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CHOICE IDEOLOGY AND THE PARAMETERS OF ITS PRACTICE: ALTERNATIVE ABORTION NARRATIVES IN NEW MEXICO

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BY

ABIGAIL RAE ADAMS

B.A., Anthropology/Sociology, College of Wooster, 1993
M.A., Anthropology, University of New Mexico, 1996

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Doctor of Philosophy
Anthropology

The University of New Mexico
Albuquerque, New Mexico

August, 2009

DEDICATION

In loving memory of my parents, Roberta and Richard,
who taught me the joy of books and good food.

And, to Candice Marie, my true love,
who guided me through the Fire Swamp.
As you wish.

ACKNOWLEDGMENTS

I would like to acknowledge my adviser, Dr. Carole Nagengast, for her grace, patience, and unwavering support of this endeavor. I would also like to thank the members of my committee- Dr. Louise Lamphere, Dr. Les Field, and Dr. Janet Cramer – for the time they devoted to scholarly and professional guidance. I also want to recognize the many dedicated and exceptional teachers who have contributed to my intellectual development at various stages of my education.

I want to express my deep gratitude to my partner Candice Bolger, who has loved me unconditionally and brought me the purest happiness. I am eternally grateful to my family, the Kennedy Clan (Amie, John, Grace and Callie), and my brothers Drew and Mark. Without their loving support, generosity, and faith, I could not have achieved this goal. I also am indebted to my dearest friend and editor Dan Dekker, who saved me the very first time we met, and has done so time and again.

I recognize the great privilege I had to speak with women about their world-views and personal histories surrounding abortion and hope to honor their courage in this ethnography. I am truly thankful to these women and am humbled by their bravery.

I am especially indebted to the amazing people who are the Powell Clinic. In the face of extreme adversity, the staff cultivates a culture of love and respect. Abortion workers are among the unsung heroes of our nation, sacrificing personal safety for the belief that women are moral decision-makers and that parenthood is too sacred to enter into without joyfulness. You have my greatest admiration.

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ABSTRACT

The ideology of choice, embedded in the pro-choice, anti-abortion debate in the United States, is founded on Enlightenment notions that take the autonomous individual with perfect knowledge and rationality as the unit of analysis. The basic premise is that each woman "chooses" from a variety of equally accessible options. Hidden in the political language of choice are the constraints all women face as they attempt to negotiate reproduction, especially if they wish to end a pregnancy. "Choice" does not exist as an abstract freedom, but is situated within the realities of power and agency. This paper examines the ability of "choice" to serve as a framework for abortion decisions and the alternative narratives employed by women to express the complexity of an abortion experience.

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Introduction: Up from the Ashes

On a sandy, sun soaked hill in Albuquerque, New Mexico sat a red brick medical complex housing a diverse array of health practitioners including a dentist office, a yoga studio, a few family practice doctors, a hand and foot specialist, a sleeping disorder center, and, since 1985, a private abortion clinic. On December 7th 2007, I drove to the clinic on a seemingly usual Friday, having missed the early morning phone call. I must have been showering. As I pulled into the parking lot of the Powell Clinic, I saw all of my fellow workers sitting on their cars, staring at the blackened and shattered door of the office. Yellow tape declaring "Crime Scene" crisscrossed the facility, and a small but steady stream of black smoke rose from the back of the office building. I did not understand what I was seeing. It was not until Samantha said, "They burned it down last night," that I realized what was transpiring. The clinic where I had worked for ten years was a blackened, hollow frame.

We stood vigil in the parking lot and shared donuts, coffee, and disbelief. The arson investigators were going in and out of the structure and Alcohol, Tobacco, and Firearms (ATF) agents congregated in front of what was once the Powell Clinic. While waiting for the fire marshal and investigators to finish, the clinic staff frantically used cell phones to call patients to reschedule appointments. Patients with early appointments were already pulling into the parking lot. The staff approached each car, asked if the occupant had an appointment, explained what had happened and gave her the number for the Planned Parenthood (PPH) clinic, knowing that the PPH appointments are full weeks

in advance. Some women had driven hours to get to the clinic for early morning appointments, but there was nothing that we could do. A provider at a local hospital graciously agreed to see two women whose abortion procedure had begun the previous day and had to be completed within hours or they risked infection and hemorrhaging. For the women who were on the second day of a three-day, advance procedure, the clinic was able to use the facilities of a private Obstetrics and Gynecology (Ob/Gyn) doctor less than two blocks from the clinic. The Powell Clinic had a long relationship with a doctor there.

After the arson investigators finished collecting evidence, the staff was permitted to enter the building to try to salvage anything we could, including computers and office equipment. The ceiling of the familiar mauve rooms where I had counseled hundreds of women about their abortion decisions and conducted interviews with clients and staff for this dissertation had collapsed. Everything was covered in a thick, black ash, rendering it unrecognizable. Once bucolic paintings were so thickly layered in soot that they appeared as black boxes protruding from the wall. The familiar became foreign and the smell was toxic. It was an eerie experience passing coworkers wearing facemasks as we tromped through the blackened halls. The fire started in a surgery room in the back of the building where someone broke a window with a cinder block and poured and ignited a large container of gasoline. The fire spread through the ceiling of the clinic and the damage was extreme. Surgery room three, where the fire had started, looked like ground zero. The examination table was a metal skeleton and the surgery lamp had melted into a supernatural drooping figure.

The staff of the clinic, including owners Dr. Clifford Powell and Dr. Roberta Powell, had an emergency meeting and it was agreed that we would not stop providing abortions. When interviewed for a local, free paper, a staff member said:

> I think right in the beginning it was like, what are we going to do? After we had that meeting, we just kept moving. We all sat down, talked about our options. At that point, it was clear we were committed (McCormack 2008:8).

The Powell staff was dedicated to continuing to provide abortion services, even without a permanent place. Planned Parenthood agreed to rent us their facility after hours and the staff of the Powell Clinic worked in this unfamiliar setting late into the night throughout December and January until we were able to rent a new building. In a testament to the commitment of the Powells and their staff, only one day of surgery was missed because of the fire. The staff endured long, hard days to make sure that women in New Mexico continued to have timely access to abortion services. Inevitably, some clients of the clinic experienced hardships from the fire. The clinic had unusual appointment times, only in the evenings after five and on Saturdays. In a piece about anti-abortion "terror tactics" in the U.S., Bader wrote:

> Some women have shown that they will travel through hell and high-water to terminate a pregnancy – for example, after a December 2007 arson destroyed Dr. Clifford Powell's clinic…desperate patients traveled to temporary sites to keep their appointments. (Bader 2008:3).

A typical appointment before the fire was three hours. While the Powell staff worked out of an unfamiliar setting with fewer surgery rooms, appointments took up to five hours. The late hours were especially prohibitive for the women who were traveling long distances. Both the staff and clients of the Powell Clinic were negatively impacted by the incident.

The Powells also have a clinic in Dallas, Texas that was burned on Christmas Eve of 1988, so although it was not by any means easy, this was not unfamiliar territory for them. Other clinics have been damaged by arson in Albuquerque. For example, the PPH surgical center was set on fire in 1999. Only a few weeks after the burning of the Powell Clinic, Planned Parenthood had two more small fires in separate locations. ATF agents believed those to have been copycat crimes inspired by the successful devastation of the Powell building. Dr. Powell released a press statement that said:

> After working on the abortion reform movement for 40 years, I wake up and I still can't believe we're still where we are. When will it stop? I'm going to have to accept the fact that I'm going to die before the rights of women are secured, and the violence against providers and staff comes to an end (Frosch 2007:A, 16).

Two of the three local network news stations reported that the fire had been contained to one room, but this was inaccurate. The fire caused enough damage that the property owner had to completely rebuild the internal structure of the office. Fortunately, the Powell Clinic was fully insured. The difficulty was not in the funding for a new location, but rather, in finding someone that would lease or sell to an abortion clinic. Some landlords and property companies considered it just too "risky" and others were morally opposed to abortion. Because over eighteen properties rejected the Powell application to rent, they ultimately were forced to buy an empty building that once served as a neurosurgery center.

At the time, the clinic staff assumed that a pro-life activist, possibly a member of a national organization, had started the fire. After a few weeks of investigation, the authorities identified two suspects, a local Albuquerque man and his friend. Twenty-two year old Mr. Sanchez decided to firebomb the clinic in an attempt to prevent his ex-

girlfriend from having an abortion that was scheduled at the clinic the following day. In early January of 2009, the two men pleaded guilty to federal charges of conspiracy to commit arson. Once sentenced, Mr. Sanchez is expected to receive 46 months in prison and his accomplice 40 months. Both must also pay financial restitution, not to the Powells, but to the clinic's insurance company.

Mr. Sanchez' lawyer, interviewed by the local paper, called the arson an "emotional crime." He went on to say, "Mr. Sanchez was upset about the planned abortion of his unborn son" (Uyttebrouck 2009:D2). This statement was remarkable considering Mr. Sanchez' ex-girlfriend was very early in her pregnancy when she made her appointment with the Powell Clinic. Before twelve weeks, the sex of a pregnancy cannot be determined. We cannot know if this was a lawyer's tactic to personify and give value to the pregnancy, thus gaining sympathy for Mr. Sanchez or if it was Mr. Sanchez' true belief that the potential child was a boy. During a staff meeting a few days after the plea deal was reached, Dr. Powell said of Mr. Sanchez; "This is the same man who holds the sign in front of the clinic that says, 'How Can Any Man Let A Woman Kill His Baby.' It is the same man. The woman's desires are completely absent. She is property. She doesn't figure into the equation" (Clinic field notes:01/14/2009). Mr. Sanchez is not literally the same man who protests in front of the clinic. Metaphorically, he is the same man who disregards the point of view of women, whether it is all women with an unintended pregnancy or an ex-girlfriend.

The event of the fire was traumatizing for the staff of the Powell Clinic and this violent act echoes other sensational events that have occurred in the abortion-providing community. For instance, the murder of Dr. David Gunn in Florida (1993), the murder of

two clinic receptionists in Massachusetts (1994), the fatal bombing at a family planning clinic in Atlanta (1998), the murder of the New York abortion doctor Bernard Slepian (1998), and the repeated arsons at clinics in Florida (1989, 1991, 1993, 1995, 2000, 2003, 2004, 2005) (NAF 2009). Most recently, on the last day of May in 2009, George Tiller, one of three doctors in the U.S. who performed late term abortions, was assassinated in the entry foyer of his Wichita, Kansas Church while handing out bulletins to his congregation. After the Powells found a new location for the clinic and added more security (*i.e.*, cameras and non-breakable windows), the clinic staff began to return to the routine act of providing abortions, and I remembered why I began to do this work in the first-place. It is not the polarizing and sensational aspect of abortion that drew me to this work, but the everyday practice of interacting with women making complicated and heartfelt choices.

In May of 1996, I began working as a counselor at the clinic to provide myself a consistent income as I pursued my graduate work in Ethnology at the University of New Mexico (UNM). In my application I wrote: "I want to activate my feminist politics and work in a women centered environment." I expected women who came to the clinic for an abortion to have some ambivalence about their decision, but more-or-less identify politically as pro-choice. What I found was very different. Women who came to the clinic to terminate a pregnancy are *both* pro-choice and pro-life, some identifying as pro-life *after* having an abortion.

Choice is a foundational concept for the Powell Clinic's doctors and staff, commonly used in the everyday language of the clinic's work culture. It is also a rallying cry for supporters of a woman's right to abortion. However, women who came for an

abortion did not always conceptualize their reproductive decisions in terms of choice or "a" choice. For an anthropologist, it is often the inconsistencies, the contradictions, or seeming contradictions in peoples' lives and decisions, which draw the gaze. In human action there are sometimes gaps between what people say they believe and how they behave. This study brings into question the ability of "choice" to serve as a metanarrative for abortion decisions in the United States and examines alternative narratives that express the complexity of women's abortion experience. The personal philosophies of clinic workers and pro-life protesters inform the experiences of women terminating a pregnancy, as do the ever-present interests of the state. This research is not just about abortion; it explores women's reproductive lives in terms of the strategies they employ to control their fertility (to inhibit or promote) and the worldviews they formulate. This project is framed by the theoretical position that women's reproductive options are directly impacted by: state forces, economic disparities, gender norms, and racism. This is an exploration of the ideologies and socio-economic conditions that undergird the reproductive choices women make. The center of this project is the 55 interviews conducted with women who had abortions at the Powell Clinic (Appendix A). I repeatedly heard women state that they "had no choice." It was interesting to me that choice was one of the clinic staff's foundational ideologies, yet many of the women coming to the clinic for abortions did not use the language of choice. Choice simply did not apply to their situation.

Research Methods: Participant-Observation, Interviews, and Statistics

The greater part of the fieldwork for this project extended over two years, from September of 2005 to December of 2007. The majority of interviews were conducted in 2006. However, I also utilize video interviews of clinic protesters from 1997. During this time of participant-observation and interviewing, I investigated the complexity of the practice of abortion along multiple dimensions (gender, class, ethnicity, and sexuality) in the environment of a private abortion clinic. This project, which addresses the praxis of women around pregnancy termination, requires several methods of data collection. I used participant-observation, semi-structured interviews, abortion related literature (*i.e.*, pamphlets), statistical analysis of participants' social indicators, and state recorded data on abortions in New Mexico. These methods were used to gather information on the discourse of pregnancy termination and "choice" in American politics as represented by individuals on both sides of the debate. I utilized the central methodology of anthropology, participant-observation, by taking field notes regarding the interactions of staff, clients, and protesters.

The subject population consisted of women who came to the clinic for an elective termination procedure as opposed to non-elective (*i.e.*, fetal demise clients who constitute 2% of the clinic's clientele). Clients who came to the clinic during their post-operative exam (two to four weeks after their procedure) were given a "Request for Participation" form along with the usual medical report form they are given to fill out by the nurse. The form stated:

> A counselor at this clinic who is also a doctoral candidate at the University of New Mexico is conducting a study regarding women's abortion decisions. Please indicate below if you are interested in answering some of

her questions regarding your decision making process. Your responses will be used to understand how women experience unintended pregnancies and abortion.

The study is completely anonymous and will take 15 to 20 minutes. This may add 5 minutes to your office visit time. You can discontinue the interview at any time. You must be at least 18 to participate. If you feel that you would experience negative emotional effects from participating, please decline for your own wellbeing. Your response below will in no way influence the care you receive at this clinic. Thank you.

At the time of a free post-operative exam, a co-worker recruited clients who qualified according to the "Protocol for Screening Client Participation." (Appendix B). Having the nurse solicit clients, rather than myself, was a strategy to diffuse any coercion that they might have felt. My co-worker was instructed not to solicit participation from clients that she assessed to be under profound emotional duress. Women who had a fetal demise or fetal anomaly were also excluded from participation to avoid causing psychological trauma. The clinic recruiter assured clients that they were under no obligation to participate and their refusal to do so would in no way affect their care at the clinic.

Clients for whom I was the counselor during the time of their abortion were also excluded. These women were not recruited because they may have felt some obligation to me as their counselor, when in fact participating was not in their interest. Furthermore, conducting a private interview session with a woman I had counseled might be a confusing context. Participants might consider the interaction to be modeled after a counseling session and feel bewildered when asked specific and pre-formulated questions regarding beliefs about abortion. A structured interview differs considerably from the counseling model used by the Powell Clinic in which the client directs the interaction. It also enabled me to function more as an anthropologist and less as a counselor or clinic

worker. Because of consent issues, clients under the age of eighteen were excluded, as were mentally ill or mentally handicapped individuals.

Before the interview, clients were asked to sign a consent form (Appendix C), and all participants were offered a copy to keep. Before beginning the interview, each participant was informed that she can "pass" on any questions that she did not feel comfortable answering and could discontinue the interview at any time. Clients were also assured that their identities would be protected through the use of pseudonyms, which I explained as "fake names." This is a traditional approach in anthropology to protect participants' identities and is also important for compliance with HIPAA, or the Health Insurance Portability and Accountability Act of 1996, which mandates privacy protection for health information. I also have changed or omitted specific personal information. For example, a woman from Clovis might be identified as being from a town in southern New Mexico. Each participant was asked to fill out a brief questionnaire regarding her demographic information, such as ethnic identification, age, education, place of residence, reproductive history, and marital status (Appendix D). During the open-ended interview, participants were asked questions regarding their ideas about abortion, reproductive histories, ideas about motherhood and personhood, and how they identified politically before and after their abortion (Appendix E).

Between January and December of 2006, I interviewed 55 women regarding their abortion experience. In addition to clients, I asked the other constituents at the abortion clinic to participate in interviews, including the staff and protesters. I asked some of the clinic staff questions regarding their political motivations, their understanding of the concept of choice, their ideas about motherhood and personhood, and their perceptions of

clients' use of choice language. The clinic manager, Jill Rue, asked the staff individually and privately if they would like to participate in my study, stressing that they were under no obligation to do so. All interviews, both client and staff, took place in a private counseling room in the clinic.

Outside of the clinic, I collected literature and testimonial from the pro-life protesters. Protesters' personal perspectives of abortion as well as the literature they distribute is important information in the analysis of choice as it provides a view into the other side of the debate; how the concept of choice is both rejected and co-opted (*i.e.*, choose life) by pro-life activists. Interviews with protesters were collected at an earlier time, in 1997, for an ethnographic video I co-produced with Laura Fugikawa, a women's studies student at UNM. The project was through UNM's Media Arts department and Ms. Fugikawa and I interviewed three protesters outside the clinic. I identified myself as a clinic worker and graduate student producing a video on the abortion debate. The protesters recognized me as a clinic worker and were very open to explaining their position, as theirs is a very public forum. We asked them questions regarding their political motivations, their perspective on the concept of choice, and their ideas about motherhood and the personhood of the embryo or fetus. These transcribed video interviews provide a representation of the pro-life position and the language used to promote their worldview.

Because of the extremely sensitive nature of abortion, I recognize the importance of protecting the privacy and wellbeing of all participants. For example, as mentioned beforehand, to safeguard the privacy of participants and to ensure that the information I publish will not affect them negatively, I have used pseudonyms in all cases.

Furthermore, I have used non-specific information regarding their place of residence and other particularly unique circumstances. I used a codebook with clients' names to identify interviews, which I have incinerated upon the completion of my project.

I interviewed clients two to four weeks after their abortions to ensure that they suffer no undue stress close to the time of their procedure. Waiting a few weeks after the process also gave a client time to reflect upon her experience. For the interview process, it was most ideal to interview a client after she has had time to formulate a perspective on her abortion and process the event. At the time of the post-operative exam, the experience of and the thoughts surrounding an abortion decision are still relatively fresh in a client's mind. Conducting the interviews during the time of the abortion may negatively impact the clients' processing of the experience. I also thought it was important to include information about the actual abortion and how the procedure went. Additionally, after the abortion procedure, women are heavily medicated. The strong medications used during the procedure create consent issues, not to mention the problems with nausea and alertness that would arise. Thus, the most ideal time to conduct client interviews was at the time of the post-operative exam. It was the time when women could agree to participate with the fewest coercive elements and clearly speak about their abortion decision and experience.

When conducting this research, it was helpful that I had worked at the clinic since 1996 and had developed a deep rapport with the staff and the managerial team. Because of the sensitive nature of abortion and the highly charged site of the clinic, it was through time and demonstrated professionalism that I was able to gain the management's consent to conduct this research.

A major methodological approach in cultural anthropology is participant-observation that requires immersion into a cultural context. The Powell Clinic was the ideal site to conduct abortion research. The three other clinics in New Mexico are primarily Ob/Gyn providers and perform few abortions compared to other reproductive services. Participant-observation is the canonical methodology of ethnographic research and was an extremely important element in this research. I observed the abortion work culture on an everyday basis and took notes regarding the clinic's specialized language and guiding philosophies. I attended weekly and monthly staff meetings at the clinic and listened to the staff talk about their work. Because my research as an anthropologist came after I began working as an abortion counselor, I had the unique position of being on the inside of the work culture before I began studying it as an outsider. It is both a useful and dangerous position. Already being accepted by a core group gave me immediate access to the everyday work culture when I began my research. However, being a member of the work group also required honoring certain loyalties that an outsider would not face. I had a loyalty to the clinic and had already adopted a specific moral stance on abortion. In these pages, I do not argue a moral position for abortion, but do not intend to represent myself as a neutral observer either. I am very aware as both an ethnologist and abortion worker that I blur the lines of analyst and advocate.

