from individuals who were paid by conservative religious groups to protest abortion clinics. Abortion protestors use first amendment rights arguments (Ellis and Wu 1996; Faglioni 1991; Kelly 1995) to justify the methods they use to prevent individuals from accessing abortion services. This creates a system of surveillance that individuals internalize and use to prevent interactions and confrontations with protestors. The concept of governmentality describes the way in which governance is enacted amongst populations. Various groups can play a part in governmentality, ensuring that populations are controlled as they see fit (Li 2007). Morgan and Roberts (2015, 243) discuss how “different historical configurations of actors -- such as state institutions, churches, donor agencies, and non-governmental organizations (NGOS),” use different tools held by these actors to control reproduction. Abortion protestors and the tactics that they use to intimidate individuals seeking abortions are tools held by churches and donor agencies that use “moral injunctions” and “direct coercion” in order to shape an individual’s reproductive behavior. Natalie was so distressed by the idea of having to face abortion protestors again, to her, it almost would have been worth it not to go back to the clinic. By employing strategies meant to intimidate and scare off abortion seekers, abortion protestors ensure that abortion seekers internalize negative abortion attitudes, leading to self-regulation of

their behavior by avoiding abortion clinics altogether. Protesting, such as Natalie mentioned, are one way in which these groups enact governmentality and shape how patients access abortion care.

After making it into the abortion clinic, Natalie states that she was unable to receive care that day due to a machine failure and states that she was told to come the next day. Natalie expressed fear at having to face abortion protestors again, however, she states that they were gone when she came back the next day. Natalie describes going through the steps leading up to the abortion itself. The doctor suggested a surgical procedure, which Natalie agreed to. However, problems arose again during the procedure. Natalie states that midway through, the doctor told her that they could not continue on. She was told to go into the waiting room, where she promptly began bleeding heavily. Natalie states that they went on with the procedure, after which she had pain and bleeding for a few days. Natalie contacted the clinic, which told her that this was normal. However, when Natalie Googled these symptoms, she found stigmatizing answers and literature that were meant to make her regret her abortion. She described:

And I remember Googling it and it was like, 'It's not normal.' It was like absolutely the worst. It was like, 'First of all, you shouldn't have had an abortion' and just like terrible. And I was like, you know what I'm going to stop doing this because it's making me feel bad.

Kumar and colleagues (2009, 628) define abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood.” Norris and colleagues (2011) expand on the idea of stigmatization of abortion to discuss groups who are affected by the stigmatization of abortion as well as why abortion is stigmatized. This stigma in turn lends itself to social control. Individuals

who are stigmatized face potential discrimination if their stigmatized status becomes widely known, which ensures that individuals will do their best to avoid stigma (Barnett et al. 2016). In Natalie's case, we see abortion stigma play out through the attacks she faced while walking into the clinic, as well as the lack of support and information she found after receiving her abortion. Both of these experiences were meant to cast doubt on her decision to have an abortion.

Furthermore, Natalie acknowledges having felt "bad" after reading what pro-life blogs had posted about abortion. We can also see this internalization of abortion stigma in how long Natalie waited to call about her follow up appointment. Natalie states that she was afraid to go back to the doctor after this experience and that she failed to go to her follow-up appointment. When she called the clinic two weeks after it was supposed to occur, she faced a hostile response from the clinic worker, who stated that they could no longer see her due to liability issues. Patient care and liability issues are an ever present discussion in the reproductive medical field. Morris (2013) describes the environment in obstetric care as being under constant liability threat.

Natalie was able to receive minimal follow up care through the office that her mother worked at. Natalie states that after the experience, she was reluctant to seek reproductive care of any kind because the first experience had been so difficult due to the culmination of protestors, lack of social support, and lack of care from the clinic. She said, "I guess I wish it was just easier and I wish they were, they were more informative and I wish it didn't seem so shady because it's just the whole experience just is extremely shady."

A different participant, Katy, a white graduate student, had a similarly negative experience at the same abortion provider. Katy describes having a surgical abortion while only being given topical anesthetic:

It didn't even come up. She said that he put like some Lidocaine, um, on the outside because they have this like put a very long, um, like there's basically like a larger, uh, whatever the thing is that they use when you go for your annual exam. I can't remember what that's called...Um, and uh, they, he just kind of, explained that I might feel like a pinch or something. Um, yeah, so just again, [he] kind of just like downplayed like that this is going to hurt... I just would have rather been able to brace myself because I just remember like I'm putting my head back because my body is like naturally kind of trying to get away from the thing that's causing pain, and that the nurse just like holding my wrists down was saying like, stop putting your head back, you're going to pass out. And uh, I was just kind of like, you know, maybe we should stop for a second.