When counseling clients before an abortion procedure, I heard their stories and was impressed by the fact that most women did not talk about choice, but spoke of an absence of choice. I was moved because the perceived absence of choice speaks to the desperation many women feel. I was also fascinated because I did not expect that choice would be so rare in the vernacular of women having abortions. I utilize in-depth

interviews and field notes, allowing this ethnography to be a marriage of first person narratives and grounded observations of a research site. I have deliberately included larger texts of the interviews or complete statements from the participants. Interviews are inherently edited during ethnographic writing. If appropriate, I have attempted to keep the quotations longer and less truncated. I believe this is important when investigating women's worldviews and abortion narratives because it is more representative of the "whole story."

I will present the interviews conducted with abortion workers, clients, and protesters in larger text blocks of full responses in the hope that the content of the narratives will better represent a portion of people's lives. As experimental ethnographer Margery Wolf writes:

> Although feminists have been at the forefront of experimenting with strategies of co-authoring, polyvocality, and representation as a way of confronting or changing power differences, academic feminists have tended to maintain control over research projects and "knowledge creation," as have conventional nonfeminist researchers, rarely empowering the women they study (Wolf 1996:3).

In examining women's experiences of abortion, I want to avoid the traditional ethnographic technique of quoting brief excerpts of interviews, which are then heavily interpreted by the anthropologist. It is my hope that the longer excerpts will aid in creating a more complete picture of women's abortion decisions and provide an alternative perspective.[1]

[1] To aid in the analysis of the interviews, I used the visual qualitative data analysis program ATLAS.ti. With ATLAS.ti, I coded the interviews based on specific themes, or hermeneutic units. Some of these themes were established in the original proposal and many new themes emerged during the research process. These themes included choice, health concerns, political identification, economic survival, motherhood, personhood, state coercion, mental health, the family, and legality.

In addition to participant-observation and interviews, I have included statistical information regarding abortion rates in the United States, New Mexico, and the Powell Clinic. The clinic's 2006 National Abortion Federation statistical report lists 2,608 abortions at the Powell Clinic, or 45% of all abortions reported in the state of New Mexico. I randomly selected 420 of the 2,107 charts filed in 2006 and compiled the statistics on these individuals to provide an indication of the total population served by the clinic that year. Sampling theory recommends that in a population of 3,000, a sample minimum of 341 is sufficient for a five percent confidence interval (Bernard 1995:79). From the total of 2,107 charts available to sample, I employed systematic random sampling by including every fifth chart (Bernard 1995:83). Looking at the quantitative side of abortion allows us to place the 55 participants in the context of its practice. Abortion rates in the U.S. and New Mexico tell us about who gets abortions and how frequently, providing a better understanding of the conditions under which abortion decisions are made.

The Silence of Women Choosing

The Alan Guttmacher Institute estimates that 24% of all pregnancies in the United States are terminated by abortion, excluding spontaneous abortion or miscarriages, and more than 40% of all women who live in the United States will have an abortion by the age of forty-five (Guttmacher 2006:3). Most journalistic and academic attention to abortion in the U.S. utilizes abortion rates and moral claims, never soliciting the point of view of the more than one million women undergoing the procedure every year (Strauss *et al*., 2006:8). Little of the abortion literature includes the personal experiences and decision-

making processes of women. This deficiency occurs for several reasons. First, abortion throughout the world is most commonly undertaken as a clandestine procedure, either because of illegality or personal privacy issues. Even in the United States, where abortion has been a legal procedure since 1973, women rarely discuss their abortion experiences. These experiences are concealed from family members, close friends, and, by extension, public forum. Second, the first social scientists to study abortion were primarily demographers concerned with fertility rates, not personal experience. Demographic methodologies rely almost entirely on quantitative data, excluding the social conditions and cultural understanding of pregnancy termination.

> What is missing in much of the literature are the voices of women, their experiences and perceptions of abortion, the circumstances that shape their reproductive decisions, and the socio-cultural context so necessary to our understanding of the ideology, discourse and practice surrounding abortion at the local, regional, national and global levels (Rylko-Baure 1996:479).

Although academic and literary attention to abortion and women's reproduction focuses primarily on public policy issues and quantitative analysis, there are a few exceptions. Margaret Sanger's *Motherhood and Bondage* (1928), a seminal volume of letters from women and a few men, utilized first-person experiences to argue for access to reproductive health care and birth control. Sanger established the American Birth Control League in 1916, which later became the Planned Parenthood Federation of America (PPFA).[2] More than seventy years later, inspired by Sanger's approach, Gloria Feldt published a collection of letters written to PPFA entitled *Behind Every Choice Is a Story* (2002). The volume includes women's ideas and personal stories related to

[2] Sanger has been ridiculed for having a racist and eugenic agenda for promoting birth control among poor immigrant populations. She is more widely recognized as a hero and champion for women's reproductive rights.

sexuality, birth control, and abortion decisions. More recently, a collection of personal essays addressing the issues of birth, contraception, infertility, adoption, and abortion was published (Bender and de Gramont 2007). Bender and de Gramont speculate that there is a dearth of qualitative abortion literature because hearing women's voices would compromise the ideological opposition of the pro-choice and pro-life strongholds:

> When an issue is as polarizing as abortion, people on both sides see the world in black and white. In order to preserve these extremes, stories that reveal gray areas are kept secret (Bender and de Gramont 2007:4).

Anthropology has produced little research addressing abortion decisions, even after the surge in women-centered research starting in the 1970s. Faye Ginsburg's classic ethnography (1989) is an exception. Ginsburg's study, in Fargo, North Dakota, is a pioneering ethnography of the cultural war waged by abortion activists. Ginsburg argues that pro-life discourse upholds the image of the nurturing mother as the ideal female. When women are valued first and foremost for reproductive capacities, abortion becomes a destructive, unnatural act for women. Ginsburg's research shows how the interpretation and cultural status of reproduction is contested by both sides of the abortion debate through a dialectical process of appropriation and rebuttal. However, Ginsburg's ethnography does not include the perspectives of women terminating pregnancies.

Winny Koster's (2003) ethnography of the Yoruba women of Nigeria is an excellent, but rare example of how the analysis of women's abortion practices and the ideologies surrounding them can provide an illuminating vantage point into a culture's belief system. Koster's three-year study revealed how Yoruba women use abortion as a secret strategy within and as a resistance to the dominant rules of their patrilineal society. Abortion is illegal in Nigeria, and the high abortion rates are in direct contrast to the

societal mores and laws that deem abortion immoral. Koster utilizes both a survey and an in-depth questionnaire in her exploration of Yoruba women's fertility practices, asking about the conditions surrounding unwanted pregnancy, women's experience in an illegal context, and their beliefs about abortion.

Women worldwide who terminate a pregnancy, for whatever reason, are often silenced by culturally imposed shame.[3] I argue that social scientists can only make sense of abortion by including the perspectives of the women having abortions. The absence of women's voices leaves a gaping hole in the literature, especially when one considers the widespread and frequent practice of abortion as a method of fertility control around the globe (Guttmacher 2003).

The central thesis of this research is that it is absolutely critical that the multiplicity of practices and the beliefs of individuals, including pro-choice advocates, pro-life advocates, *and* women terminating a pregnancy, be incorporated to achieve a complete and ethical understanding of the issue of abortion in the United States. Before the American Medical Association (AMA) promoted the illegalization of abortion at the very beginning of the twentieth century, abortion was not a political or religious issue and was, relative to risks with childbirth, practiced safely by midwives and women healers throughout the U.S. (Mohr 1978). In the early twenty-first century, abortion has emerged as one of the most divisive ideological wedges in modern U.S. politics and law. In just four generations, abortion has become a violently debated issue and a major platform for each political party.

[3] There are exceptions to the abortion taboo, such as in the Netherlands, where abortion is not only legal, but has very little social stigma attached to its practice

Choice Ideology and its Critiques

The ideology of choice, embedded in the pro-choice, anti-abortion debate in the United States, is founded on Enlightenment notions that take the autonomous individual with perfect knowledge and perfect rationality as the unit of analysis. The basic premise is that each woman "chooses" from a variety of equally accessible options about which she is fully informed during the course of her reproductive life. Hidden in the political language of choice are the constraints all women face as they attempt to control their reproductive lives, *especially* if they wish to end a pregnancy.

In its present incarnation in the United States, reproductive freedom and justice is voiced almost entirely in the language of choice. Choice ideology serves a political function by providing a degree of separation from abortion, especially enabling non-fecund women to identify as against abortion personally but morally in support of a woman's right to choose. Adopting "choice" to signify reproductive freedom has also successfully obscured the feminist roots of the issue, instead allying the pro-abortion position with capitalistic America's promotion of consumer choice.

Although politically compelling, if not expedient, choice ideology fails to illuminate the profoundly divergent experiences of women in America whose reproductive lives are situated within a matrix of social identities, economic circumstances, and cultural practices. Building upon the liberal/neo-liberal category of the undifferentiated, individual decision-maker, choice ideology promotes the freedom of choice for *all* women regardless of social position. Celeste Condit writes:

> In practice, middle-class women were in the position to articulate their private vocabulary as a public one; poor women were not. Because the "articulate" class's primary limits on *their* choices were not economic, but legal, their primary arguments were directed at the single factor that prevented their wants from being realized - the coercive power of the state (Condit 1990:188).

The pro-choice movement has long ignored in particular the voices of women of color and women who are economically marginalized. Choice ideology invokes an autonomous, raceless, ageless woman of unlimited means. By promoting a shared right for women as a homogeneous group, most women are not represented. Until recently, most of the literature on women's reproduction lacked an analysis based on class, race, or ethnicity. For example, the concept of stratified reproduction has gained a great deal of currency in feminist anthropologists' study of reproduction. Stratified reproduction is a theoretical framework which approaches women's fertility as mediated by race and class, founded on the assumption that there is no equity in reproduction. It is "the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (Colen 1995:3). Using stratified reproduction as a theoretical framework, feminist anthropologists deconstruct the concept of reproductive choice that is premised on equal access (Lopez 1997, Petchesky 1984 and 1995, Raymond 1993, Robertson 1994).

In the pro-abortion movement in the United States, women of color, poor women, rural women, and women with disabilities have been subsumed under the banner of choice. In her study of the systematic sterilization of Puerto Rican women in New York, Iris Lopez revisits the concept of choice. She writes,

> The discrepancy and contradictions between agency and constraints led me to reconceptualize the ideology of choice in order to develop and

> refine a new language that enables us to think in more dialectical way about Puerto Rican women's fertility behavior. In this formulation of individual choice, a distinction needs to be made between a decision that is based on a lack of alternatives versus one that is based on reproductive freedom (Lopez 1997:160).

Lopez argues that "choice" is an inadequate framework for understanding women's reproductive decisions because most women have limited options around their reproductive futures; particularly people of color, women living in poverty, and underserved populations. Looking at the common sterilization of Puerto Rican women in New York City, Lopez explores the relationship between agency and constraint, revealing the economic and racial politics of reproduction. According to Lopez, "reproductive decisions are based on a lack of options circumscribed by a myriad of personal, social and historical forces that operate simultaneously to shape and constrain Puerto Rican women's fertility options" (Lopez 1997:157). Using the ethnographic methods of participant-observation, oral histories, and in-depth interviews with 128 Puerto Rican women, Lopez determines that this population had such a high rate of sterilization because of cultural and economic conditions that limit their options and certain state policy objectives that promoted their sterilization. Lopez's research is significant in its contribution to the literature on women's reproduction in the United States because the author does not reify her respondents as passive victims in the marginalizing system of medicine. Rather, Lopez stresses the importance of a nuanced analysis of women's experiences that explores both the constraints women face and the agency they employ to make the best decision for their lives within the established parameters of reproductive choices.

Abortion in the United States is essentialized by the polarization of the issue, pro-life versus pro-choice. Between these political bookends are the women making decisions about their reproductive lives, with few alternatives available to them. Why do women who are terminating a pregnancy not articulate their abortion as a choice, but rather, as the *absence* of choices? Lola Samuels, a counselor at the clinic, explained why she thinks clients do not often talk about choice:

> When it comes down to the way the woman talks about it, she doesn't talk about choice. She talks about being stuck with no choices. Women with unwanted pregnancies are desperate. It is not a time in her life when she feels empowered or feels like she has many options (Lola Samuels, staff interview: 3/22/03).

According to the National Center for Health Statistics, in the United States, approximately one quarter of all pregnancies are terminated each year (Henshaw and Van Vort 1992:6). This research project identifies some of the different ways that women speak about and think about their abortion decision and offers new ways to understand women's choices in the context of the politics of abortion. Because "choice" does not exist as an abstract freedom, but is situated within the realities of power and powerlessness, this project examines the ways in which women who seek abortions have been deterred or, in some cases, encouraged to end a pregnancy. I propose, through my ongoing work as a counselor at the Powell Clinic, to problematize the abstract concept of reproductive choice by situating it within the concrete range of parameters, both personal and systemic, that facilitate and limit women's ability to control their reproduction.

Raymond (1993) critiques the liberal discourse on individual choice and its application to new reproductive technologies and argues that the discourse of choice is used to legitimize what she views as violence against women through invasive fertility

treatments. Roberts (1997) also questions the liberal western discourse of choice that has excluded black women. She argues that black procreation is constructed as a social problem, requiring intervention and causing infertility to be promoted among poor, black Americans. Robert's research looked at the way in which black women perceive abortion in the historical and cultural context of their racial and class oppression. In reproductive policy, black women are regularly constructed as excessively fertile and welfare dependent. Roberts shows that black women recognize that these stereotypes are used to justify policies aimed at curbing their reproduction. As a result, black women understandably view abortion and birth control as tools of state control, ultimately giving women fewer options and undermining the health of families.

Because reproduction is situated within the political economy of the most "desirable" citizens, certain social groups are viewed as more legitimate reproducers than others. It seems contradictory that cultural forces delegitimize some women's reproduction while simultaneously create barriers for these same women attempting to terminate a pregnancy. However, the practice of abortion must be placed within its cultural context, for in the late twentieth and early twenty-first century U.S., the moral debate surrounding the identity of the fetus as a person/citizen has superseded the state's eugenic objectives (Hadley 1996:6).

In her sociological analysis of abortion in the United States, Kristin Luker studies the worldviews of women abortion activists on both sides of the debate. Analyzing interviews from over 200 activists, Luker concludes that these women's position on abortion is derived from the way in which they relate to their own reproductive abilities. According to her research, women who identify as pro-choice perceive their reproductive

potential as problematic, a possible barrier in achieving gender equality. Women who identify as pro-life typically value their reproduction and motherhood above all other roles. It is a women's stake in their reproduction that positions them within the abortion debate. Luker's analysis eschews racial analysis as her interview sample consisted almost completely of middle-class white women. In her support, most women who are actively involved in abortion politics *are* middle-class and white. However, the ways in which women of "other" races, economic classes, and religious backgrounds regard abortion has been little studied in anthropology or social sciences. Important cross-cultural studies have been done, such as La Fleur's (1992) study of abortion practice in Japan and Huseby-Darvas' (1996) study of abortion and Hungarian nationalism. Also, there is a substantial body of literature that addresses the historical development of abortion in America (Joffe 1995, Reagan 1997, Staggenborg 1991). Andrea Smith's article (2005) on the exclusion of women of color, poor women, women with disabilities, and other groups of women on the periphery from both the pro-life and the pro-choice sides demonstrates the failure of the debate to include or acknowledge the classism and racism that comes to bear on women's reproductive options in the United States. The critics of choice ideology argue that a discussion of abortion needs to move beyond the reductive language and paradigms of choice versus life. We must develop a new model of abortion rights that includes a critique of capitalism and racial inequalities.

Abortion and Reproductive Rights in The United States

The Physicians' Campaign

Before the 1850's, abortions performed before "quickening" (the first movement perceived by a woman) occurred, around the fifth month, was legal in the new American states. Abortion before quickening was legal in the British common law tradition at this historical moment because of an ongoing medieval theological debate about when a soul inhabits a pregnancy (Mohr 1978:4). With the emergence of the AMA in 1847, abortion became outlawed in every state in the U.S. by 1900, what abortion scholars have dubbed the "century of criminalization" (Petchesky 1984:79). As male physicians began to practice obstetrics and, according to feminist analysis, usurp the role of the midwife, abortions became more and more taboo. The conflict between formally schooled and licensed physicians and unlicensed healthcare providers and women healers (so-called quacks), led to the AMA's drive to make performing or receiving abortions a punishable offense (Tome 1997:62). In 1851, the physician J.P. Leonard wrote in a letter to the Boston Medical and Surgical Journal:

> Abortionists are better known than they would like to be. It is said that a woman cannot keep a secret. Whether this is so or not, the man who procures abortions is generally well known. He needs no hand-bills, placards, or other advertisement: he is soon notorious. Inglorious fame! Who would sell his claim to honor and principle: who would shed innocent blood for a few pieces of silver? After a man has thus degraded himself, after he has sunk so low, can he expect to retrieve his character? Who ever knew such a man to reform? If he is susceptible to feelings of remorse, like Judas he will go out and hang himself to hide his own shame (J.P. Leonard 1851:478).

The AMA lobbied lawmakers to criminalize abortion by characterizing it as an immoral act, unsafely practiced by untrained and lascivious charlatans. The illegalization of

abortion first occurred in mid 19th century at the state level, but became federal law with the Comstock Act of 1873. The Comstock Act was essentially an anti-obscenity law that illegalized pornography, contraception and abortifacients, and abortion information as "obscene, lewd, and/or lascivious." (Comstock Act ch. 258 17 stat 598, enacted March 3, 1873). This anti-vice movement culminated at this historical moment and targeted abortion because of alarm over falling birth rates and an increase in public advertising of abortion services (Davis 1985:211). Within a fifty-year span, abortion was criminalized in America, and remained so until the decriminalization movement began to gain saliency in the 1960s, coinciding with the emergence of the civil rights movement and the second wave of feminism.

Roe v. Wade and the Hyde Amendment

On January 22, 1973, The United States Supreme Court ruled in a 7 to 2 vote that the criminalization of abortion was a violation of a woman's constitutional "right to privacy." It was ruled that, at least within the first trimester, a woman has the right to choose to abort a pregnancy. Pro-life advocates call January 22 the "day of infamy." For abortion advocates, this day is recognized as the dividing line between a terrible era when women's reproduction was controlled by the state, to a modern era in which women have control of the decisions regarding their bodies and self-determination in their reproductive lives, that is, reproductive freedom.

Roe v. Wade is paradoxical because the court's decision was based on the right to privacy, yet it thrust abortion and the life of one woman, who represented all women, Norma McCorvey (Jane Roe), into the public arena. Abortions today are often public

acts involving clinics, counselors, physicians, insurance carriers, the state Medicaid system, and protesters. The abortion clinic is a site where women who "choose" can be directly challenged. As pro-life protesters recognize, the clinic is the physical and symbolic center of choice ideology.

The contemporary relationship between the pro-abortion movement and choice ideology began in the 1980's. In the early part of the decade, "choice" was present in the political discourse of abortion advocates. However, it was after the 1989 Supreme Court decision in *Webster v. Reproductive Services* (giving states more authority to limit abortions) that the term "choice" proliferated, becoming omnipresent in pro-abortion rhetoric (Raymond 1993). On a political level, the promotion of a woman's choice has become a powerful strategy that builds upon the important category of the individual in American culture. The ideology of choice is founded on the liberal principles of bodily integrity and "property in one's own person" (MacPherson 1962:140). In pro-choice feminism, the concept of bodily integrity translates into the idea that it is essential for women to be able to control their bodies through reproductive choice in order to achieve gender equality. Adopting choice to signify reproductive freedom has, at the same time, successfully obscured the feminist roots of the issue, instead allying the pro-abortion position with capitalistic America's promotion of consumer choice. Clearly, choice ideology could not have achieved the same political resonance in a socialist state.

Before *Roe v. Wade* in 1973, the illegalization of abortion had the greatest impact on the economically marginalized: the indigent, the working class, rural women, women of color, and young women. Women with greater economic resources could have a safe abortion in another country or through the expensive services of a willing doctor. It was

primarily working class, poor and young women who were dying from the infections and uncontrolled bleeding associated with "back alley" illegal procedures (Zinn 1980). Fortunately, some doctors of conscience were providing abortions to middle class and poor women, and underground abortion referral networks, such as Jane and The Underground Clergy Counsel, were able to help many economically marginalized women find and get to a safe abortionist (Kaplan 1995). Since abortion has been legalized, class continues to affect the parameters of a woman's options, both in terms of the affordability of an abortion for an unwanted pregnancy or being able to afford to continue a wanted pregnancy. Since *Roe v. Wade*, many restrictive policies have been passed such as the prohibition of state funded abortion, parental consent laws, and waiting periods, all of which disproportionately impact poor women, women of color, and young women.

The *Roe v. Wade* decision was based on the Constitution's 14th Amendment that established a citizen's right to privacy from the state. The Supreme Court ruled that women have the right to privacy surrounding pregnancy without state intervention. Abortion was conceptualized as a private issue that should not involve the government, and, as a result, restriction on federal funding of abortions introduced by Representative Henry Hyde (R- IL) in 1976 did not conflict ideologically with the Supreme Courts findings in *Roe v. Wade*. Medicaid covered abortion services without restriction for the three years between *Roe v. Wade* (1973) and the Hyde Amendment. When it came time for the Supreme Court to consider the right to public funding for abortion, the pro-abortion movement's argument of abortion as a right based on individual privacy contingent upon the exclusion of the governmental proved to be catastrophic. Consistent with the way the Supreme Court ruled in other privacy contexts, it concluded that the

right to an abortion only entitles women to be free from state interference when exercising that right, but women were not entitled to financial assistance from the state in order to obtain one (McDonagh 1996:108). The right to abortion in the U.S. is a negative right, meaning that this right requires state inaction or noninterference. *Roe v. Wade* did not establish that women have a right to abortion, but rather, that women had the right to not be coerced by the state regarding the private issue of a pregnancy. Thus, public funding of abortion was rejected because lawmakers did not consider abortion a positive right, or one that is ensured by the action of the state. When the Hyde Amendment first passed in 1976, Medicaid would not longer cover elective abortions, but it continued to cover abortion services for women who were raped, victims of incest, when their life was endangered, or when their physical health was threatened. In 1979, the physical health exception was dropped and in 1981, rape and incest were also excluded (NAF. 2005a:11).

Restrictions on Medicaid funded abortions "successfully tapped into a vein in middle ground public thinking that women should not be allowed to get away with something (that is, sex) and expect a free ride" (Hadley 1996:7). It was this welfare argument, more than the rights of the fetus, which lead to Medicaid's restrictions on elective abortions. Congressional supporters of the Hyde Amendment thought that tax money should not be used to pay for women's abortions. Nonetheless, this is clearly not a financial argument because first trimester abortions cost around $400 while deliveries cost $4,000 dollars and more. When poor women are considered "problematic" reproducers it follows that their sexuality is de-legitimized. Women in the United States who are the least valued "reproducers" are also perceived to be the least deserving of abortion access. In this case the problematic reproducer is the least valued citizen, and

the appropriate reproducer is the most legitimate citizen. It could be argued that problematic reproducers have less access to abortion services because their rights/social value does not supersede that of the fetus/baby. In Christian America, the fetus is privileged (McDonagh 1996:172). Representative Martin Fusso, a Democrat from Illinois, supported the restriction of federally funded abortion. He said,

> Eliminating the source of funds [for abortion] may tip the balance toward bringing the child into the world and I believe in tipping the scales in favor of life almost every time...if Medicaid money were unavailable for this purpose [abortion] . . . [t]hat would save approximately 240,000 lives every year (McDonagh 1996:167).

By "tipping the scales in favor of life," the Congressman is not considering the life circumstances of the pregnant woman, only the survival of the potential child. According to the Alan Guttmacher Institute, restricting federal funds for abortion does prevent women from receiving abortions: 20-30% of Medicaid-eligible women who would chose to end a pregnancy will carry a pregnancy to term when public funds are unavailable (Boonstra and Sonfield 2000).

New Mexico is one of only a handful of states where Medicaid covers abortion procedures. New Mexico adopted an Equal Rights Amendment in 1973. In November 1998, the New Mexico Supreme Court ruled (5 to 0) that the state could not refuse to pay for abortions because there was no equivalent medical procedure for men that was excluded, and this was prohibited by the ERA (NM Right to Choose/NARAL vs. Johnson No 1999 – NMSC 005). Beyond class, access to reproductive choice is also impacted by the policies of each state, regional differences, ethnicity, race, and knowledge. For all women, choice has been compromised by the ability of the anti-abortion movement to assume the moral high-ground and become the most vocal side of the debate. As one co-

worker stated, “It’s a miracle that women get their abortions at all” (Clinic field notes:11/24/2006).

New Mexico is one of eleven states with more liberal laws regarding Medicaid coverage of abortions. NARAL Pro-choice America gave New Mexico a B+ on the 2006 Report Card on women’s reproductive rights. This is not a bad grade considering the grades of other poorer states such as Mississippi and Kentucky received Fs. New Mexico is somewhat of geographical anomaly with Arizona earning a C+ to the West, Colorado a D to the North, and Texas an F to the East (NARAL 2006:32, 35, 73).

The State’s Investment: Fetal Personhood vs. Women’s Rights

Women’s experiences of reproduction are profoundly shaped by cultural ideologies and practices; however, women reproduce within the context of the modern state. As a result, reproduction cannot be aptly considered outside of state policies that construct and control the parameters of local practices. The state is a modern regime of power as deeply invested in controlling women’s reproduction as it is tied to ideas about population and social worth.

> Among the primary goals of the modern, post-Enlightenment state are assimilation, homogenization, and conformity within a fairly narrow ethnic and political range, as well as the creation of societal agreement about the kinds of people there are and the kinds there ought to be (Nagengast 1994:109).

The state functions to promote an idealized society by encouraging or dissuading certain practices, this includes practices concerning women’s reproduction. State intervention is motivated by socially constructed beliefs surrounding desirable citizens, appropriate sexuality, and the imagined future of a nation (Anderson 1983).

When the Supreme Court ruled on *Roe v. Wade*, it decided that an embryo or fetus, at least in the first twelve weeks of pregnancy, was not a person "in the whole sense," and was therefore not yet entitled to the law's protection. Personhood is an important concept in the analysis of women's reproductive choice because it relates to ideas about societal membership and who has rights to laws and protection (Fogelson 1982; Fortes 1987; Morgan 1989). The concept of personhood informs the cultural production of knowledge regarding pregnancy, fetuses and infants. Personhood is a social birth that gives moral status and membership into a community. It is a function of "cultural divisions of the life cycle, attitudes toward death, the social organization of descent and inheritance, and social systems of authority and achievement" (Morgan 1989:24). A cross-cultural perspective shows that the beginning of life and personhood are a function of who society considers a person, under what conditions, and why. Personhood is a social status that can be conferred before physical birth, such as by members of the U.S. pro-life movement, it can occur at the moment of physical birth as in orthodox Jewish law, or it can occur several weeks to even years after birth. Or, personhood may not be conferred at all, even to an entire group, such as during the Spanish Conquest of what is now Mexico and New Mexico, when the Catholic Church doctrine held that Native Americans did not have souls and were therefore not human (Pescatello 1973:26). Because some Americans confer personhood at the moment of conception, for them, a fetus becomes a citizen within a citizen. Some states have implicitly adopted this ideology by charging the accused killers of pregnant women with two felony murders. This legally establishes a fetus as a citizen deserving of state protection.

The federal and state government is currently attempting to change the legal status of the fetus at both of these levels. The state has begun to expand its control over women's bodies by extending the definition of personhood to fetuses as they are now being legally constituted as victims of crimes. At the federal level, in April of 2004, the House of Representatives passed the Unborn Victims of Violence Act, also called the "Laci and Conner's Law," which for the first time gave embryos or fertilized eggs in the womb legal rights equal to and separate from the pregnant woman. This law would impose the same penalties for injuring or killing an embryo or fetus in an attack as for harming a pregnant woman. The bill defines an "unborn child" as "a member of the species homo sapiens, at any stage of development, who is carried in the womb" (Kaiser Daily Reproductive Health Report 2005:1). The legislation exempts legal abortions, but opens the door to the legal embodiment of the fetus. For pro-choice advocates and the ACLU, the Unborn Victims of Violence Act is a dangerous effort to separate a woman from her fetus in the eyes of the law and it threatens the foundations of *Roe v. Wade*.

Looking at the way the U.S. government promotes its agenda through reproductive policy, I have come to conceptualize abortion as a state's rights issue because most abortion laws are decided at the level of the state. For instance, each state has different laws regarding waiting periods, gestational limits, Medicaid coverage, and parental consent. If *Roe v. Wade* were to be overturned by the Supreme Court, it would be up to each individual state to determine the legal status of abortion. The U.S. is currently undergoing a war of definitions as policymakers attempt to legally constitute a pregnancy as a citizen through "Fetal Protection Laws." Through such laws, protection of an embryo is constructed as a positive right, making it the state's obligation to protect.

The state can enforce stricter control of pregnant women and continue the assault on the ever shrinking right to abortion in the United Sates.

Stratified Reproduction and the State's Interest in the Womb

The concept of stratified reproduction supports the notion that women do not simply choose from a variety of available options. Rather, reproduction is constrained and promoted by very real forces of the state. A woman in Milwaukee, convicted for her role in the dehydration death of her infant daughter, was ordered by a judge in 2001 not to have any more children without permission from the court or her probation officer. The sentence came after the Wisconsin Supreme Court ruled that the state could bar an individual from having additional children under some circumstances. According to the judge, it was "the best for society" (Milwaukee Journal Sentinel 2001).

Kim, a client at the Powell Clinic, was also deemed an inappropriate reproducer by the state. In May of 2006, I interviewed Kim, who was then an eighteen year-old woman. She identified as Hispanic and she grew-up and lived in Albuquerque. She had twins when she was fifteen years old. She discussed with me how the state coerced her to have an abortion in order to regain custody of her children:

> With my first abortion, the state had taken my kids. I was living with my Mom and all this other stuff happened. So, they took my kids, and this guy I was with, I ended up getting pregnant. They had me hooked up with a counselor, because I was going through all these problems being away from my kids. Then when I ended up getting pregnant I thought, oh look, I can show you all that I can actually take care of my kids. They were like, if you have that baby, you are never going to get your kids back. If you have that kid, it is just another one you have to take care of, and you're only eighteen. They were always, you're only eighteen. I'm like, yeah I am only eighteen. Let me get my life started. My counselor, I thought she was with me through the whole thing. She said, "it is

> whatever you want to do." I said I didn't want to have an abortion and she was like "you have to Kim. You just have to do it. I'm going to set you up an appointment." I felt betrayed by her too because she was supposed to be on my side (Kim, client interview:5/16/2006).

Kim's story reveals that women's reproductive decisions are not always actual "choices," but occur within the context of the power of the state. Kim felt that she was forced to have an abortion. The state has, based on its interest, both promoted and deterred women from terminating a pregnancy. Absent from this dissertation are the voices of women who wanted to terminate a pregnancy, but were deterred by coercive forces, the state, her family, or misinformation. These are women I never had the opportunity to interview.

Conclusion: the Structure of the Dissertation

This project will contribute to the growing body of literature that addresses the politics of women's reproduction (Ginsburg and Rapp 1995; Holmes 1992; Hubbard 1990; Martin 1987). In Chapter 2, I discuss the Powell Clinic in Albuquerque, New Mexico. I introduce the ideological founders of the clinic, Dr. Clifford and Dr. Roberta Powell, and the clinic staff. I explain the research methods used to conduct the research and the conflicts and obstacles encountered during the process. In Chapter 3, I discuss the national, state, and clinic specific abortion rates. I also provide statistics on the study participants as well as a biographical sketch of the abortion workers interviewed. Chapter 4 provides an explanation of the abortion procedure itself in order to establish the context for the experiences of the participants. Because both most women deciding to end a pregnancy and the general public are unaware of the methods used to terminate

pregnancies, I explain the Mifeprex abortion (*i.e.*, RU-486) and first and second trimester surgical procedures in order to demystify the practice. I present information on the relative risks of abortions and the consent provided to each woman who walks through the Powell Clinic doors. I also discuss the relative costs of different abortion procedures at the clinic and the coverage provided by private insurances and New Mexico Medicaid.

Chapter 5 shifts to the other side of the debate and outside of the clinic walls to the protesters who stand on the sidewalk every Saturday morning. I analyze the language of the pro-life advocates and the ways that women who come to the clinic feel about their presence. Chapter 6 focuses on the alternative narratives to choice that are employed by women terminating a pregnancy. In this chapter, I explore the ideological beliefs of women and how women in New Mexico articulate their abortion experience. Chapter 7 focuses on participants in the study who identify as pro-life before and after having an elective pregnancy termination. According to CBS/New York Times polls, the support of legal abortion dropped significantly among young women from 1993 to 2005, yet abortions rates changed little, leading to the assumption that more pro-life women were terminating pregnancies. Some participants understand their abortion experience in terms of the specificities of their own pregnancy, and they view that as different from their moral beliefs about abortion. In Chapter 8, the conclusion, I look at the issue of the illegality of abortion and outline the social justice model for reproductive rights. Such a model would include the perspectives of marginalized women and redirect the language of abortion proponents away from choice toward reproductive justice and the wellbeing of women and families. In the conclusion, I recommend alternative ways to think about abortion and discuss the future of abortion access in the United States.

CHAPTER 2
Conducting Research at an Abortion Clinic

> *[M]y intention is to emphasize a seemingly obvious, yet largely undiscussed aspect of the abortion issue – that the actual delivery of abortions cannot take place unless some persons are willing to view this phenomenon as their "work."*
>
> - Carole Joffe in *Doctors of Conscience: The Struggle to Provide Abortions Before and After Roe v. Wade* (1995:6)

Becoming an Abortion Worker

I began working as a counselor at the Powell Clinic in 1996 after having moved to Albuquerque a year earlier. I met a woman through the local women's soccer league who worked at the Powell Clinic. When we would meet for coffee, she would talk about her experiences at the clinic and I was drawn to the women's stories. I came to identify as pro-choice in high school when a progressive English teacher in my town in western Pennsylvania recommended that I read John Irving's *The Cider House Rules* (1985). I was an inquisitive 15-year-old. From reading this book and the discussions that followed with my parents and English teacher, I came to a consciousness about the morality of abortion. During my senior year, as the daughter of an outspoken and liberal Presbyterian Minister, some classmates viewed me suspiciously when the "other" Presbyterian Church in our town publicly accused my father of being "pro-death." The story is this: during a convocation for the memory of women killed by illegal abortion held at the local state university on the anniversary of *Roe v. Wade*, my father said he believed abortion to be a moral option for women. This was printed in the local

newspaper. In response, a representative of the Redstone Presbyterian Church, directly across the street from my father's church, called the newspaper, and stated, "the Reverend is promoting the killing of innocent lives." Two churches of the same denomination, two hundred feet separating them, were utterly divided by the abortion issue. I spoke with my parents about my cohorts' condemnation, and they explained abortion to me as a very personal and spiritual issue: a decision between a woman and her God.

Later, an undergraduate history class gave me a more theoretically framed pro-choice position. I began to view abortion as more than just a spiritual issue. I saw it inextricably linked to women's equality. Reading Howard Zinn's *A People's History of the United States* (1980) expanded my intellectual curiosity and commitment to a pro-choice stance. Zinn writes,

> Before 1970, about a million abortions were done every year, of which only about ten thousand were legal. Perhaps a third of the women having illegal abortions – mostly poor people – had to be hospitalized for complications. How many thousands died as a result of these illegal abortions no one really knows. But the illegalization of abortion clearly worked against the poor, for the rich could manage either to have their baby or to have their abortion under safe conditions (Zinn 1980:422).

Abortion became for me a social justice issue. When abortions are illegal, marginalized women have a higher risk of dying from abortion related complication. If a child is born, these same women, strategizing from the economic periphery, are more likely to experience higher poverty levels, most especially single mothers (Graber 1996:40). I began to understand how abortion restrictions had a differential impact on poor women.

My Positionality as Researcher and Abortion Worker

Like Ginsburg and her exploration of abortion activists, I was “both curious anthropologist and concerned native” during my research (1989:x). However, I make no claims of objectivity regarding abortion. Ginsburg goes on to write “I have made every effort to respect the integrity of both positions in the abortion debate, as I understand them . . . It is not my place or task in this book to take a partisan position” (1989:xi). Because I had worked at the Powell Clinic for almost ten years at the time of my research project, I doubt I can honestly make claims of bipartisanship, as I am earnestly established in the pro-choice camp. The fallacy of the objective observer has been fully deconstructed by postmodern and post-colonialist analysis in anthropology. I have adopted the language of the pro-choice movement in this dissertation. For instance, I have used the term “pregnancy” over the pro-life term “baby.” I sincerely hope that I have respectfully presented the philosophies and beliefs of pro-life activists as well as women who come to the clinic that identify as pro-life.

In her study of gender identity, Butler (1990) argues that people's coherence and continuity are not "logical or analytic features of personhood, but, rather, socially instituted and maintained norms of intelligibility" (Butler 1990:17). For Butler, identities are socially constructed units with conferred membership, but each identity construction is grounded in different coherencies. Identity denotes an individual’s particular history in power-laden interaction of the everyday. It is not a fixed thing, but shifting, negotiated, and culturally manufactured. My identities as an anthropologist and abortion worker are constantly being re-negotiated. Even as I write these words, I am recreated in the text – my anthropologist and abortion worker selves working in tandem.

When I discussed my dissertation research with my father in 2004, he told me that he and my mother had seriously considered having an abortion when she became pregnant for a third time, almost six years after her last child had been born. The salary of a small-town minister and a special education teacher did not go very far in 1970, and my father told me he had a doctor in his congregation at the time that "helped women." During the week they were discussing their options, unexpectedly, my mother's aunt sent them a check for one hundred dollars, a lot of money at the time. According to my father, they took it as a sign that they could manage to have another child. I am not bothered, nor ashamed that my parents considered having an abortion when my mom was pregnant with me. It provides an interesting twist in the experience of being an abortion worker and conducting this research. Mostly, I am thankful that my parents had options to deal with an unintended pregnancy in 1970, and that they could choose to enter into parenthood with joy.

When my soccer league acquaintance mentioned that there was an opening for a counselor at the clinic and that she thought I should apply for the position, I believed it would be an excellent way to activate my politics while working my way through graduate school. The wage I was earning as a waitress at a small breakfast and lunch place in downtown Albuquerque was insufficient and I was interested in a change. Prior counseling experience was not required, but a bachelor's degree was. I had no counseling experience, but the clinic manager at the time explained that all training around abortion counseling, birth control, and patient care would be provided by the head counselors. During the eight-month training period, I was taught the goals of the counseling session, the philosophy of the clinic, and the focus on "complete" patient care.

During my first year at the clinic, all of my stereotypes about women who have abortions were challenged. Although I supported a woman's right to choose on a political level, I had certain ideas about women who have abortions. In someway, I imagined that they must be sexually active, bordering on promiscuous. I imagined that these women were not using birth control. I imagined that they probably made bad decisions in their lives, and that they were not very educated about their bodies. I imagined that they were not necessarily politically active, but that they identified as pro-choice. All of these imaginary thoughts were shattered when I began to talk to the women actually living the political quagmire. Women who came to the clinic were sometimes mothers or grandmothers, educated women on birth control, devout Christians, teachers, feminist women, and women who identified as pro-life. During my training, a licensed counselor named Lola Samuels explained to me succinctly that the kind of woman that gets an abortion is the kind of woman who ovulates. In other words, women from all walks of life decide to end a pregnancy. Before becoming a counselor at the clinic, I did not realize that I had held those stereotypes until I came face to face with the everyday practice of abortion and was somehow surprised by what I saw.

My anthropological career and my work at an abortion clinic of course informed each other, but these two realms remained relatively separate until my participation in the Medicaid Managed Care (MMC) project in 2000. This was a collaborative study between the anthropology department and the department of Family and Community Medicine at the University of New Mexico. The MMC project investigated the impact of the privatization of Medicaid by the State of New Mexico. In 1997, New Mexico privatized Medicaid following a recent trend over the last decade in which large, for-

profit corporations were contracted to take over state obligations. The Medicaid managed care (MMC) program, called Salud!, was instituted in Bernalillo County, where Albuquerque is located, in July of 1997. While working at the Powell Clinic, I noted an obvious increase in logistical problems experienced by women covered by Medicaid during the first few months after privatization occurred, issues which continue to this day. After I joined the MMC project, I interviewed some abortion clinic workers about the way Medicaid converge requirements had changed with the privatization of Medicaid. Specifically, I investigated the way in which privatization had created new barriers for women, such as increased paperwork which caused delays, transportation and privacy issues, and differential treatment during counseling sessions (Adams 2001). From this experience, I began to formulate my dissertation research. Abortion is such an illuminating window through which to view American culture. The struggle to define beliefs about personhood and the rights of the fetus makes abortion a "condensational" issue in the United States, akin to euthanasia and capital punishment (Fried 1988:178). As such, abortion touches on cultural issues such as life and ethics, the role of the state, and gender norms.