Upset with her experience, Katy consulted with a member of a local abortion fund after her experience and found that the doctor at this clinic was notorious for cruel remarks towards patients and that the clinic was plagued with controversy. Katy talks about a discussion she had with a board member of a local abortion fund:

So I talked about it finally with Tracy one time...but like she said that he, that that doctor, is notorious for making punishing comments to women.

Katy's comments point to several issues with the way in which historical restrictions and stigmatization of abortion still have effects today. Restrictions on abortion were originally pushed by doctors and the American Medical Association during the mid-1800s. This was achieved through strategically stigmatizing midwives, who were often poor women of color, by painting them as ignorant and unclean. Doctors also created an image of abortion as unsafe and potentially harmful to the body (Solinger 2013). Current stigmas associated with abortion combine with this historical context to create an uncertain abortion landscape (Joffe et al. 1998).

What further frustrated Katy is that after her abortion procedure, the doctor asked her if there was anything else he could help her with. Katy was interested in having an IUD inserted, as she had been on birth control pills when she became pregnant. The doctor refused Katy's request, saying "...no, you don't want an IUD. That's for old ladies who have already had their children."

In the contemporary anti-abortion movement, one of the main talking points has become the safety of women's health. Many states have passed Targeted Regulation of Abortion Provider (TRAP) laws that create barriers for abortion providers and abortion clinics (Guttmacher 2018). These barriers are then passed on to the individuals seeking abortions. One example of this is the passage of House Bill 2 (HB 2) in Texas. HB 2 required: abortion providers in the state to have admitting privileges within 30 miles of where abortions were performed, clinics meet the same standards as ambulatory surgical centers, criminalized abortion after 20 weeks, and changed the process of medical abortion (Texas Legislature 2013). Legislators argued that women had plenty of time prior to 20 weeks in order to find out they were pregnant and terminate their pregnancies. The ambulatory surgical center requirement closed down the abortion clinics in El Paso for a few months, which meant that Katy had to travel to Santa Teresa, New Mexico to receive her abortion. The next closest clinic would have been a four-hour drive away, requiring time off. While the clinic was not too far away, her treatment at the hands of someone she described as a negligent and cruel doctor shaped the way she felt receiving medical care in the future. Katy and Natalie's reliance on a provider who had a negative reputation was shaped by the legislative decisions of those in power.

Another related concept is biopolitics, which discusses how structures, such as governments, can shape and control biological processes of individuals (Foucault 2004). In Katy

and Natalie's cases, the stigmatization of abortion led to the push for abortion restrictions as well as the development of a grand narrative where abortion is harmful to individuals seeking them, despite contrary evidence (Biggs et al. 2017). This meant that Katy and Natalie were left to navigate a broken provider network. Furthermore, TRAP laws did not actually protect Katy or Natalie's health, as a questionable provider was still able to operate despite these laws.

Pruitt and Vanegas (2015, 98-99) use urban normativity to examine what they term the spatial privilege of judges who uphold legislation such as HB 2. They argue that because those upholding legislation such as HB 2 tend to be from urban environments, their spatial privilege blinds them to the barriers that individuals in rural areas face when attempting to access abortion providers. This spatial privilege goes beyond rural environments to urban ones as well. Katy had the means to travel to the abortion clinic in New Mexico in a personal car. This is an 11-minute, 4.5-mile drive from the closest Texas zip code. However, without a car, this 11-minute drive becomes a 43-minute bus ride (including a 15-minute walk to the bus stop, and a 15-minute walk to the clinic from the bus stop) (Google Maps 2019). Furthermore, Natalie's abortion happened several years prior to Katy's. Natalie was not subject to the restrictions placed by HB 2 while Katy was. However, they were both recipients of poor care.