A History of the Clinic

Doctor Powell opened a clinic in Santa Fe in June of 1972 shortly after abortions were legalized in New Mexico (prior to *Roe v. Wade* of 1973), then he opened a clinic in Albuquerque thirteen years later as a more central location in the state. From 1985 through 1994, the Powell's had clinics in both Santa Fe and Albuquerque. For a few of those years, staff members would work in the mornings in Albuquerque and then drive an

hour north to Santa Fe for afternoon appointments. In 1994, the Powell's closed the practice in Santa Fe because the Santa Fe clinic's doctor resigned.

Doctors Clifford and Roberta Powell are well known among abortion providers in the United States. Both have served in leadership positions for national organizations, including the National Abortion Federation (NAF). Dr. Clifford Powell is an M.D. and Dr. Roberta Powell is a Ph.D. in developmental psychology. They met in Dallas, Texas shortly after the *Roe v. Wade* decision was handed down in 1973. Dr. Clifford was planning to open a clinic in the Dallas area and wanted to develop a counseling program for women specifically around abortion decisions. Because *Roe v. Wade* had just made abortions legal in all states, there was no existing paradigm for abortion counseling. The Clergy Consultation Service on Abortion, which began in 1967 in New York City, approached abortion counseling only from a spiritual model. In psychology, abortion counseling was brand new and uncharted territory. The Powells worked together to develop an abortion counseling model, which is still taught to the counselors today. Dr. Roberta explained the evolution of her counseling model:

> I started with the assumption that this was a trauma in women's life and that I was essentially doing crisis intervention. So, I started with a crisis intervention model. It quickly became apparent to me that most of the women we were counseling, once abortion had become available and legal, did not experience this as a crisis in their lives necessarily. Or they did not consider it any more of a crisis than a lot of other things in their lives. The crisis was if abortion wasn't legal, and you were going to have to arrange for an illegal procedure or have a child that you were not prepared to have. That was the crisis, the pregnancy was the crisis! Not the abortion (Roberta Powell, staff interview:11/15/2006).

Dr. Roberta recognized that women who came to the Dallas clinic for an abortion were averting a crisis, not necessarily experiencing one and she shifted her approach to

abortion counseling. Because Dr. Roberta did not find women having the experience she had expected, she revisited her abortion counseling paradigm and adopted an existential approach. She said:

> So, I then shifted to what I was schooled in, which was my more natural inclination to work from an existentialist model and to emphasize the particular individual's meaning of the events, the pregnancy, the termination of the pregnancy, what was going on in this relationship, as the focus of the work (Roberta Powell, staff interview:11/15/2006).

Shifting from a crisis model to an existential model allowed Dr. Roberta to view women as moral agents rather than passive victims. The abortion counseling developed by the Powells is also informed by the feminist health movement in the tradition of *Our Bodies, Our Selves* (Boston Women's Health Book Collective 1971), which educates women about reproduction and demystifies medical information and terminology. The clinic was created in order to provide total care for women, both medical and emotional, as they underwent an abortion procedure.

Clifford Powell's Beginnings as an Illegal Abortionist

Dr. Clifford Powell, who is now in his seventies, was raised in a white, working-class, extremely religious Baptist home in rural Texas. When he was in high school and very active in his fundamentalist church, Clifford was thought to be a "prophet" by many of his congregation for his knowledge of scripture and preaching abilities. After graduating from high school however, he decided to go to medical school rather than seminary. After graduating medical school, he returned to his hometown with his first wife and opened a family practice with a friend from medical school. He lived what he describes as a "normal and unremarkable life." Then he became involved in the civil rights

movement in the late 1960s and began a journey fighting for human rights, which almost 50 years later continues.

When Dr. Powell began to perform abortions prior to *Roe v. Wade* in his small Texas town, it was because he felt that it was his moral obligation to help desperate women with unintended pregnancies. For Dr. Powell, his abortion work was and still is linked to human rights:

> Abortion work for me started out of the human rights movement that I was involved with in the Sixties - political reform. I was very active in both the civil rights movement and other human rights issues, fairness, employment issues. It was about a fair society and a just society. That is when I became aware of the women's movement. I learned about it mostly in California and the women there. So, that was another human rights issues. Needless to say, it had never been at the forefront of my thinking before that time. Then abortion began to be an issue. The Unitarian Universalist Association had been working on abortion reform and I, being a member of the Unitarian Church, began to offer advice to some of the ministers. That is where it started. Then it went on to the Clergy Consultation for Problem Pregnancies, which developed into a whole range of not only various Christian denominations and the Unitarian Universalists, but also some rabbis and others. That is where it developed, from general human rights issues and political reform (Clifford Powell, staff interview:11/15/2006).

Like many abortion activists of the time, including those involved in underground referral organizations, Dr. Clifford's beliefs and commitment to helping women came from a spiritual place and began from his involvement with the Unitarian Church. It is one of the many hidden histories of the abortion rights movement that a significant number of the organizations that pushed for legalization in the late 60's and early 70's were faith based.

> The Unitarian Church at that time had very active social action programs, so I was involved with their social action all the time. Abortion work came up. They were trying to send women to different countries, to safe places and trying to change public attitude, have legislation enacted. It

> was that kind of action. I had no intention of providing abortions prior to that. Then it happened. I began to see the need. That is where it became so apparent, how great was the need and how important this was to women. It was a central issue to their place in society and equality. It was hard to go out of the country and it was expensive (Clifford Powell, staff interview:11/15/2006).

Before *Roe v. Wade*, women of means were able to travel outside of the United States for procedures in such places as Puerto Rico, other Caribbean islands, some to Mexico, and Japan. However, women without the financial resources or young women without familial support had few safe options.

When Dr. Powell became active in his church's efforts to help women, it was originally as an organizer. As he stated, he never intended to provide abortions. But, once he began to see the human element and the profound need, he was driven to act and become more involved in helping the many women who were pregnant and desperate not to be.

> Once I began to hear all these stories, I began to think, I could do this, I could help with this. Then, it began to get hard to say no to desperate women who couldn't get out of the country to get an abortion. Even if they had the money, they couldn't manage because of confidentiality, children or other issues. It was often too frightening for them to go to the Caribbean or to Mexico, but of course, having one in the United States was high risk too. Still, it was more than they could manage. The need just became so apparent to me, and the importance of it. Hearing all of these stories. I began talking to these women and I felt compelled to do something (Clifford Powell, staff interview:11/15/2006).

In many ways, the risks were too great for his practice and his family, particularly his three small children. There was always the possibility that a woman would suffer complications from a procedure. Besides the fact that Dr. Powell did not want to cause women harm, he could have been prosecuted, lost his license, and spent time in jail, in

which case his family would have no financial provider. If a patient died, Dr. Powell was very aware that he could be charged with murder.

> So, the only ones who knew were the very closest of friends and my wife. They tried to talk me out of doing it. They said "stop this foolishness" (Laughs.) (Clifford Powell, staff interview:11/15/2006).

When he was providing illegal abortions in a small Texas town, Dr. Powell faced very real dangers. He never intended to make this his life's work, but when he trained himself and performed his first abortion, he opened the flood gates to the thousands of women across the United States seeking a medically safe, financially obtainable, and respectfully performed abortion. Word of mouth and the clergy referral organizations began a steady stream of calls and after hour appointments. Many of his referrals came from the Clergy Consultation Service. In 1967, a Baptist minister from New York named Howard Moody started the Clergy Consultation Service on Abortion. Around this time, Harris Wilson, a Baptist Chaplin at the University of Chicago, also started an abortion referral and education group. These faith-based organizations branched out across the country and a clandestine nation-wide referral system was actively locating physicians, raising funds, and arranging transportation, and counseling women.

The residents of Dr. Powell's Texas town began to "talk" and his friend and long time medical partner left their practice because of fear and moral objection. Most of the town's residents ignored the caravan of VW buses through their cornfields, and thankfully, so did the law.

> That was a fearful time. You get involved in the day's work. Once you began doing it, that was the big thing, my family practice began to go by the wayside. Once I began doing, the need was so great, it was almost impossible to meet the need. I had women coming to see me from all over the United States, Mexico and Canada. They came in hitchhiking, by bus,

> by train, by Volkswagen, anyway that they could get there. They were referred by ministers, and many of them were university chaplains. These women would find their way to this little medical practice in East Texas. They were taking their chance that they were getting good information and that things were going to go well. The need was so great and the calls came in at such a rate that I could never see everyone (Clifford Powell, staff interview:11/15/2006).

The reality that he could go to prison at any time was not a deterrent for Dr. Powell. He was driven by a social justice consciousness that told him that the benefit outweighed the risk. If he could prevent one more death from a botched abortion or one more woman's life being ruined by having an unwanted child, he would do that. Dr. Powell vividly remembers the 1960s, when half of the women in the obstetrics and gynecology hospital wards were there because of infection, bleeding, or the incompleteness of a clandestine, unprofessional abortion. For Dr. Powell, the illegality of abortion was the direct cause of the need, and he had to take the risks:

> At that time, the risks weren't really calculated. You're young and you are enthusiastic about changing the world and making it a better place. You can think abstractly about going to prison, but I was just very naive. I thought, well, if I go to prison there are a lot of good books that I want to read (Clifford Powell, staff interview:11/15/2006).

With the help of a dedicated nurse and the liberties allowed by having his own practice, Dr. Powell began helping women from all over the country. His calling as a prophet to the Baptist church went unfulfilled and members of his family were disappointed that he was doing what they believed to be unspeakable things. Abortions had been happening all over the United States for generations, now a practitioner of western medicine was doing them in Heartland County, Texas. Later in his career, Dr. Powell learned something about his family tree.

> Actually, abortion would have been more OK then than it is now. It wasn't so much a religious issue. It was out of sight, so people didn't talk about it. It was really a taboo issue. It was part of women's secret society. It went on but it was not something that had an active opposition like it has now. I came to find out later…there was a documentary made about me and my family was watching it and my brother-in-law came over to me and whispered in my ear "You are not the first one in your family to do abortions." I found out that my grandmother, my maternal grandmother, had done abortions as a midwife. Of course, she was a powerful maternal figure for me (Clifford Powell, staff interview:11/15/2006).

Like his grandmother, Dr. Powell performed abortions in a clandestine way, reducing most public scrutiny or objection.

When *Roe v. Wade* was handed down on January 22, 1973, Dr. Powell, divorced from his first wife, had moved his practice from his hometown in Texas to Santa Fe, where abortions had been legalized prior to the federal ruling. He describes that day:

> It was a powerful feeling. I was in the clinic that day doing work and this wave of relief came over me. Tears began to roll down my face. It was such a powerful emotion. I thought, it is over. I thought that the struggle we had been engaged in had been won, this constant fear of a terrible outcome. I hadn't realized how much fear I had until it was suddenly gone. I always had fear that I was going to be arrested. I always had the fear that a woman was going to die, because then it is murder. I don't have any defense for that. I can't argue that I didn't do it. If a woman dies in the office, if she dies from the abortion, then I am going to be charged with murder, not just the abortion. It was that constant fear for my own safety, my family, and my children (Clifford Powell, staff interview:11/15/2006).

The *Roe v. Wade* ruling was beyond the abortion movement's wildest dreams. No one who supported abortion rights thought that the illegality of abortion would suddenly be overturned. Dr. Powell and others committed to preventing dangerous and exploitive abortions believed that the struggle for legalization would require many more years of struggle and legal strategizing.

> I didn't really expect…this ruling gave us more than we ever expected. It was just incredible. They just overturned it. No one believed that there was going to be a favorable ruling on this. Nixon had just made some appointments. It was more than we had hoped for. There was a tremendous sense of relief. It was the first time in history that women had been involved in the decisions made about abortions. The church had decided, the governments had decided, doctors and hospital committees had decided, husbands had decided. No one had thought to ask a pregnant woman. That was revolutionary (Clifford Powell, staff interview:11/15/2006).

Roe v. Wade gave women the right to decide the outcome of a pregnancy, but this once very private process was wholly transformed by legalization into a very public act. The legalization of abortion in the U.S. leads to the creation of the abortion clinic, where anti-abortion activists could target both abortion workers and women having abortions.

The Ghettoization of Abortion Service

When the *Roe v. Wade* decision came into effect, the many brave doctors, lawyers, clergy, and individuals who stood for abortion rights breathed a collective sigh of relief. They would no longer have to send scared young women to other countries for procedures or smuggle them like contraband across state lines. There would be no more fear. The expectation that legality would translate into acceptance and access was soon recognized as naïve. Most of the doctors and medical professionals who were illegally helping women before *Roe v. Wade* anticipated that abortion, as a medical procedure, would be incorporated into everyday medical practices. Dr. Powell and his like-minded colleagues imagined that the clandestine clinic would be a thing of the past. Dr. Powell explained:

> My feeling was that initially there was a need for clinics and eventually there was not going to be a need for them. It was going to become a part

> of medicine. It is now legal. Women would go to hospitals for the service. I thought, it is over, the struggle. I found out that it wasn't over. The struggle had changed. In some ways, for me it became more difficult to provide abortions. I did not have the same risk (Clifford Powell, staff interview:11/15/2006).

With *Roe v. Wade*, Dr. Powell thought that his struggle for abortion rights and the dangers he faced while performing illegal abortions were a thing of the past. Instead of the battle ending, the fighting became more intense: death threats to doctors and their families, clinic fires, angry mobs, and mountains of hateful mail. Dr. Powell had been scared to go to jail before *Roe. v. Wade,* but after abortion became legal, he feared for his life and the life of his family. Abortion services remained separate from "normal" medical care. In 2001, there were 5,801 hospitals in the United States. A study by the Alan Guttmacher Institute found that only 603 (slightly more than 10%) of these hospitals provided abortion services (Guttmacher 2002:7). Since *Roe v. Wade*, the vast majority of abortions in the U.S. have been preformed in outpatient clinics. Approximately 93% of U.S. abortions are performed at clinics, five percent at hospitals, and two percent at private physicians' offices (Guttmacher 2009b).

Dr. Sara Dunn, a white woman in her early sixties at the time of the interview, began working with Dr. Powell a few months after *Roe v. Wade* was passed. She first began working as both a family practice physician and abortion provider but eventually ended up providing only abortions because of the great demand. Dr. Dunn identifies herself as a spiritual woman, the daughter of a staunch Presbyterian Minister. While providing at the Powell Clinic, she was either reading a theology book during her breaks or stitching a quilt. She told me that providing abortions makes her feel "significant" and

closer to God. In a statement she made for an organization called Physicians for Reproductive Choice and Health, Dr. Dunn said:

> I continue to do abortions after 25 years because the voices of gratitude and relief from my patients drown out the hatred and intolerance from the protesters outside. In the small still hours of the night I am at peace with myself and with God, who gave me this mission in life (Why I Provide Abortions 2005).

Like Dr. Powell, Dr. Dunn had never intended to become an abortion provider. She opened a family practice clinic, but the extreme need for willing providers after legalization lead her to work full time with Dr. Powell. Dr. Dunn explained how she became involved with abortion and what she had expected to occur after legalization:

> The minister of the church came out one day and said that there is a doctor in Dallas that needs help, and, would you consider it. I said "Oh, yea, sure." (Laughs.) Little did I know. I thought it was...I thought all the doctors would be like, all right, its legal now and we are all going to do them. I thought I would be just one in a chain of many doctors doing them. So I went down, and I met Clifford, and he taught me how to do them (Sara Dunn, staff interview:04/08/2006).

Abortion services remain ostracized from standard medical care. Because abortions are rarely performed in hospitals but more commonly in free-standing clinics, this isolates both women who have an abortion and abortion workers from "legitimate" medicine, making them easier targets for violence and protest.

Guiding Philosophy

Although the Powells have been the target of hate crimes, they strive to continue to embrace a philosophy of love and joy, and this translates into respect for the clients. The clinic manager, Jill Rue, discussed the philosophy that guides the clinic:

> Well, Dr. Powell believes in a culture of love, and in a culture of love, he believes in supporting the best aspects of people. We work with each other as an organization helping each other succeed and work with our strengths and allow for weaknesses. I think that is a really important thing. Also, in treating each other and our patients with dignity and respect. That is the clinic's way, Clifford's philosophy in practice. It works here and it feels really good…Unfortunately, I think it is unique for an abortion provider. I think it is unique for most providers of health care. We approach a woman as an individual, and care for her both physically and emotionally (Jill Rue, staff interview:12/06/2004).

The clinic's philosophy is grounded in the liberal Unitarian Universalist belief in the moral obligation of dignity and respect for all people. More recently, the Powells have drawn philosophically from the book *Emotional Intelligence* (Goleman 1995), and have recommended it to many of the staff. Emotional Intelligence is a set of socially based skills that enable an individual to successfully and morally negotiate the world. During the smaller weekly staff meetings (when the Powells are not present) and the larger monthly staff meetings (when the Powells are present and the meeting is all day long), the clinic staff discussed how to make the clinic better, both logistically and emotionally. The clinic staff was very close, with some conflict between workers, but mostly a harmonious group. I believe this is true because the workers are united by a common cause. The clinic staff was always very protective of one another, united by the dragon outside the city walls. Furthermore, the Powell Clinic was considered by the staff to be a very sacred place, where abortion is a right of passage. The women who have walked in through the clinic doors are profoundly transformed when they walk out of them. The religiosity of the Powell Clinic often surprises clients, where women are offered prayer and ceremony are held. The 2007 fire was so devastating to the staff because the clinic itself was much more than just an office building. It was a sacred space.

Staff Politics

The clinic staff was all motivated by an ideological commitment. Essentially, you must be committed to a cause in order to deal on an everyday basis with fears about safety and living in the "abortion worker's closet." Many staff members have children, and live with the fear that parents of their children's friends or classmates will find out what they do for a living. One staff member had been at the clinic for three years and had told her mother only that she worked in a doctor's office to avoid the conflict she would have with her parents. Other staff members were "out" to their friends and family, and many were supported. The staff members worked at the clinic because they believe that they were providing a critical service. For Dr. Sara Dunn, who had been performing abortions for over 30 years, her involvement came in response to the suffering she witnessed when abortion was illegal.

> I had a block on the gynecology floor. I think the floor was half full of women who had problems from abortions…It was before *Roe v. Wade*. They all had infections and were severely ill. Some women had stuck things up them and, to me it was just horrifying, but yet I felt so bad for them. I think then my whole attitude was changing then about abortions. Or, maybe I was just coming up with an opinion about it. In Pennsylvania at that time, if you could get three doctors to say that you needed an abortion, then you could have one. So, the very wealthy women came in to a private floor at the medical hospital and they had their nice little D and C done (dilation and curettage) and they would be fine and everybody else was having septic abortions. I didn't plan to become an abortionist, or anything. I was going to be a pediatrician (Sarah Dunn, staff interview:04/08/2006).

The individuals who worked at the clinic were very political, often involved in other human justice issues such as immigration rights and domestic violence prevention. Ruth Ortega, a white woman married to a Hispanic man, was a counselor in her early

70's, and she was a tireless volunteer for the Democratic Party. Staff members volunteered at the New Mexico state fair, donating their free time to sit at the "Pro-choice" booth run by the Religious Coalition for Reproductive Choice (RCRC). One counselor named Tasha, who was also a midwife, served a large number of undocumented families in Albuquerque, working on a sliding scale fee.

Ultimately, it requires a special kind of dedication to work at an abortion clinic. In 2006, when the majority of interviews for this thesis were collected, there were a total of nine counselors including myself, three nurses, a clinic manager, three doctors and Dr. Clifford Powell and Dr. Roberta Powell. Most of the counselors worked part-time, around 25 hours a week. Three counselors and two nurses as well as the clinic manager had fulltime positions. The staff was diverse in age (from 23 to 72), but had been mostly racially homogenous for many years. In 2006, all of the staff members self-identified as White with the exception of Mara Patel and Rhonda Hausen. Mara Patel's mother is from Turkey and her father is from India. Mara self-identifies as "Persian," and Rhonda Hausen who identifies as "Hispanic."

In her study of abortion workers at a clinic she calls "The Womancare Center," Simonds (1996) found that the way in which staff interpreted the clinic's racial relations was dependent upon the race of the respondent. She wrote:

> The black women I interviewed after 1991 said that while some white staff members might welcome their participation, covert racism and subtle exclusionism pervade their work lives. In their view, the Center was a clinic run by white women who were part of a white feminist movement that was itself suspect because of its history of racism (Simonds 1996:173).

The reproductive health movement has, from its inception in the 1960s, failed women of color in very significant ways. Many clinics can be characterized as white women counseling women of color. For me, this has always had something of a colonialist dynamic. At the Powell Clinic, approximately 56% of the clients identified as Hispanic in 2006 and only one out of eighteen, or five percent of the staff was Hispanic. There had been another Hispanic woman on staff, and before her departure, she expressed to the all white management team that there were not so subtle racisms that the organization needed to address, including hiring more women of color. The clinic staff openly discussed the need for a more diverse staff at a monthly staff meeting, and since the interviews, an African American woman and a Cuban woman of African descent have been hired, as a counselor and a nurse respectively. Additionally, after a white male doctor left the Powell Clinic to open his own family clinic, serving people living in poverty, the Powells hired a female doctor whose parents are from the Philippines.

Interestingly, of the eighteen staff members including the Powells, six, or a third, including myself, identify as gay or bisexual. I know that Albuquerque's not-for-profit women's reproductive health clinic also has several women working there who are lesbian identified. I would one day like to conduct a study at abortion clinics throughout the United States, focusing on lesbian and bisexual abortion workers and their political perspectives. For myself, abortion and gay rights are both sexuality and justice issues, and easily go hand in hand. A straight, male friend of mine who identifies as pro-choice once asked me; "Why do all you gay girls work there anyway if you will never need an abortion?" I have learned from women's stories that women do not always choose to have intercourse, so it is possible that a gay woman could have an unintended pregnancy

from a rape. Or, the sex may be consensual. For instance, in the spring of 2004, I counseled a lesbian before her abortion. At the very beginning of counsel she stated, "I'm a homosexual." She explained that she was in her thirties and had never had sex with a man. She decided to have intercourse with a close male friend to see if she was "missing anything." She said her experience was not enjoyable and the condom broke. She felt that needing an abortion was her punishment for doubting her "true sexuality" (Clinic field notes 4/ 8/2004). Sometimes lesbians do need abortion services.

In an interview with counselor Mara Patel in July 2006, twenty-seven year old Mara discussed her political evolution. Mara is the daughter of immigrant parents, a Turkish mother and an East Indian father. She grew up in Boston, Massachusetts and identifies as "queer." She started working at the clinic in March of 2004. At the time of the interview, Mara was working towards a Bachelor's Degree in Women's Studies from the University of New Mexico. When asked why she wanted to work at an abortion clinic, she responded:

> I was first exposed to abortion as a political issue when I was thirteen. In eighth grade, I was invited by another politically minded friend to go with her mom, a teacher, and we all went down to the pro-choice march in 1992, I believe it was. It was the first time I was exposed to a kind of activist culture, people who cared enough to really drive ten hours to the capital. That was really my first exposure to abortion. And then, I personally had experience with abortion in 2003, and that was really the more significant catalyst to getting involved and working at a clinic. When I had my abortion, although I think I was completely educated about it, I was still absolutely terrified. I went to Planned Parenthood in Albuquerque and had such a pleasant experience that I decided that I would like to be part of that process for other women (Mara Patel, staff interview:7/6/05).

Mara was motivated to work at the Powell Clinic because of her own abortion experience and her desire to support other women during their procedure. Going through an abortion

decision, her degree in Women's Studies, and the experience of working at the Powell Clinic had given Mara a very pro-choice consciousness.

> I have learned that access to a safe abortion is indispensable and that women deserve to have as pleasant an experience as can be provided and they deserve to be in a very safe atmosphere surrounded by supportive people. The struggles that women have every day are just amazing. It is incredible what women go through, the things that they endure. It is just remarkable, and abortion is a necessity. Women have to be able to provide the best they can for their children and families (Mara Patel, staff interview:7/6/05).

The staff comes to abortion work with a feminist consciousness, some through their own abortion experience. Feminism is a fundamental identity for the women and men who work at the clinic. The clinic manager, Jill Rue, grew up in a liberal home and had always identified as pro-choice. She explained:

> Well, I have always been a feminist, and I have always been pro-choice, even before I could put words to that. I was raised in a very staunch Democratic family. So, it was very liberal when I was growing up. But, I was also raised Catholic, so there is a mix there. I guess our politics were stronger than our religion, and my Catholic family was very liberal in terms of choice. The majority of them identified as pro-choice. I couldn't say exactly now how everyone identifies as people grew up and have changes. That has pretty much been the case since I became conscious as a political being (Jill Rue, staff interview:12/06/2004).

Besides a feminist consciousness abortion workers are highly invested in the concept of choice. For the staff, choice is an essential tenet at the Powell Clinic.

Conclusion: Abortion Work as a Calling

Clifford Powell began to teach himself abortion techniques the 1960s to help a few desperate women in an east Texas town, and what was meant to be a small and temporary contribution to women's equality became his life's work, what he has termed his

"calling." Roberta Powell, then Roberta Harrison, was recruited fresh out of graduate school to start an abortion counseling program in 1973 after the *Roe v. Wade* decision was handed down. She expected that it would take a few years to establish and then she would move onto something else. In 2009, some 35 years later, she is the leading authority on abortion counseling in the United States and is an invited lecturer at Harvard University. Other staff members have had similar experiences. The clinic manager, Jill Rue, started working at the Powell Clinic in 1988. She said:

> I think the biggest thing is the philosophy here, the environment of this particular clinic. I don't think I could remain at any job for that long and certainly didn't have the thoughts of remaining at any particular job for so long...It is also the good work that we do with women here. So, it is both the organization itself and the work that we do. (Jill Rue, staff interview: 12/06/04).

Some staff members have left to pursue more pedestrian work only to find themselves calling the Powell Clinic to see if there was still a place for them. When beginning my work as an abortion counselor at the Powell Clinic, I imagined that this part-time position would be one of several jobs I would have while pursing my graduate degree in Anthropology at UNM. I would probably conduct fieldwork on some "legitimate" research topic like Oaxacan women and indigenous identity or U.S. – Mexican boarder discourse. As I create this thesis, I know that abortion and reproductive justice are and will remain the center of my academic universe.

CHAPTER 3
Women Who Have Abortions in New Mexico

The purpose of this chapter is to provide an overview of abortion practices and rates in order to frame the in-depth interviews with women who have had an abortion. I will discuss the abortion rates in the United States, in New Mexico, and at the Powell Clinic. I will also introduce the 55 clients who participated in the study. Presenting abortion rates gives us an opportunity to see who are the women choosing abortion, or at least, how they are categorized by ethnicity, age, marital status, and class.

Lawrence Finer, associate director for domestic research at the Guttmacher Institute said:

> The United States has one of the highest abortion rates in the developed world, with women from every socioeconomic, racial, ethnic, religious, and age-group obtaining abortions. We study abortion so we can learn more about how well current efforts to improve contraceptive use and reduce unintended pregnancy are working, the circumstances under which women have difficulty accessing abortion and, ultimately, how to reduce the need for abortion (Guttmacher 2009:1).

Women in the United States who utilize abortion services come from all walks of life and there is no single type of woman who has abortion, although women living in poverty and younger women under the age of 25 have the highest abortion rates.

Abortion Rates in the United States

The Institute of Medicine estimates that 57% of pregnancies in the United States are unintended, meaning they were "either mistimed or unwanted at the time of conception" (Brown and Eisenberg eds. 1995:11). About 22% of all pregnancies were electively

terminated in 2006 (Guttmacher 2008:1). Since 1969, the Center for Disease Control (CDC) has been collecting abortion rates from each state and compiling national abortion rates. Abortion rates in the United States were continually increasing from 1973 through to 1990. From 1990 to 2001, the rate of reported abortions declined. It increased nominally in 2002, and then continued to decline through 2003 (Strauss *et al*. 2007:22). The decline has been attributed to increased availability of birth control, effective pro-life campaigning, and the drastic drop in abortion providers, by 37% from 1982 to 2005 (NAF 2005a:1).

Abortion Rates in New Mexico

Demographers measure the abortion ratio or the number of abortions for every 1,000 births. Between 1997 and 2006, the abortion ratio in New Mexico ranged from 175.6 to 200.8 abortions to every 1,000 live births. Over 85% of abortions in New Mexico were performed in the first trimester (NMSHSAR 2006:15). In 2006, the abortion ratio in New Mexico was 192.7 abortions for every 1,000 births, a rate only slightly lower than the national average (NMSHSAR 2006:44). In other words, around one in five pregnancies in New Mexico ends in abortion. During 2006, the New Mexico Bureau of Vital Records reported 5,764 abortions in the state. At the Powell Clinic, 78% of abortions in 2006 were performed in the first trimester. I believe that the Powell Clinic performs more second trimester abortions than the average in New Mexico because it is the only clinic in the state that goes beyond the gestation of 18 weeks from the Last Menstrual Period (LMP). A female provider in Santa Fe and Dr. McPherson in Albuquerque both have a gestational limit of 14 weeks LMP. The Planned Parenthood clinic in Albuquerque is the

only Planned Parenthood in the state that provides abortions, and it has a gestational limit of 18 weeks LMP. The Powell Clinic's gestational limit changes over time and can even change weekly based on which doctor is working. Some doctors do not perform abortions beyond 20 weeks LMP where as others have a limit of 23 weeks. Doctors' gestational preferences are based on skill-level, safety issues, and belief systems. After 24 weeks gestation, the calverium (head) of the fetus begins to calcify, creating a greater risk of laceration to the uterus or cervix during extraction. Also, doctors make gestational limits based on viability. Because ultrasound measurements can have a margin of error of a week more or less, no doctors at the clinic go beyond the gestational limit of 23 weeks. This allows for the margin of error to not exceed 24 weeks, or what the medical community currently holds as the week of viability.

Statistical Analysis of Clinic Clients

In 2006, the year in which I conducted this research, 2,608 women had abortions at the Powell Clinic. These numbers are taken from the National Abortion Federation (NAF) Monthly Reports which all NAF accredited clinics are required to submit. In short, about 45% of all reported abortions in New Mexico are performed at the Powell Clinic. One of the clinic staff members, Rhonda Hausen, goes through the patient charts and compiles the number of abortions at the clinic on a weekly basis. According to Rhonda's clinic count, of the 2,608 women who had abortions, 624 or 24% of clients returned for a free and private post-operative exam.

Every patient chart from the year 2006 has a clinic statistics form filed with their paperwork (Appendix F). From the 2006 charts, I compiled the anonymous statistical

forms for the clinic's clients by taking the stats from every fifth chart that were organized alphabetically. I randomly gathered the statistical information from 420 charts and multiplied these results by five. These statistics provide a general view of the population the clinic serves in regards to ethnicity, age, education, residence, pregnancy history, and gestation for 2006.

The clinic is required to fill out the state-provided statistics form for every pregnancy that is terminated "electively," which, according to the state, are all abortions with the exception of fetuses that died inside the uterus (in-utero) (Appendix F). A woman whose fetus has a condition that is not compatible with life (i.e., anencephaly where the fetus has no brain) is still categorized as an elective abortion if the fetus is alive, even though it will die during the pregnancy or within hours of birth. The clinic has similar statistical form that the client fills out with her paperwork at the beginning of her appointment. After the termination, a staff member transfers this information to the official state vital records form. The counselor writes in gestational age (last menstrual period minus two weeks) and the date of the pregnancy termination.

On the clinic's statistical form, some women place the number of previous abortions in the line that says "now dead." Although the section says "live births" above it, many women do not read the heading. This speaks to the conflicting belief systems of women having abortions as some women regard a previous abortion as a child that is dead. For these women, the pregnancy was a child that they have had to sacrifice. One very memorable client that has come to the Powell Clinic on three occasions for termination services always asks the sonographer for a copy of the ultrasound so that she

can put the picture in the "baby book" that she makes after each abortion. In this baby book, she includes the ultrasound picture and the name that she had chosen for the fetus.

I compiled the information on 420 clients or 20% of all 2006 clientele (2,107 total). Although the clinic's NAF report had 2,608 patients total, clients who returned for services after 2006 have their charts filed in the year of more recent services. As a result, some patient charts from 2006 may be filed in 2007, 2008, or 2009. Also, there is a staff member at the Powell Clinic whose primary roll is to appeal insurance claims that have been denied. Jennifer Ditkus, a fifty-nine year old self-identified white woman has been working for Dr. Powell since 2002, is constantly working on insurance claims. Some clients' charts from 2006 may be located in her work area. However, I do not anticipate that many charts from 2006 would still be in a claim dispute, as both New Mexico Medicaid and most major private insurances require that claims be completed within two years of the date of service. I cannot confirm this, but I believe most of the "missing" 2006 charts are filed in future years because a client had returned for services. Of the 2006 clients, approximately 18.5% had at least one previous abortion. Of the 55 client participants, 20% had had at least one previous abortion. This indicates that as time passes and subsequent unintended pregnancies occur, charts from 2006 are moved to future years.

I interviewed slightly more than two percent of all clients during 2006, or about nine percent of women who returned for a check-up exam. Interviewing these fifty-five clients allowed me to begin to peel back some of the many layers that form a woman's abortion decision. Recent rhetoric in the abortion debate focuses solely on the status of the fetus, essentially erasing women's experiences outside that of her value as a pregnant

mother. These interviews reveal how choice is usurped by desperation, and women's abortion decisions are not made in the context of preferences, but necessity.

Limitations of the Data

Conducting interviews at the time of the post-operative exam created certain limitations in data collection. As mentioned, around 24% of clients returned to the Powell Clinic for a follow-up exam. Follow-up exams are considered elective, unless a woman is undergoing a Mifeprex abortion, in which case she is required to return to the clinic for an ultrasound to confirm that the process has been successful as there is a failure rate of four percent (See Chapter 4). Some clients make appointments with local providers if they live far from the clinic. However, we know from the post-operative exam forms mailed to the clinic from other providers that only around seven percent of all clients have post-operative exams elsewhere. Again, privacy issues are prohibitive for women who live outside of Albuquerque, as they are required to disclose to a provider, who may be a family doctor, that they have undergone an elective abortion procedure. Therefore, taking into account the women who return to the clinic and the exam forms returned from other providers, it would appear that only 31% of clients get follow-up care after an abortion procedure at the Powell Clinic. Privacy issues and travel prohibitions create barriers for many clients, both to receiving post-operative care, but also to participating in this study. Because the interviews were conducted at the clinic, almost 60% of the participants were from the Albuquerque area. (See Figure 3:1 for a breakdown of participants' place of residence.)

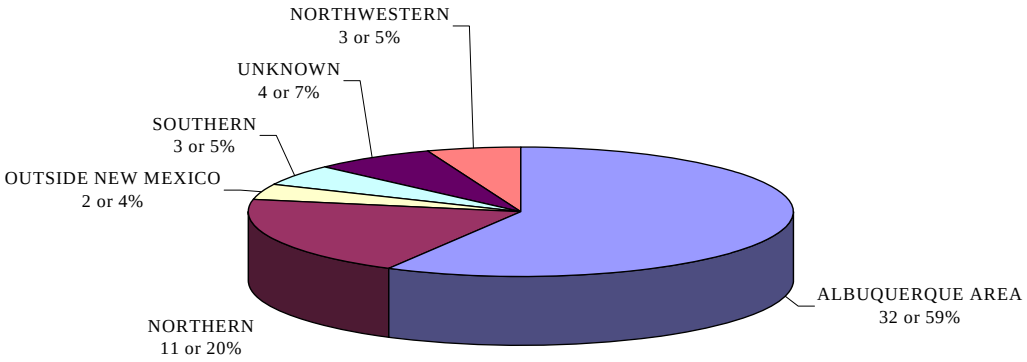

Figure 3:1 Participants' Place of Residence

In the United States, 87% of counties and 31% of urban areas have no abortion provider. One-quarter of women who have abortions in non-hospital facilities (the majority) like the Powell Clinic travel 50 or more miles for services. Women who need second trimester abortions often need to travel long distances, since only a small number of providers perform these procedures (Henshaw 2003:17). In New Mexico, the two providers that do perform second trimester abortion, the Powell Clinic and Planned Parenthood, are both in Albuquerque. Close to one in four participants were from

nothern New Mexico and only 5% from southern New Mexcio. Women in southern New Mexico may have traveled to El Paso for abortion services. Because of travel and privacy issues, over 75% of the clinic's clients do not get a follow-up examination. As a result, the interviews do not include much information regarding the hardships many women may have when it comes to transportation issues as these very women were not able to return to the clinic for follow-up care.

The city of Las Cruces, New Mexico is located approximately 225 miles south of Albuquerque. Las Cruces, with a population of 90,000 and a large state university, has no abortion provider. There may be private doctors performing abortions on a very small scale, but a physician that was known to provide abortion in Las Cruces retired in 2002. In 2006, a new abortion clinic in Sunland Park, New Mexico opened, about 270 miles southeast of Albuquerque, on the New Mexico and Texas border; however, this clinic does not accept New Mexico Medicaid and many women from southern New Mexico have to travel all the way to Albuquerque to use their state insurance. Women from cities from all over New Mexico -- Gallup, Farmington, Portales, Taos, and Deming -- travel to Albuquerque for abortion services. Also, the city of Amarillo, Texas is close to 300 miles away and has no abortion provider. There is a Planned Parenthood in Amarillo, but they do not perform abortions. The Powell Clinic regularly serves women from this west Texan city that drive four hours one way for an appointment. Conducting interviews during an elective exam has excluded many women from outside of the Albuquerque area. Of the 420 patient charts examined for 2006, 38% lived more than 75 miles from Albuquerque, and 28% lived more than 50 miles away.

As discussed previously, to reduce any element of coercion, I did not solicit participation from any clients who I had counseled during their abortion procedure. This was an important element in having an ethical protocol for recruiting; however, excluding women I had counseled during their abortion procedure indirectly prohibited Spanish-speaking clients from participating. In 2006, I was one of two Spanish-speaking counselors employed by the clinic.[4] The other Spanish-speaking counselor in the clinic during the field period was 70 year-old Ruth Ortega, a self-identified white woman who had lived in Nicaragua for ten years. She was responsible for keeping all of the clinic's paperwork in order, a goliath of a job. As a result, I was conducting most of the Spanish counseling. I had been the counselor for all but one of the eight Spanish-speakers who returned for a check-up during the interviewing process, and her interview was unfortunately very brief because she was on her lunch break from work. It is truly unfortunate that the perspectives of the immigrant women who came to the Powell Clinic for services were excluded.

Ethnography is a process of writing and, as such, rich description is a tool the ethnographer can use to create a sense of places and people. Because of the extremely private nature of abortion, I have avoided specific descriptions of clients and staff, and have used pseudonyms for all participants. To ensure the privacy of clients, I have also avoided using precise personal information. For instance, one client terminated her pregnancy because of the real possibility of passing on a genetic disease. I did not name the disease or its physical manifestation to ensure her privacy. I prefer a more expressive

[4] Spanish is the mother tongue of the clinic's sonographer Rhonda Hausen. Also, one of the nurses and two of the doctors speak Spanish, so Spanish-speaking women are with Spanish-speakers during the entire office visit.

ethnography, but in some cases I chose to err on the side of caution in describing participants because I am very aware that compromising privacy can threaten women's safety. Instead of outward description, I hope the words of the clients, staff, and protesters create a rich picture of abortion practices in New Mexico.

Ethnic Identity

Albuquerque, as the urban heart of the rural state of New Mexico, is a uniquely diverse place as the land's history is one rich in both colonial heritage and cultural survival. The mixing of Native American, Spanish, Mexican, and Anglo peoples has created a truly "mestizo" state, racially and culturally (Gonzales-Berry and Maciel 2000). Ethnic variation among women who have abortions reflects differences among populations in socioeconomic status, use of contraception, the occurrence of unintended pregnancies, and peoples' attitudes and acceptance of abortion.

According to New Mexico Health Statistics Annual Report for 2006, 43.2% of all New Mexicans were White, 41.4% were Hispanic, 11.1% were Native American, 2.7% were African American or Black, and 1.7% were Asian or Pacific Islander (NMSHSAR 2006:5). These are the ethnic categories used by the New Mexico Department of Health and the United States Census Bureau. Although some of these categories, especially the terms Hispanic and Black, are problematic, I employ these ethnic/racial categories to allow for the comparison of state, clinic, and interview participant statistics.

Abortions are more common among minority women in the U.S. In 2000-2001, the rates among Blacks and Hispanics were 49 per 1,000 and 33 per 1,000, respectively. For white (non-Hispanic) women , the rate was 13 per 1,000 (Guttmacher 2009b).