Restrictions on funding for abortion also create biopolitical control of patients by perpetuating conditions that contribute to negative care experiences. In 1976, the Hyde amendment was passed, which cut federal funding for abortions. This left marginalized individuals, particularly those who were poor and of color, without a means for funding abortion (Davis 1983). In 1992, the Supreme Court heard *Planned Parenthood of Southeastern Pa. v. Casey*, which was poised to reverse *Roe v. Wade*. Although that did not happen, the case did create the "undue burden standard", which allowed for states to create abortion restrictions as

long as they did not create an undue burden on those seeking or providing abortions (Planned Parenthood of Southeastern Pa. v. Casey 1992). HB 2 did not outlaw abortion in the state of Texas, but its implementation of an ambulatory surgical center standard on abortion clinics led to three-fourths of the abortion clinics in the state of Texas closing, particularly those in rural areas (Whole Woman’s Health v. Hellerstedt 2016). This left individuals in those areas with no options for care and added burdens of increased travel time and costs. These burdens mean that an abortion is attainable for someone who has the money and financial security to be able to travel across state lines in order to access an abortion. However, for individuals like Natalie and Katy who were both young college students at the time of their procedure, this would have been difficult to do. Abortion restrictions also fail to “protect women’s health” (Greenhouse and Siegel 2016), and can make physicians with bad reputations the only option for desperate individuals. This demonstrates a process of eroding away access to abortion care that leaves marginalized individuals without the means to access abortion (Davis 1983).

Restrictions to abortion care also led to a decline in accessible reproductive care overall in Texas. Cuts to Texas’ family planning budget meant that individuals who relied on subsidized care from the state saw the types of care they could receive reduced, the locations and times they could receive care cut, and the fees that they faced while accessing care raised (Hopkins et al. 2015; White et al. 2012). Furthermore, Texas removed Planned Parenthood as an affiliated provider of reproductive care due to its status as an abortion provider. The areas where Planned Parenthood had been the only provider saw rises in Medicaid covered pregnancies, as well as decreases in continued Long-Acting Reversible Contraceptive (LARC) and other lapses in reproductive care access (Stevenson et al. 2016). The aggressive restrictions that Texas placed on abortion providers thus had far-reaching consequences in terms of reproductive care for

individuals who relied on state care. Ultimately, restrictions on abortion care are a form of biopolitical control by the state. Legislation passed by states that restricts abortion create barriers to access. However, these barriers disproportionately affect marginalized individuals' such as Katy and Natalie. Because of their disproportionate effects, these pieces of legislation create stratified access for those who are prevented from accessing care or who report experiences of substandard care. Furthermore, in Katy and Natalie's cases, biopolitical control goes beyond legislation to include doctor-patient interactions.

Iatrogenic Effects of Care

Negative care experiences went beyond contraceptive and abortion care. Iatrogenic effects are negative health experiences that are the results of interventions on patients (Krishnan and Kasthuri 2011). Davis-Floyd (2001) notes that in childbirth in particular processes which are normal become pathologized and viewed as a point of intervention. The purpose of this intervention is not a long-term issue, but rather a short-term fix. Tessa, a Mexican-American woman in her thirties, was a participant who described a negative experience while receiving obstetric care. Since entering adulthood, Tessa's reproductive care had been conducted by the military. She had enlisted in the army at a young age and had a miscarriage early in her enlistment. She described her care as ok, although she did state that there were often long wait times or doctor shortages. Tessa's experience with her second pregnancy started off well. She stated that she liked her OB/GYN and that they had created a birth plan. She had planned to have a vaginal birth without an epidural or c-section. However, when it came time for Tessa to actually give birth, her OB/GYN was out of town. She went to the hospital where her OB/GYN had admitting rights and was seen by one of her OB/GYN's colleagues. Tessa stated that her birth plan immediately went out the window. The doctor stated that Tessa had to have a c-

section. When Tessa and her husband began to argue this, they were ignored. Tessa further stated that while she was being prepared for a c-section despite her and her husband's protests, the nurse was flirting with Tessa's husband instead of listening to their concerns. Tessa explained that she felt that the reason she was told she needed a c-section was so that the hospital could mark-up her delivery bill. She noted that several of her friends who had military insurance had similar experiences. Tessa stated that in her post-birth follow up with her initial OB/GYN, her OB/GYN stated that her c-section had been unnecessary. Research shows that c-section push, termed the "c-section epidemic," stems in part from malpractice concerns that then drive financial concerns in hospitals, as well as physician ideology about birth (Morris 2013). While many individuals would see Tessa's availability to access health care through her insurance coverage as a plus, it also brings to question whether Tessa's health insurance coverage and physician malpractice liability and ideologies placed her on a path to negative care experiences.