Minority women also experience a greater number of unintended pregnancies, in the United States, speaking to healthcare disparities in reproductive services. White women obtain 60% of all abortions in the U.S., but their abortion rate is below that of minority women. For instance, Hispanic women are twice as likely as white women to have an abortion and black women are more than three times as likely (Guttmacher 2006).

Almost 42 percent (41.8%) of women who came to the Powell Clinic in 2006 identified as Hispanic, 39% identified as White, 12% as Native American, 3.6% as Black, and 2.6% identified as "other," including Asian American women, and slightly less than one percent was unknown. In the interview sample of 55 women who returned to the clinic for a post-operative exam, 26 participants (47%) identified as Hispanic. Twelve percent of the total clinic clientele identified as Native American in 2006 where as 15 study participants (27%) identified as Native American. Thirty-nine percent of clients in 2006 identified as White in contrast to the 8 participants (15%) in the study. Several of the client participants marked both "White" and also wrote "Spanish" on the questionnaire, so I coded their ethnicity as Hispanic but used their self-referential term, Spanish, in the biographical sketches. (See Figure 3:2 for ethnic identity of participants). Both English speaking Hispanic women and Native American women are somewhat overrepresented in the study sample when compared to the populations served by the clinic in 2006.

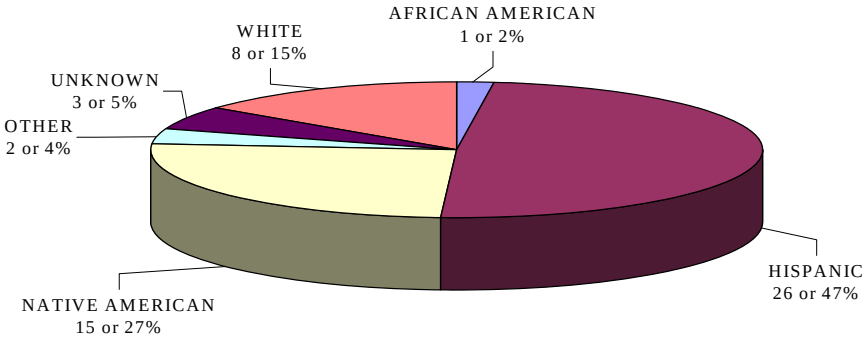

Figure 3:2 Ethnic Identity of Participants

Based on the random sampling of 2006 clients, the Powell Clinic serves more Hispanic women than white women. The following graph juxtaposes the ethnicity of the total population served by the Powell Clinic in 2006 with the study participants.

Ethnicity	Total number of clients 420 x 5 ≈ 2,100	Total of study precipitants 55
Hispanic	175 or 41.6%	26 or 47.2%
Native American	50 or 11.9%	15 or 27.2%
White	164 or 39.0%	8 or 14.5%
Black or African American	15 or 3.6%	1 or 1.8%
Mixed or Other	11 or 2.6%	2 or 3.6%
Asian or Pacific Islander	3 or 0.7%	0 or 0.0%
Unknown	2 or 0.5%	3 or 5.4%

Figure 3:3 Client and Participant Ethnic Demographic for 2006

More than twice as many Native Americans participated in the study than had terminations and more than three times as many white women came to the clinic for services than participated in the study.

Hispanic Women

Twenty-six of the client participants (47%) identified as Hispanic. This is an ethnic category used by the New Mexico Vital Records forms, but is not accepted by all clients nor social researchers because it confounds individuals of diverse cultural origin (U.S. Southwest, Puerto Rican, Cuban, and Mexican, Central American, and South American). There is no ethnic moniker that is used by all participants of "Hispanic" descent. In an ethnographic study of factory workers in Albuquerque in the early 1980's, most of the participants identified as "Spanish" or "Spanish American" as opposed to "Hispanic."

> Very few of our interviewees called themselves Chicano, Mexicano, or Mexican American. Most considered themselves "Spanish" or "Spanish American" (terms they used interchangeably). But for most scholars those terms erase the Indian and Mexican mestizo heritage of northern New Mexican Hispano populations and carry a conservative political connotation (Lamphere *et al*. 1993:22).

In New Mexico, many women who are of Hispanic heritage identify as "White" or "Spanish" to differentiate themselves from Mexican Hispanics. These women of Hispanic ancestry identify with the European Spaniards, or conquistadores, that came into New Spain (New Mexico) at the end of the 1500's. As with my biographical form, on the statistical form that the clients complete with all the other clinic paperwork, they will commonly check the "White" box *and* the boxes for "Of Hispanic Origin," and write in "Spanish" in the "Other" category. According to the CDC, abortion rates among white and Hispanic women are skewed because a substantial majority of Hispanic women report themselves as White (Strauss *et al*. 2007:17). In a few instances, clients have written "Chicana" in the "Other" category in the clinic's statistical form. These are both women who have moved to New Mexico from the west coast and women who I would interpret to have a more radicalized ethnic identity.

At the clinic, there were women who checked the box for Mexican because their parents are from Mexico, but they had been born and raised in New Mexico or Texas. Hispano is the most commonly accepted term for people in New Mexico; however, many Cuban women come to the clinic. Albuquerque has a significant Cuban population that began to immigrate to the city in the 1990s. Cuba supplied Albuquerque with the third largest number of immigrants, after Mexico, and Vietnam (Federation for American Immigration Reform 2001). Some immigrants have an Afro-Cuban heritage and may identify as "Black" or "Hispanic," or both. I will use self-referential ethnic identifiers when quoting interviews and use the sometimes external classification of Hispanic when discussing abortion rates so they can be compared to state and national data.

About 42% of the clinic's total clientele was Hispanic in 2006 as compared to the 47% of study participants. Sixty-five percent of Hispanic participants live in the Albuquerque metro area (17 of 26). Fifteen percent of the Hispanic participants came from northern New Mexico (4 of 26). Seven percent came from southern New Mexico (2 of 26), one participant was from outside of New Mexico and the residence of the two Hispanic participants was unknown.

Of the 26 Hispanic participants in the study, ten (38%) had some undergraduate education, eight (31%) had a high school education, and five (19%) had a grade school education and three (12%) participants educational level was unknown**.** Fourteen Hispanic participants (54%) used New Mexico Medicaid, six (23%) used commercial insurance, and six (23%) paid cash for their abortion. Twenty-two (85%) Hispanic participants were unmarried. Eleven Hispanic women had no children at the time of the interview, and fifteen were mothers (or 57% of all Hispanic participants). Seven of the Hispanic women with children (46%) were single mothers.

Fifteen of the 26 Hispanic participants (58%) were either practicing Catholics or had been raised in a Catholic household. For the leaders of the Catholic Church, abortion is a major sin. Interestingly, some Catholic women have a moral conflict with their decision, while others do not. Amanda, for example, was 19 years old and a student at the University of New Mexico in 2006. She identified as Spanish and her family has been in New Mexico for many generations. She grew up in a small town thirty minutes south of Albuquerque. When asked what she thought about "choice," she said:

Before I found out I was pregnant, I always thought abortion was wrong.

> I was raised Catholic and it is a sin to have an abortion. I went to church and prayed for the souls of babies killed by abortion and everything (Amanda, client interview:01/24/2006).

Because of her Catholic upbringing, she had always been adamantly against abortion, but Amanda felt "OK" about her decision. She does not think women should have abortions "willy-nilly." In a second case, Lena was a single mother with two small children. She identified as "Spanish" and was a 25 year-old secretary from a small town approximately three hours south of Albuquerque. She said,

> I thought it was wrong and that you should never do it. I was raised in a real strict Catholic family and it is a real sin to kill a baby. I never thought I would do this, but I really didn't have a choice (Lena, client interview:04/04/2006).

Both of these women had varying degree of moral conflict with their decision because of their family's beliefs.

On the other hand, in a third example, Beatrice was raised in a Catholic home and has felt no moral conflict with her decision. Beatrice was a twenty four year old Hispanic women and a student at UNM when she was interviewed. She said:

> Yea, my parents are Catholic and they don't know about this. They would be totally…they would be very upset with me. My Mom has three kids and my Dad has seven. They are real poor, and I don't know why they keep having kids if they can't afford to have these kids. I guess that has swayed me the other way too. I don't want to end up like that. I don't think I would ever tell my Mom, because she wouldn't understand. So I was raised that this was wrong. But it is strange, I was brought up that way, but I don't believe that way. With my first abortion when I was 18, I felt no emotional connection at all. That is how I know I made the right decision because I had no doubts. Neither time was I sad. I knew it was the right thing to do (Beatrice, client interview:02/14/2006).

Hispanic and Catholic are not conflated categories. Ruth was a thirty one year old, Hispanic woman from Albuquerque. She had a bachelor's degree, and was a teacher. Ruth was married and had two children and one previous abortion. She said:

> I was raised Catholic, but I think that this is a personal thing. Abortion isn't a political decision. It isn't a religious decision. It is a personal decision (Ruth, client interview:07/18/2006).

Some of the Hispanic women were raised Catholic but no longer identify with the Catholic Church. The Guttmacher Institute reports that while 22% of U.S women are Catholics, 27% of abortion patients identify as Catholic (Guttmacher 2002:6).

Of the 26 Hispanic women interviewed, 17 (65%) called themselves pro-life before they terminated a pregnancy and six (23%) identified as pro-choice. One Hispanic participant (2%) was undecided and two (4%) were both pro-choice and pro-life. After having an abortion, seven of the Hispanic participants (27%) identified as pro-life and 14 (54%) identified as pro-choice. Afterwards, five participants who were originally pro-life switched to a more middle ground: one was both (2%), two were undecided (4%), and two participants (4%) had no opinion. Six Hispanic participants (23%) changed from pro-life to pro-choice.

Native American Women

Native American women in New Mexico are primarily Navajo, Jicarilla Apache, or Pueblo. Native peoples have long inhabited what is now New Mexico but modern Native Americans in New Mexico are considerably changed from pre-colonial days. The Native Americans of New Mexico have had their cultural practices impacted by colonization, both Spanish and Anglo. There is a definite mix of urban Pueblo and Navajo women and

those who lived closer to their natal communities. Seven of the 15 Native participants lived in Albuquerque (47%), five (33%) were from Pueblos in Northern New Mexico, and three women were Navajo (20%) and lived in northwest New Mexico, Gallup, Farmington and the Four Corners area near the Navajo reservation.

Fifteen of the 55 participants (27%) identified as Native American and only four specified their tribe or Pueblo. On the New Mexico statistics form, it requests that a woman "specify tribe" when completing her paperwork. Women will designate that they are Native American, but in most instances, do not indicate their tribal association.

Of the 15 Native participants, 13 were single, one was married, and one was divorced. Of the Native Americans, 11 had children and ten, including the divorced participant, were single mothers. Four Native participants were single with no children. For the educational level of Native participants, three had attended grade school only, four had some high school education, three had undergraduate experience, two had graduate school experience, and three of the Native American participants' educational level was unknown. Eleven Native American participants were on Medicaid, one was on a private insurance plan, and three paid cash for their abortion procedure.

Kristina was a 22 year-old woman from northwestern New Mexico. She described herself as ¼ Navajo and ¾ "Spanish" and was raised by her grandmother in a traditional Navajo belief system. Although she is ¾ Hispanic, I coded Kristina as Native American because she identifies as Navajo. Also, the Navajo practice matrilineal descent and Kristina would be considered Navajo in Navajo circles, through her mother and grandmother. Kristina was living in Albuquerque at the time of the interview, away from her three children, as she attended a vocational school. She had dropped out of school at

age fifteen when she became pregnant with her first child. She was married but her husband works in a mine in Arizona and commutes back and forth during the weekends. She had an emergency cesarean during her last delivery and her doctor told her that another pregnancy would be very dangerous to her health. Kristina did not feel that she had a choice because her doctor had warned her about the danger of delivery. The choice was made for her. Kristin and her mother and grandmother held a ceremony after her abortion. In order to have the necessary participants in the ceremony, Kristina had to tell her grandmother that she had an abortion.

> She was very sad when I told her what I did. She said it was not right to do, against nature. I had to tell her that I had an abortion because she had to help me and my Mom do a ceremony, you know, to protect me from the baby – from its spirit. You know, to make it right with him…Or her, but I felt it was a boy. For three days we were in the hogan and we couldn't wash our bodies or hair. We sat around and talked and smoked mountain smoke, it is like a bunch of herbs. The medicine man came and blessed us and said prayers. On the morning of the fourth day, we washed our hair with yucca root. It makes it feel all soft (Kristina, client interview:01/24/2006).

Ceremonies always involve multiple participants and as a result, most Native American women cannot have a ceremony unless they disclose that they had abortion to the medicine man and/or family members. According to Kristina, her medicine man only agreed to perform a ceremony for her because of her health indications. If her abortion decision had been considered more elective, he would not have performed the blessing. Rita, a 42-year-old Native American woman explained to me that she could not have any type of ceremonial intervention because it would compromise her privacy. When I asked if she was raised with certain beliefs, Rita said:

> Traditional. And that is what got me is that I couldn't do anything. I couldn't have a ceremony because then everybody would know. Then I

> would have to explain everything…This is just something that we are not supposed to do (Rita, client interview: 08/29/06).

For Navajo women who practice the traditional religion, not performing a ceremony for a surgery can be very dangerous for them and can anger the Holy People. Ideally, the Blessing Way ceremony is performed before the surgery to ensure protection during the process and a ceremony should also be preformed after the surgery as well. Native women have asked to take the pregnancy with them so they can perform a ceremony; however, New Mexico state law forbids that a fetus or yolk sac is released to anyone other than a funeral home. This law dismissed traditional Navajo religious practice.

> Detached body parts such as skin cells, blood, umbilical cords, saliva, hair, fingernails, and toenails retain a lifelong connection with the person from whom they originated and can therefore be manipulated for good or ill (Schwarz 2008:224).

Navajo women who practice the traditional religion and ask to take the remains of their pregnancy to bury it themselves want to properly return the pregnancy to Mother Earth. However, because of laws created by the state, they are left unprotected as a part of their body is left behind. This can affect them negatively throughout their lifetime.

Some women who practice traditional religion have adapted ceremony to the state imposed restrictions. I have placed ash from a hearth over the aborted fetus of a Navajo woman in order to appease the soul of the child and prevent bad things from happening to her. She brought the ashes in a little baggie and while she was resting after her abortion, I gently sprinkled the fetus with the powdery, grey ash. I recited as she had instructed three times, “Return to the Mother, you must not stay here. It is time to go.” Later, when talking to a Navajo friend named Connie, she explained that cedar ash was something

that was used to protect the living from dead spirits. For instance, Connie would place ash on different parts of her own body before she went to a funeral in order to protect herself. She explained that death is jealous of life, and will try to "jump on it." According to Connie, it was a healthy thing for the client to protect herself with the ash. Connie wishes more Native women could have an opportunity to do some kind of cleansing ritual around an abortion procedure. She has two sisters that she believes suffer from mental illness because they did not perform traditional Navajo ceremonies after they had abortions.

Before terminating a pregnancy, nine Native women (60%) identified as pro-choice and four Native women (27%) identified as pro-life. Two Native women had no opinion before and after their abortion. After their abortion, eight (54%) Native women identified as pro-choice, and three Native women (20%) identified as pro-life. Two out of 15 Native women (13%) shifted from decidedly pro-life before their abortion to undecided after.

White Women

In the interview sample, 15% of the study participants (eight) identified as White in contrast to the 39% of total clinic clientele for 2006. I have adopted the term "White" over "Anglo," again because it is used by the State of New Mexico's census form. One explanation for the under representation of white women in the study may be because the clinic serves a large number of white women from the Amarillo, Texas area. Because of the distance and the rarity of postoperative complications, these clients rarely return to Albuquerque for a check-up. One participant was from southern New Mexico and two

participants' place of residence was unknown. All eight white participants were unmarried and four of these women had children. Of the eight white clients, two had a high school education, four had an undergraduate education, and two had some graduate schooling. Exactly half of white participants had New Mexico Medicaid and half paid cash for their abortions.

Four white participants (50%) came from Evangelical Christian homes. Nicky was a 25-year-old woman who participated in the study. She was not married and has a one-year old child. She said:

> Well, I am Christian, and my grandmother actually works at a crisis pregnancy center, so I am pretty sure my family wouldn't agree with my decision, but at the same time, they wouldn't be happy if I was pregnant either, because we aren't married. No matter what, I'm not going to win (Nicky, client interview: 2/14/07).

Tiffany was also raised in a Christian home. She was 25 years old and had had a previous abortion. She said:

> I was raised very conservatively. We were very Christian Baptist. So, nobody in my family knows. (Laughs). It was something that was out of my realm of thought when I was growing up. If you are not in this situation, then you have an outside opinion of it. I thought it was wrong and I knew I would never do it. But, then, you know, you are in that situation (Tiffany, client interview:08/22/2006).

Of the eight white participants, three identified as prolife (3.75%) and three identified as prochoice before their abortions. Two had no opinion. After their abortion, one continued to identify as pro-life and five identified as pro-choice. The two white women who had no opinion before their abortion continued to have no opinion afterwards.

Black Women

Since 1991, the first year which rates by race were published by the CDC, the abortion rate for black women in the United States was three times as high as the rate for white women (Strauss *et al.*, 2007:16). This national comparison does not hold true for New Mexico where the African American population is less than 3%. Only one participant identified as Black. African American is more accepted as an ethnic category than Black as a racial category. The CDC uses the term Black and African American interchangeably. The participant, named Nuria, identified as "Black" with an Afro-Cuban mother and a "Spanish" Father (from the U.S. Southwest). Two other participants had parents of African American descent, but both identified as "mixed" (See next section). Nuria identified as pro-life before her abortion and had "no opinion" after her abortion. She was from southern New Mexico, had some undergraduate education and she paid cash for her abortion.

The issues surrounding abortion are particularly sensitive for the black community. Rodrique wrote:

> Historical analysis makes clear why issues surrounding birth control can touch...such high voltage sensitivity among black people. They provoke fears of genocide; they prompt concerns about who should make decisions and control the direction of the African-American community; [a]nd they expose the perniciousness and tenacity of racial stereotypes (Rodrique 1991:112).

Including race in reproductive analysis is critical because the political context and power dynamics within which women of color operate are often discounted by social research. Few studies attempt to theorize the differences among women's beliefs around and practice of birth control and abortion in terms of class and race.

Mixed Women

Two participants (3.6%) identified as mixed race. For example, Reanna was a 23 year-old who lives in Albuquerque who identified as mixed; half Black and half White. Madeline was twenty-six and single from Albuquerque and she also identified as mixed race, half Black and half White. Both participants that identified as mixed identified as pro-choice before and after their abortion. Madeline was raised in a pro-life home, but said that she herself was pro-choice:

> My mother is pro-life. It was upsetting for her to hear that I would be doing this. She had a harder time accepting it than I did. (Laughs) But, she supported me as best she could…I always thought that it depended on the situation. I personally think that it is the woman's choice. If a woman just went out there and had sex and didn't take care of herself and was just like, oh well, I'll just get rid of it. It doesn't make it wrong just because you're careless, or situations like rape. Women need to have the option (Madeline, client interview:04/11/06).

Age

In the U.S. as a whole, women under the age of 15 account for about one percent of all abortions, women between the ages of 15 and 19 account for about 19% of all abortions in the United States; women 20 to 24 account for another 33%; 22% of abortions are obtained by women 25 to 30, and about 25% of abortions are obtained by women who are 30 years or older (Jones *et al*. 2008:14).

In 2006 in New Mexico, women under the age of 15 account for 2% of terminations. Women between the ages of 15 and 19 account for 21% of abortion; women 20 to 24 account for almost 36% of abortions, 20% of women in New Mexico who have abortions are 25 to 30 years old, and 21% of abortions are obtained by women 30 years or older (NMSHSAR 2006:25). New Mexico approximates national rates when

it comes to abortions by age groups. Many young women came to the Powell Clinic in 2006, with 68% of clients under the age of 25.

Ginsberg's study of the "Problem Pregnancy Industry" is important because it recognizes the political economy of our gender system that holds certain women (unwed mothers/poor /teenagers) to be “deviant.” Ginsburg writes:

> This is the political economy of gender in which power and resources are being renegotiated constantly in relation to changing attitudes toward pregnant women, especially teenagers. In the United States, the combination of the rise of teen pregnancy and the legalization of abortion (teenagers comprise approximately one-third of all abortion clients) has contributed to the creation of this new category of "problematic women” (Ginsburg 1990:65).

Women who participated in the study were primarily young women, with over 25% age eighteen and nineteen. (All clients under the age of 18 were excluded from the interviews as recommended by the Human Subjects Review Board at the University of New Mexico). Women 20 to 24 account for 33% of participants, women 25 to 30 account for 24% of participants, and 18% of client participants were 30 years or older.

	Age
Mean	24
Minimum	18
Maximum	42
Range	24
Mode	18
Median	23

Figure 3:4 Mean and Median Age of Participants

Age of Clients	Number of Clients this Age out of 55 Total Number of Clients
18	8
19	6
20	5
21	3
22	3
23	4
24	3
25	5
26	4
27	2
28	1
29	1
30	1
31	2
32	1
33	1
34	3
37	1
42	1

Figure 3:5 Ages of Participants

Mothers

The majority of women (56%) who participated in the study were already mothers. Many of the women who choose to end a pregnancy do so because they have limited resources in caring for a child. Couple this with the fact that 85% of the study participants were single. New Mexico has a high rate of single-parenthood. In 2006, 51% of births were to single mothers (NMSHSAR 2006:16).

Terminating a pregnancy is viewed by some as unmotherly and contrary to the cultural construction of woman as nurturer. In the modern U.S. construction of womanhood, women are naturalized as having a deep instinct to protect their children. When we naturalize motherhood and equate woman with mother, abortion becomes

unfemale. Women who have abortions, especially if they are already mothers, have competing identities.

Scheper-Hughes writes:

> The hegemonic biomedical model of maternal bonding makes the experience of alternative maternal emotions seem unnatural, indeed almost criminal, in the United States today (Scheper-Hughes 1992:412).

When women have a child or have more children, our society promotes a certain context in which it is acceptable to reproduce.

> Make sure, that if you want to bring that baby into the world, that you are prepared to take care of that baby. I told my Mom, when I have babies, I don't want help from nobody, not from the state, not from nobody. When I am ready to have a baby, I want it to be just me and my husband. I don't want to ask for no additional help or nothing. All these girls are having kids that are so young, and all of our taxes are going to support them because they don't have a job or a boyfriend. I don't believe that our money should be going to that. I'm not a very mean person. I pay taxes too. I don't want to be paying taxes for this twelve year-old and supporting her and her baby. If she couldn't take care of it, she shouldn't bring it into the world in the first place (Cindy, client interview:04/11/2006).

For Cindy, young women who have children and are on welfare are undeserving of taxpayer support. These women, as problematic reproducers, cannot support a child and therefore should not be reproducing. Cindy invokes the rhetoric of the "problem" of teenage pregnancy

There is pressure for some women to reproduce, but this can be turned around for stigmatized women as problematic reproducers. Within the hierarchy of stratified reproduction, many of the clients that participated could be viewed as illegitimate reproducers. For example, Nadya Suleman, a single, low-income woman from California who gave birth to octuplets through in-vitro fertilization (IVF) in January of 2009 became

what Oprah Winfrey called “the most judged woman in the world.” Ms. Suleman received death threats because her extreme fertility was deemed inappropriate and offensive because she was an unmarried mother who, as the media regularly has pointed out, received food stamps and disability. I am sure that at a time of less economic hardship in the United States, Ms. Suleman’s reproductive choices would not be quite so vilified. Women like Ms. Suleman, who are single, are considered problematic reproducers, especially if they are dependent upon public welfare.

A client named Polly remembered when the clinic in her town informed her that she was pregnant:

> They already judge me harsh at the clinic up there because of my two. The girls that are married get hugs and they say congratulations and they let them use their phone to call their husbands. When they tell me that I am pregnant, they put their head down and don’t say nothing and leave the room. I know they judge me. If I told them that I did this, they would judge me for it too. But, there was no way. I can’t afford another kid right now and being pregnant is real hard for me (Polly, client interview:12/20/2006).

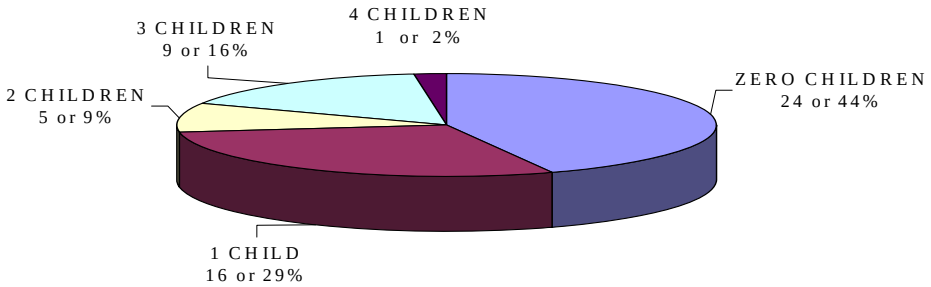

Figure 3:6 Participants’ Number of Children

Previous Abortions:

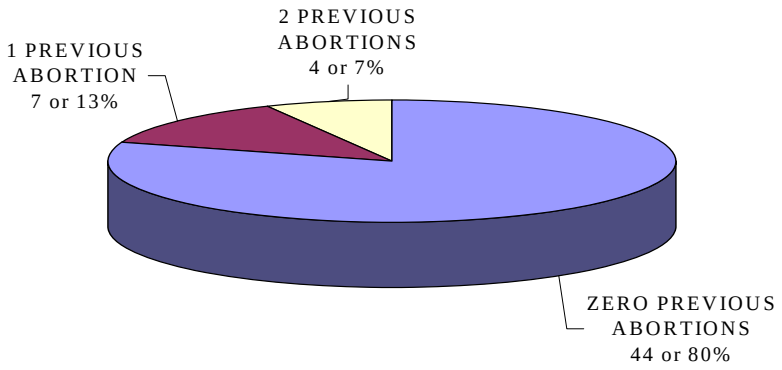

Figure 3:7 Number of Previous Abortions

When it comes to abortion, many women who come to the clinic for a first termination talk about it as a single, unrepeatable mistake. Mattie, a 26 year-old Hispanic and Native American woman who is a graduate student at the University of New Mexico stated:

> I think that there will always be that wondering of what would have happened. I don't think that will ever go away, but I think that is normal. Maybe there are people that never look back. I know I'll always think about it. I kind of look at it as my one get out of jail free card. Because, if I were to become pregnant again, I probably wouldn't get another abortion. One is the limit for me. You know, unless there are complications or something. I just hope that I don't have to come to that decision again (Mattie, client interview:02/07/2006).

Twenty percent of participants have had at least one previous abortion. There is no evidence that having multiple abortions can reduce a woman's fertility. However, the

clinic always offers birth control to clients and provides referrals for gynecological care to help women better navigate the health care system.

Marital Status: Partnered or Unpartnered

According to the CDC statistics, approximately 80% of women who obtained an abortion in the United States are not married (Strauss *et al.* 2006:22). This rate has remained fairly stable from 1995 to 2004, fluctuating from a high of 82.8 in 2004 to a low of 80.3 in 1995. The percentage of unmarried women who participated in this study is slightly higher than the national average at 85%. Many of the women who participated in the interview said that they wanted to be married when they started their family. Twenty-five of the 55 participants (45%) were single mothers, many of whom had little financial support from the father.

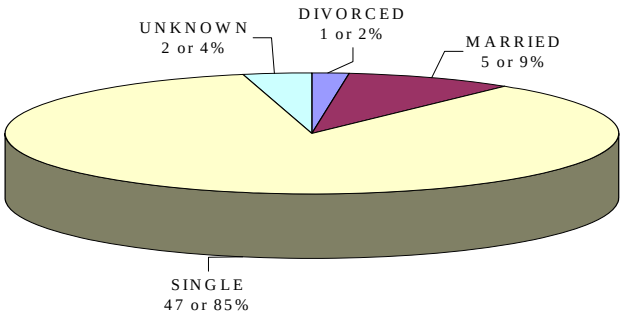

Figure 3:8 Marital Status

Women who are single also continue pregnancies. In New Mexico, births to single women have been increasing. Since 1985, births to single mothers have doubled from 26.4% to 51.2% of live births in 2006 (NMSHSAR 2006:47). Compared to the 36.9% national birth rate for single, births to single women in New Mexico are high. One of every two children is born to a single mother in the state. Since 1980, the percentage of births to single mothers increased 158.6% (NMSHAR 2006:47). It is important to look at which women are having children in New Mexico as the other side of "choice."

Educational Level

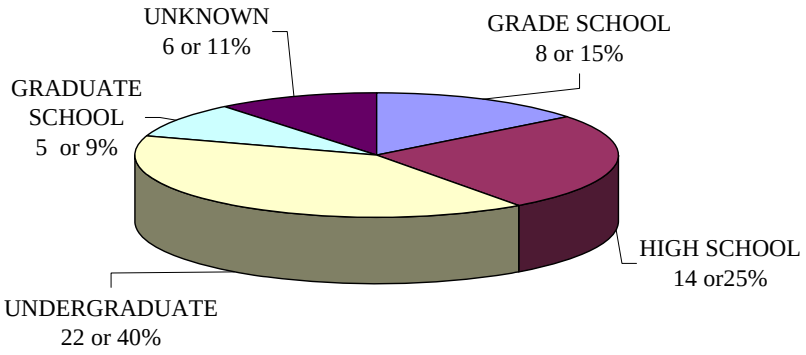

Figure 3:9 Educational Level

The 55 participants in the study had a wide range of education, but, overall, were a highly educated group. Forty percent of participants had some undergraduate education, and 9% had graduate experience. Practically half of participants had some college education and only 15% had less than a High School degree. Some women had yet to finish their degree and terminated their pregnancy because motherhood was in direct conflict with their commitment to school. Amanda was 19 years old and a student at UNM. She said:

> I even used that pill, the morning after, but it didn't work. I didn't want to have anything happen to the baby because of the morning after pill, so we talked and decided this was the best thing. We are both young and need to finish school. I want kids later, but it is not just the right time (Amanda, client interview:01/24/2006).

Amanda knew if she had a child while in college, her likelihood of finishing would be slim. Beatrice was a 24-year-old, single Hispanic woman. She was in her last year at UNM and talked about how having a child would negatively impact her education:

> I'm going to school now and my boyfriend is trying to get into the Fire Department, it would totally ruin all of that. I've seen a lot of my friends who have had kids and not wanted them, and the kid suffers later. They just feel like they were a mistake, and blow them off, and let their mothers take care of their kids. I never want to do that to my kid (Beatrice, client interview:02/14/2006).

Income

In 2006, New Mexico ranked 43rd in per capita income in the United States. The mean annual per capita income for the state in 2006 was $29,929, 17.5% lower than the national mean per capita income of $36,276 (NMSHSAR 2006:23). Because of the presence of government run laboratories in the state, there is a huge gap in income from county to county in New Mexico. For instance, Los Alamos County, where the Los Alamos National Laboratory is located, has a mean income of $52,524, or 90.2% higher

than the state's mean per capita income. Since the establishment of the secret "City on the Hill" in 1943, defense has had a significant impact on the economy of New Mexico. Santa Fe County, adjacent to Los Alamos, has a per capita income ($42,363) is 67.1% higher than the rest of the state. At the low end, Guadalupe County's per capita personal income is $17,047 (NMSHSAR 2006:23). The county in which Albuquerque is located, Bernalillo County, has a per capita income of $34,495. Approximately 58% of clients who participated in the study were from the Bernalillo County.

New Mexico has a high rate of children living in poverty, with 26% at or below the poverty level compared to 18.5% nationally (NMSHSAR 2006:23). Data from the Census Bureau lists New Mexico as 48th among states for children living in poverty.

> There could be a time when I was subscribing to this idea that abortion was OK as long as women don't use it as birth control or as a substitute for birth control. And, I assumed that that was a fairly reasonable opinion. But, now after living in New Mexico for a number of years and experiencing life in an economically depressed state, and a primarily rural state, it makes you realize how there is such limited access to birth control, to health care, to education. There are just so many barriers to that. It is really unrealistic...we know that statistically, 43% of American women have abortions, yet there is a total climate of shame and silence around it, even though it is something that affects a significant proportion of our population and we only talk about enough to demonize them and stereotype them as uncaring and promiscuous and irresponsible (Mara Patel, staff interview:07/06/2005).

Women living in poverty are marginalized in medical systems and may not have insurance or access to current care. When an individual does not have regular healthcare care, any healthcare becomes crisis care, and unintended pregnancies definitely fit into the category of crisis care.

Participants' Political Identification Before the Abortion

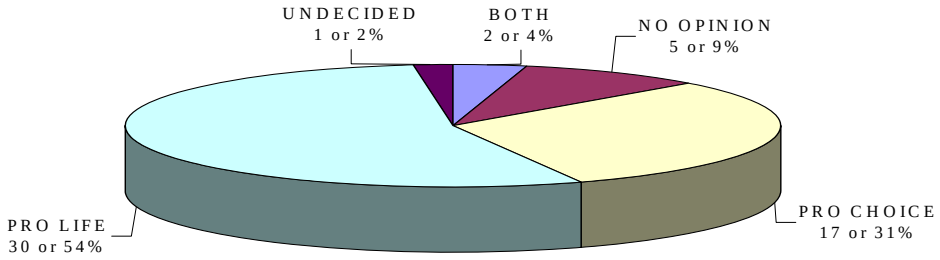

Figure 3:10 Identification before Abortion

Most of the clients who came to the Powell Clinic identified as pro-life before their abortion (54%). These women never thought they would be in a position where they would have to decide to end a pregnancy, and some had even been active in pro-life organizations through their school or church. Thirty-one percent identified as pro-choice before their abortion, and 2 % were undecided. Four percent identified as both pro-life and pro-choice. When I asked one client was asked if she was pro-life or pro-choice, she said:

> I am both. I don't think that you should have an abortion willy-nilly, without thinking about it. There are women out there who have seven or eight abortions and they don't even care or feel any guilt about it. I respect life. Who are we to decide who gets to live and who gets to die, really? That should be up to God (Amanda, client interview:01/24/2006).

Nine percent of participants had no opinion or had never thought about being pro-life or pro-choice. I asked Tanya, a 19-year-old Hispanic woman if she was ever taught anything about abortion when she was growing up and she said: "No, we didn't talk about it…I never really thought about it" (Tanya, client interview:02/07/06). For many women, abortion was a political issue that did not apply to them or their life; therefore, they had never really taken it into consideration. Women who had not had an abortion before and found themselves walking through the doors of the Powell Clinic never imagined that this was a decision they would make. Many women were not aware of the frequencies at which unintended pregnancies occur, or of the relative commonness of abortion in the U.S.

Payor: Cash, Private Insurance, and Medicaid

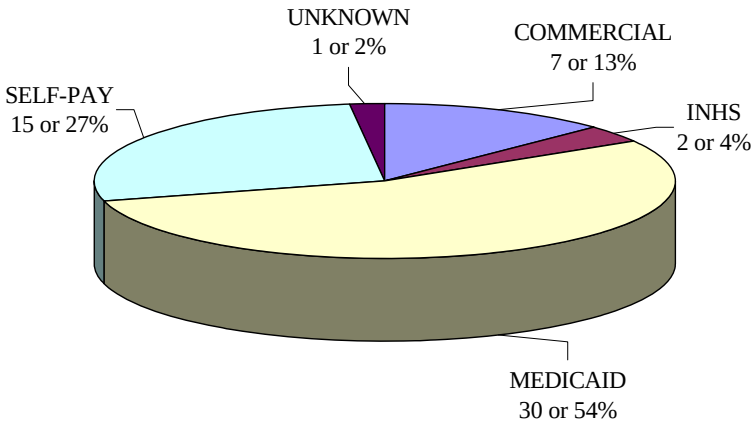

Figure 3:11 Payor

Medicaid Funded Abortions and Access in Albuquerque, New Mexico

Before the Hyde Amendment of 1977, which outlawed most Medicaid funded abortions, Medicaid paid for "elective" abortions, but even then many states covered only a small percentage of the financial cost. This is not to underplay the negative impact of the Hyde Amendment. After it was passed, the annual number of Medicaid-funded abortions dropped nationally from 295,000 in 1977 to 194,000 in 1978 (Henshaw and Wallisch 1984:171). This was a significant decline, even though 16 states and the District of Columbia continued to fund elective abortions in 1978 with their own funds, either voluntarily or by court order. In the other 34 states, including New Mexico, that along with the federal government refused to fund abortions, publicly subsidized abortions fell by 99% (Gold 1990:42). Several appeals to the Supreme Court upheld the Hyde Amendment. The Court essentially denied that the federal government's refusal to fund Medicaid abortion "interferes" with a poor woman's constitutional right to abortion (*Maher v. Roe* (1977), *Beal v. Doe* (1977), *Poelker v. Doe* (1977), *Harris v. McRae* (1980)). According to these rulings, a poor woman "remains free" to seek abortions with her own funds. However, such statements ignore the realities of poverty and the difficulty of finding funds for pregnancy terminations that cost between $350 to $450 in the first trimester and increases significantly in cost each week after 12 weeks (Kolbert and Miller 1998:98). In *Planned Parenthood v. Casey*, the Supreme Court adopted a new "undue-burden" standard that permitted states to enact limitations on abortions as long as the policies did not have the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion" (*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833[1992]).

In 2006, abortions were only covered by federal funds when the pregnancy was the result of rape, incest, or would harm the health of a woman. According to a study done before the Hyde Amendment, "Medicaid-eligible patients experienced no delay in obtaining abortions compared with other women, even when demographic differences were considered. However in 1982, they were significantly delayed" (Henshaw and Wallisch 1984:170). The *Roe v. Wade* decision of 1973 made abortion a legal choice. However, with the Hyde Amendment women on Medicaid cannot just "choose" to terminate an unwanted or poorly timed pregnancy. There are multiple barriers placed between low-income women and access to abortions.

Although federal funding cannot be used to cover "elective" abortions, individual states have the option of expanding their coverage of Medicaid funded abortions. In 1994, New Mexico adopted a policy that required Medicaid to pay for "medically necessary" abortions. New Mexico dedicated state monies to the coverage of medically necessary abortions, defined as when a pregnancy "aggravates a preexisting condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis or has a profound negative impact on the physical or mental health of an individual" (Baker, D. 1998: D, 2). Under the current interpretation of the law, women with unintended pregnancies would experience a "profound negative impact" if she was forced to carry the unintended pregnancy to term.

Beginning in 1995, New Mexico politicians attempted to reverse the earlier decision and only provide coverage for abortions to save a woman's life. Three years later, the State Supreme Court of New Mexico ruled unanimously that restricting state funding of "medically necessary" abortions was unconstitutional. The Court agreed with

abortion-rights advocates that the efforts to restrict Medicaid abortions would have an unequal, detrimental impact on the lives and health of women, therefore, violating the state's Equal Rights Amendment adopted in 1973. One State Supreme Court Justice stated "there is no comparable restrictions on medically necessary services relating to physical characteristics or conditions that are unique to men" (Baker D. 1998: D, 3).

This was an important decision for the Powell Clinic where about half of the women we serve are covered by New Mexico Medicaid. For example in 2006, over 51% of clients were enrolled in New Mexico Medicaid. At our "sister clinic" in Dallas, Texas, Medicaid does not cover abortion procedures. Dr. Dunn lives in Texas and flies to Albuquerque every other week to provide abortions at the Powell Clinic. She said:

> The state of Texas really doesn't care about the poor. They have one of the lowest amounts of money that they give people that are on welfare. They don't pay for abortions like they do here in New Mexico. Then, they badmouth them when they have all these children (Sara Dunn, staff interview:04/08/2006).

When asked how women pay for their abortions in Texas, she said:

> They have to come up with cash. You don't see a lot of really poor people having abortions. A lot of times we see mothers bringing their daughters in, but we don't see a lot of poor people like here in New Mexico. If we do, they have somehow managed to come up with the money (Sara Dunn, staff interview:04/08/2006).

There are some resources for low-income women from Texas such as the Lilith Fund and the Texas Equal Access Fund (TEA Fund). These are grant organizations, which pay for a portion of pregnancy termination services, and they are resources available only to women from Texas. The Lilith Fund gives from $50 to $75 toward the cost of a

termination, which can be helpful if you are in the first trimester and a procedure costs around $400. However, it is negligible when your abortion fee may be well over a thousand dollars in the second trimester. On the website, the Lilith Fund gives women advice on how to get enough funds together to cover and abortion procedure. The website says,

> Determine how much money you have right now and all the possible ways you can acquire the amount needed. List five people you can ask for twenty or more dollars. Write down the next time you will receive a paycheck or other form of income and how much money you can take out of it. Consider other ways to raise money: hold a yard sale, sell CDs or books, pawn something, get a temporary job, do odd jobs, babysit, clean houses, housesit, be a dog walker, use a credit card, use a trusted friend or family member's credit card, etc. Add up all of the figures written down: this is the amount of money you can raise for your abortion. If you have all you need, then that's great! Please keep in mind that abortion assistance funds have small budgets and must help many, many women. You will be responsible for most of the cost of your abortion (Lilith Fund 2009).