Melanie, a 34-year-old Latina, was also covered by military insurance through her husband. Melanie states that military doctors "always want to offer birth control...when you're married into the military." Melanie's statement is verified by research that shows higher birth control usage rates amongst female military service members (Enewold et al. 2010). Melanie states that she could not use condoms because of an allergy to them. When Melanie mentioned this to her doctor, he offered alternatives such as birth control pills. Melanie states that she did try the birth control, but that it was causing her to menstruate twice a month. When Melanie mentioned this to her doctor, she was told that she just needed to get used to it. She ended up switching to NuvaRing, however, this also caused her to menstruate twice a month. Melanie mentions that she carried on like that for about seven months. Melanie states that when she said she no longer wanted to use these methods, she was given more long-term options. However,

having recently gotten married, she did not want a long-term contraceptive option. Ultimately, Melanie decided that she would not take birth control at all. Melanie's push for birth control resulted in negative health effects for her. However, her coverage through military insurance meant that Melanie's decisions relating to birth control use would always be watched and questioned by providers, given the birth control push among military providers. While Melanie never mentions a reason for this push, and even states that she thought she was well "taken care of," the effects of the birth control she was prescribed were a negative result of this care. If the birth control was a means of preventing pregnancy, its use as a preventative created an iatrogenic effect for Melanie (Davis Floyd 2001, S9-S10).

Both Melanie and Tessa experienced iatrogenic effects due to their insurance coverage. While Melanie and Tessa would normally be considered privileged because of their insurance coverage, this coverage ultimately led to negative health effects for both of them. Instead of being a source of better care as expected, this coverage led to a push for unwanted and unnecessary treatments. Melanie and Tessa's experiences also demonstrate a less explored way in which health insurance can create stratified access to care. Their experiences highlight how, in some cases, health insurance can lead to negative care experiences and negative care outcomes. Tessa felt that if she did not have health insurance to cover her birth, she would not have been forced to have a c-section and could have proceeded with a vaginal birth as planned. Melanie was able to stop using birth control after it had had negative effects on her body. However, during the time periods in that Melanie did not have health insurance, she states there was never a push for her to use birth control because she did not have the means to pay for it.

Limitations

This study has potential limitations. The first limitation concerns sample size. The sample size of the study means that it is not generalizable, instead serving to analyze this specific border context. The second limitation concerns the sampled group. Many of the individuals who were sampled were members of reproductive rights groups, or students in the sociology program, and were thus somewhat familiar with issues in reproductive health care and race. This means that these participants may have been more critical of issues related to race, class, and quality of care. Lastly, El Paso, TX as the location for this study does not allow for generalizability. The location in which research took place means that Latinx/Hispanic people are over-sampled. However, despite potential limitations, this study still provides a valuable case that demonstrates sociological phenomena in the realm of reproductive health. This group of participants demonstrates how despite having a perceived advantage over others due to their knowledge of reproductive issues, this group still struggles while receiving care. Furthermore, in a subfield that primarily focuses on the experience of white women, this study provides a counter example.

Conclusion

Patient care experiences play a significant role in how patients will perceive and receive care. These perceptions, along with outside forces, play a role in stratifying patients access to reproductive care. Negative doctor-patient interactions, such as those experienced by Roxanne, Lauren, Hilda, and Jenny led to an internalization of experiences. This internalization became an explanation for participants' experiences of stratified access to reproductive care. For Roxanne, Hilda, and Jenny, the internalization of negative doctor-patient interactions centered on their social positions as young Latina women. Roxanne, Hilda, and Jenny were aware of stereotypes related to their positions in these categories, and felt that this is what guided their interactions with doctors. Roxanne, Hilda, and Jenny felt that if these interactions had not been guided by their identities, they would have received the type of reproductive care that they actually wanted. Unlike other participants, Lauren felt that her interactions with doctors were guided by her sexual orientation, despite not having discussed this with her doctors. Lauren felt that this changed the type of care she received, but was ok with this because she did not want to discuss her sexuality with providers. Roxanne, Hilda, Jenny, and Lauren all experienced stratified access because of their social positions, but were impacted in different ways. Roxanne, Hilda, and Jenny had birth control pushed on to them because of their social positions, while Lauren missed out on discussions of birth control because her sexual behaviors meant that she was not at risk for pregnancy. Negative experiences with doctors led to changes in future patient health care choices, such as Roxanne's decision to change doctors until she found one who would remove her IUD. While these experiences were described as negative, patients who chose to leave their doctors or disregard their treatment demonstrated agency by making these choices. Further examples of patient agency come from Hilda, and Melanie's decisions to cross the border into

Ciudad Juarez to visit providers they felt comfortable with when they were unhappy with the care that they received in the U.S.

Natalie's experience also demonstrates agency, as she decided to no longer receive medical care for a while after her experience. Furthermore, both Natalie and Katy's experiences also serve to demonstrate how groups and laws, along-with doctor-patient interactions, create biopolitical control. Although legislation can create stratified access to reproductive care by limiting the types of services available, it is not the sole cause of biopolitical control of participants' reproductive processes. By limiting Natalie and Katy's ability to access care, as well as by creating situations that would make them think twice before accessing care, interest groups and legislators ultimately influence and control a broader spectrum of Natalie and Katy's reproductive choices. However, it was their negative experiences with doctors in conjunction with other factors that led to control of their reproductive processes.

Lastly, despite having health insurance that placed them in a category of privilege, Tessa and Melanie's reproductive health care experiences work to further demonstrate how doctor-patient interactions in conjunction with insurance coverage can create negative health care outcomes for patients. Although having health insurance is often tied to better medical care, Tessa and Melanie's experiences show how health insurance can mean that patients are given interventions that they do not want or need. In some cases, such as Melanie's, these treatments can cause worsening of a patient's health, bringing in to question the need for these treatments.

Ultimately, participant's experiences of care demonstrate that it is not merely social and structural issues, such as restrictive legislation, or insurance status, that create stratification in access reproductive care. Patient's experiences while receiving care and their perceptions of

these experiences can also create stratified access, by shaping understandings of what care should be like, as well as by influencing decisions about whether to access care in the future.

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Appendix

Interview Guide

What is your date of birth?

What is your gender?

What is your race and/or ethnicity?

What is your sexual orientation?

What class do you consider yourself a member of?

Did your family ever struggle with food?

Did your family ever struggle with housing?

Do you remember having any conversations about reproductive health with members of your family?

Do you remember having any conversations about reproductive health with your friends?

Do you remember having any conversations about reproductive health at school?

At what age did you first seek reproductive health care?

- What type of care did you seek?
- How would you describe this experience?
- Did you face any difficulties? If so, what were they?

What types of care have you sought?

- Why did you seek these types of services?
- Were there any services that were difficult to access? If so, which ones?

- What would you attribute the difficulty of seeking these services to?

While seeking these types of care, did you encounter any difficulties finding a provider or service? If so, what were they?

- Have there been any time periods where you have had more difficulty accessing a service or a provider? If so, what do you attribute the difficulty to?

When is the last time that you sought reproductive health care?

- What services did you seek?
- Did you face any difficulties finding a provider or the service that you needed? If so, what were they?

Where have you sought reproductive services?

- What motivated you to pick these specific providers?
- With whom did you seek services?
- Has this changed? If so, why?

Have you sought reproductive health care services outside of the U.S.?

- If so, what motivated you to do so?
- Where were these services sought?

Has your citizenship status affected your ability to seek care in any ways?

For the services providers that you have used, how did you find out about them?

Have you had insurance coverage during your care seeking experiences?

- During the entire time?
- If not, during which periods have you had insurance coverage?
- How has having/not having insurance changed your experiences seeking reproductive health care?
- How does having insurance change your decisions when it comes to seeking reproductive care?

Have you ever been reluctant to seek reproductive care?

- If so, why or why not?

Is there anything that you would change about your care seeking experience? About your care experiences? About your providers?

Vita

Maralyn Doering received her B.A. from the University of Texas at El Paso in 2016. She is currently a Ph.D. student at the University of Cincinnati in the Sociology Department. She works as a research assistant on the Ohio Policy Evaluation Network (OPEN), where she assists with research on the Safety Family Planning Net in Ohio, as well as Long-Acting Reversible Contraceptive (LARC) policies.

Contact Information: doerinmy@mail.uc.edu