All of these recommendations may be helpful, but taking the time to get an extra job or raise the cash can be problematic for women running against the exponential clock of pregnancy. Some women are not aware that the price of a termination increases weekly after the first twelve weeks of pregnancy. Women will call the clinic for an appointment and be shocked to learn that the fee has increased because they were waiting to get their payment together. The clinic tries to do a lot of over the phone education, informing women that the safest and most affordable time to terminate a pregnancy is in the first twelve weeks from the last normal period. The TEA Fund has pledged up to $1,000 for clients who come to the Powell Clinic. The TEA Fund is similar to other not-for-profit organizations throughout the United States such as the Eastern Massachusetts Abortion Fund (EMA) and The Chicago Abortion Fund (CAF). Although there is some financial

support available to women whose insurance will not cover an elective abortion or for women who are uninsured, the need far outweighs the funds. According to Dr. Dunn, there are just not enough resources to help all of the women.

For most states and for all federal plans, termination services are only covered to preserve the life of the mother. In 2006, there was a client who came to the Powell Clinic for a second trimester abortion. About a year beforehand, she had gone through a full term pregnancy only to have her baby die two hours after delivery because of severe genetic malformations. Approximately a year later, she conceived again and had an amniocentesis which revealed that her eighteen week fetus had the exact same genetic abnormality and would either die in the third trimester or die shortly after birth. She was the wife of an employee at a nuclear weapons assembly and disassembly plant run by the Department of Energy just south of Amarillo, Texas. Although her child could not survive outside the womb, her husband's federal insurance refused to pay for a termination because they argued that it not a threat to the health of the mother (Clinic field notes:4/11/2008). The insurance company refused to cover a $2,000 pregnancy termination but would cover a $10,000 high-risk delivery of a doomed child. After delivery, doctors are also required to keep the baby alive as long as possible, adding to the medical bill. The client ended up terminating her pregnancy at our clinic, but she had to pay out of pocket for her abortion because it was technically considered "elective." This is a clear instance in which the state, via the insurance corporation that covered a government employee, did not operate by financial prudence but by ideological edict. Many corporations have ideological motivations that subvert financial gain. For example, a major pharmaceutical company refused to sell a drug that controls bleeding to

abortion clinics in the U.S., including the Powell Clinic. Laws such as the Hyde amendment, which limit Medicaid coverage of abortion services, disproportionately impact women living in poverty.

Conclusion: Abortion Rates Don't Tell Stories

The U.S. has one of the highest abortion rates in the first world. When I first began counseling women at the Powell Clinic, I would mention to clients that more than one in three American women have an abortion. My intention was to normalize a client's position, attempting to reassure her that the predicament that she found herself in was in no way unusual. I quickly abandoned this approach when clients responded with looks of disgust rather than finding solace in the fact that there were many women who had made this choice. Considering the common practice of abortion in the U.S., it is surprising how little accurate information there is regarding its safety. That is the topic of the next chapter.

CHAPTER 4:
Abortion as a Medical Procedure

The purpose of this chapter is to explain the abortion procedures that take place at the Powell Clinic in order to demystify them. Although abortion is the most commonly performed surgery in the United States, few Americans know much about it, and this includes women who have had an abortion. Much of the information clients receive is misinformation. This chapter discusses the various processes (dilation and curettage, chemical abortion or RU-486, and dilation and evacuation); pain control techniques; and the ways that clinic staff and clients talk about the procedures. The National Abortion Federation (NAF) has established national standards for performing abortion procedures. As a member of NAF, the Powell Clinic adheres to the highest standards of medical care and receives regular site visits from NAF representatives. This chapter will illustrate to the reader that abortion services, when performed in a proper environment by a skilled practitioner, are safe and legitimate medical procedures.

Safety of Abortion and the Importance of Legality

Some argue that abortion, or the intentional interruption of a pregnancy, has been practiced for as long as women have been conceiving (Riddle 1992). There may lurk, however, a bit of historical positivism in the argument, as it is not uncommon to use modern practices to validate pre-modern behaviors. There is little archeological evidence regarding pregnancy and the practices surrounding it, nor do we know the degree to which abortion was used to limit population. It is an accepted tenet in demography that a

culture that values larger family or social units will promote fertility. In turn, cultures that value smaller social units will reduce fertility by various means of intervention, be it fertility suppression, the use of abortifacients, or infanticide (Polgar 1972:206). In prehistoric societies with high infant mortality rates, it is assumed that the population of social units was primarily regulated by external factors such as disease and starvation.

Most scholarly studies of population control in the ancient world hypothesize that infanticide was the primary method utilized to limit populations. This is because data suggest a much higher male-female ratio in the ancient world than would occur in a neutral reproductive environment where sex selection does not occur through human intervention. In pre-modern societies that value males over females, the sex of a child could not be determined until birth. Therefore, infanticide is believed to have been the most extensively used means of population control during antiquity (Riddle 1992: 11).

Although infanticide may have been most commonly practiced, pregnancy interruption probably has been practiced for thousands of years. For instance, in the ancient healing practice of Chinese acupuncture, there is a point on the foot called the "forbidden point," which was thought to cause a spontaneous miscarriage. In the early colonies of the United States, abortion was the domain of women practitioners who were involved in all aspects of women's reproductive health: from pregnancy prevention to termination to delivery. Abortion remained a legal, albeit, hidden practice until the mid nineteenth century. There was widespread availability of "female remedies" in the early 1800s and local apothecaries were providing herbs and instructing women on herbal methods. Petchesky argues that it is "the visibility of abortion rather than its incidence that arouses organized opposition" (Petchesky 1984:77). During the nineteenth century

abortion was becoming more socially recognized as it shifted from secret acts of women to drug companies and local pharmacists. As it became more visible, abortion gained more attention from the AMA. In 1850, the AMA won its battle against so-called abortion quackery (*i.e.*, midwives and apothecaries that provided "advice" to women), and pregnancy termination became illegal in United States. From the 1850s to 1973, it remained illegal.

The movement to re-legalize abortion began in the mid 1960s. The Vietnam War and the civil rights movement brought a new era of ideology around women's rights and abortion. Ironically, when the AMA endorsed the legalization of therapeutic abortions in the late sixties, the "pendulum of the sexual control-population control dichotomy swung far in the direction of the latter" (Petchesky 1984:122). Abortion became both visible and medicalized, making it far safer than before but perhaps also engendering a more visible opposition.

Abortion as a Medical Procedure

The methods used to perform an abortion today are well developed, making the process over ten times safer than delivery (Guttmacher 2002:3). Even though abortion is a commonly performed procedure, most women do not really know how abortions are performed and many have learned what they know from anti-abortion literature or non-medical people. Most of the women that come to the Powell Clinic for services have never been taught about abortion procedures, and there is a lot of ignorance even in the medical field. For example, Heather was a thirty-one year old Albuquerque resident at the time of her seven-week termination. She is White, single with three children, and

identified as a Christian. She worked in a hospital as a nursing assistant and she knew nothing about abortion:

> I didn't know what to expect. I didn't know what they were going to do. I didn't know what everything consisted of. I basically went into it blind. They gave more than enough information about the procedure and I was able to go in and talk with a counselor before I went in and had it done. That was very helpful. But before I got to the clinic, I knew very little (Heather, client interview:10/10/2006).

Other clients had little or no medical background and knew even less than Heather. As a result of social stigma and misinformation, many of the women who come to the clinic are surprised by the simplicity of the process. Lorena was a single, 25-year-old Hispanic woman from Albuquerque. In 2006, she was in her second year of her undergraduate education. She had an abortion at eight weeks and said:

> [I]t was a lot safer and more comfortable than I thought. When I went in there, everyone was awesome. I felt safe. I woke up and then went and had lunch with my friends. Then I went home and went to bed for a little while. But, it wasn't anything that I imagined (Lorena, client interview:05/25/2006).

Like many women, Lorena expected a physically traumatic experience. Women who come to the clinic sometimes ask if it is a "real" doctor. Women have a lot of fear and anxiety as they walk through the clinic doors. Clients often express anxiety or fear about pain. Each woman is offered 2 cubic centimeters (cc) of a pain blocker called Sublimaze and 2 cc of Versed, an anti-anxiety drug. With soft music playing, the presence of the counselor during the procedure, and the strong medications, most women in the first trimester of a pregnancy experience relatively little discomfort. There are some exceptions, and a few clients do require more pain medications. Clients at the Powell Clinic can always request additional medications if they are experiencing more pain than

is tolerable. A small, plastic catheter is placed in the crook of her arm through which the nurse administers several intravenous (IV) medications: Robinol (1cc) is given to regulate her blood pressure and heart rate during the procedure. Reglan (5mg) is a very strong medication given to counteract the common side effect of nausea associated with morphine drugs as well as pre-existing nausea caused by pregnancy hormones.

Mattie was a twenty-six year old woman who identifies as Hispanic and Native American. She grew up in Albuquerque and is attending graduate school at the University of New Mexico. This was her first pregnancy and she was in the first few weeks of pregnancy at the time of her abortion. Mattie described her procedure:

> The actual process went really well. At first I thought my boyfriend was going to be able to come in with me and when they said he couldn't, that was a little disruptive. But in the end I actually think that was better, in the long run. It was a lot easier than I had anticipated in my mind. I thought it was going to be some big procedure, but the fact that there was a counselor with me through it made it so much better. I felt like I was in a safe place (Mattie, client interview:02/07/2006).

Unfortunately, some abortion clinics do not use advanced pain-control techniques and some women have reported having extremely painful experiences. One clinic in western Texas is especially notorious for mistreating women, physically and emotionally. Nicky was a 25-year-old white woman and had a earlier abortion when she was 19 years old. She explained:

> When I was 19, I had an abortion, and it was a really horrible experience. It was in Texas, two hours from where I lived. A friend took me and, they didn't really tell me a lot before hand. I was only 19, so it was really scary. The procedure was really painful. They gave me a pain pill while I was in the waiting room, and then nothing during the procedure. Afterwards, they didn't tell me what to expect or anything and I had really horrible cramping and bleeding, and I thought that I was going to die. When I called them to say, what is wrong with me, they were like, oh, that's normal. They didn't give any painkillers for afterwards. I felt all

> alone because I couldn't tell anyone. This time, when we decided to do this, I was really scared because I had such a horrible experience. This was totally different. It was a lot more professional and I was so comfortable. It made me feel a lot better about my decision. I didn't feel like, the last time, I really regretted it. I felt like I had done the wrong thing. This time, it was a lot better. I don't feel guilty (Nicky, client interview:02/14/2006).

Nicky's first painful and traumatic abortion led to a more emotionally difficult experience. With the use of a combination of a narcotic and an anti-anxiety drug, and skilled providers, abortion procedures can be safe and relatively comfortable.

In addition to the availability of powerful pain medications, the Powells train counselors in pain control techniques. In the counseling manual, pain management is defined as "working with the patient to help her cope with, control or modify her perception of discomfort in the safest, most positive way possible." Every counselor has her own personalized approach to helping the client through the physical process of the abortion. Many of the Powells' counselors employ hypnotic suggestion in which soft tones are used to convey a sense of relaxation and wellbeing. In the counseling manual, the following is a template for a relaxation exercise that counselors can use to aid clients through the abortion process:

> Feel the relaxation flow into your thighs and hips, all the tension out…your stomach relaxes now, and the relaxation continues to spread…Deep into your chest, across your shoulders, into your arms and hands, deeply, pleasantly relaxed. Neck relaxed, the muscles of your face, the muscles around your eyes, relaxed (Script for Relaxation and Hypnotic Induction from the Powell Clinic Manuel).

The use of suggestive language can be very effective at helping a women experience less discomfort and have a greater sense of wellbeing during the procedure. Counselors will sometimes ask clients if there is a certain place that makes them feel peaceful and calm,

such as the beach or the mountains. During the abortion, counselors have been trained to do guided imagery. For instance, if the patient enjoys the beach, a counselor may take her on a mental vacation. It might go something like this: *Imagine you are at the beach. The sun is yellow and shining and warm on your skin. The green, blue waves are gently lapping at the sand. You can hear the waves meeting the beach, then softly slide backwards. You may hear a seagull or two in the distance. You can smell the salt in the water and you are lying in the warm, soft sand. You feel very relaxed laying there on the beach*. If the patient is receptive to such suggestions, the counselor may continue the guided relaxation throughout the entire abortion process. Counselors have been trained to use pleasant and descriptive words. They have also been trained to be sure that the client chooses the context of the guided imagery, for it is counterproductive to describe a beach scene to a woman who is afraid of water. Other women want to know what is happening as the process occurs. For these women, counselors will explain the process to the client and normalize any sensations (pressure and cramping) that she may be experiencing. Having a counselor beside a client during the abortion process helps a woman to feel more control during the procedure and the clients usually have a much better outcome.

Dilation and Curettage (D&C) or the Aspiration Abortion

An abortion performed in the first twelve weeks from the last menstrual period, called a dilation and curettage procedure, is an extremely safe procedure when performed by a medical professional. According to the National Abortion Federation, which first began collecting national data on the safety of abortion in 1977, major complications occur in

less than one percent of all pregnancy terminations (NAF 2002:11). Although very rare, the possible complications from a surgical abortion include infections (0.1% to 2.0%), laceration (0.6% to 1.2%), perforation (less than 0.4%), incomplete abortion (0.3% to 2.0%), and excessive bleeding (0.02% to 0.3%) (Henshaw *et al*. 1999:11-22). Deaths are rare during abortion, occurring in 0.0006% of all surgical abortion in the United States, or one in 160,000 cases (Henshaw *et al*. 1999:14). Abortion related deaths are usually the result of an adverse reaction to a medication, an embolism, severe infection, or hemorrhaging. Comparatively, a woman's risk of death when continuing a pregnancy and delivering is ten times greater than with abortion. Although anti-abortion literature often claims that women who have an abortion are more likely to develop breast cancer, large scale, longitudinal studies have revealed that there is no relationship between abortion and breast cancer (Melbye *et* a*l*. 1997:83).

At the Powell Clinic, the dilation and curettage procedure is the most commonly performed process. The procedure begins with a pelvic exam. Two fingers are inserted into the vagina and the doctor presses down on the abdomen to locate the uterus. Then a speculum is inserted into the vaginal canal to hold the walls of the vagina to the side. This helps the doctor see back into the vaginal canal to locate the cervix. The doctor uses a brown, iodine-based antiseptic called Betadine and gauze to clean the vaginal canal. Once the cervix is located, it is numbed with lidocaine (commonly used by dentists) through a series of twelve injections, six subcutaneous injections just below the cervix and then six deeper injections down the length of the cervical canal. This is called a paracervical block. It was developed by Dr. Powell and is used by abortion providers throughout the United States. When the nerve-endings of the cervix are temporarily

deadened, the cramping a woman feels while the cervix is opened is greatly reduced. Most women do not describe the cervical injections as painful, more like a pressure or a cramp. This is true because of the extremely small gauge of needle that is used and the effectiveness of the pain and anxiety control medications (Sublimaze and Versed) administered intravenously immediately prior to the procedure. After the paracervical block, a sterile instrument called a tenaculum is attached to the numbed cervix. This is a pincer-like device that allows the doctor to grasp the cervix and manipulate it during dilation. Because the cervix is numb, clients rarely feel anything when the instrument is attached and the attachment site heals quickly, within a few days, and is usually painless. I write "usually" because some women do have more pain than other women. For instance, women with a history of narcotic use do not feel the narcotic medications as strongly as women who have not had wide exposure to opiates. If a woman has had a previously identified allergy to Lidocaine the cervical block may be omitted, causing greater discomfort. Some younger women who have never been to a gynecologist before may experience more discomfort, but this is not always the case.

After the cervical canal is numbed with lidocaine, it is opened, or dilated with sterile plastic rods that start at a very small diameter, about the diameter of a matchstick, and gradually get wider, thus allowing the cervical muscle to slowly be opened. After the desired dilation is achieved (based on a woman's ultrasound results), a sterile, rigid plastic tube called a cannula is inserted through the dilated cervical canal partway into the woman's uterus. Cannulas come in several diameters, from the smallest "6" to the largest "12" for first trimester abortions. The diameter to which the cervical canal is opened and the size of the cannula used is determined by the size of the pregnancy. The size of the

pregnancy is determined by pre-operative ultrasound. However, this rule varies slightly with each doctor's personal preferences. During terminations from 6 to 9 weeks, the cannula is similar in diameter to a plastic drinking straw. For 12 weeks, the cannula is similar in diameter of a penny. The cannula is then attached to a hose that is connected to a suction machine, or aspirating machine. The doctor turns on the suction machine with a foot pedal for approximately 30 seconds to a minute. All of the contents of the uterus, including the pregnancy sac (5 to 9 weeks LMP) or fetus (after 10 weeks LMP) are removed. Sac is the clinical term for the biological matter of a pregnancy less than 10 weeks from the last menstrual period. The clinic staff uses the general term POC, or Product Of Conception, to describe the pregnancy and uterine contents.

After the first aspiration, the doctor takes an instrument called a curette, made of a small metal loop. The curette is moved back and forth along the uterine wall to loosen the decidua, or the nutrient lining of the uterus that would have become a period had conception not occurred. Then the cannula is reinserted a second time and the doctor does a final aspiration of the uterus. Lastly, the tenaculum is removed, gauze grasped by forceps is used to clean the inside of the vagina, the provider watches to be sure the bleeding level is normal, and then the speculum is removed. This is a typical first trimester termination at the Powell Clinic. Issues can arise during the process making it longer, such as patient discomfort or unusual anatomy. For instance, the clinic has seen a few women with two uteri, in which case both cavities must be evacuated, thus taking longer to perform the procedure. At the Powell Clinic, the entire abortion is guided by an ultrasound being performed on the client's abdomen to ensure the patients' safety and the

completion of the process. It literally takes a doctor as long to complete the process as it took you to read this passage, approximately five minutes.

In general, the earlier an abortion, the safer it is. There is an exception to this. If a woman is less than five weeks from her last menstrual period, the pregnancy can be too small to identify by ultrasound and, therefore, too difficult for the doctor to ensure that the pregnancy has been successfully removed from the uterus. In some cases the pregnancy is so small that during pathology when the physician views the tissue in the lab for irregularities and to ensure that the procedure is complete, it is impossible to identify the pregnancy sac. At less than 10 weeks from the last menstrual period, the biological matter looks similar to a small white piece of tissue. If the doctor cannot identify the sac, there is a small possibility that it may still be in the uterus or it may even be in the fallopian tube, which is a life-threatening condition. The clinic's policy is to try to schedule women's appointments at a time that is no-less-than five weeks from the last menstrual period. This is not too difficult for clients because most women do not establish that they are pregnant until they have missed a period, usually four weeks from their last period. If a woman comes to the clinic at less than five weeks from her last menstrual period, she is given two options. She is able to reschedule her appointment for a future time when she will be at least five weeks or she can proceed with the abortion under the early option protocol. Women may have to travel a long distance or go to great lengths to schedule the abortion procedure. Furthermore, most women who have decided to terminate a pregnancy are very anxious to "get it over with," and the idea of waiting a week or two can be distressing. With the "early option" procedure, the abortion is performed exactly like all other dilation and curettage methods. The cervix is slightly

dilated with sterile instruments and a cannula, or a sterile plastic tube, is placed part way in the uterus and connected to a suction machine or aspirator. For "early option" procedures, some doctors at the clinic turn down the suction machine in order to prevent the sac from disintegrating into small, unidentifiable pieces.

Manual Vacuum Aspiration Syringe

Some doctors at the clinic, depending on their skill and comfort level, will utilize a Manual Vacuum Aspirator (MVA). A MVA is a portable, non-electric device which, when used in the first 12 weeks, LMP, can safely and effectively empty a uterus. The syringe creates negative pressure after the plunger is manually withdrawn. Sterile cannulas, the part that actually enters the uterus, are interchangeable and the MVA can be used repeatedly with washing. The MVA is the perfect solution to providing first-trimester abortion services safely and cost-effectively in a low-resource context.

The MVA allows the doctor to have gentler aspiration than the electric powered aspiration machines. The lighter suction is more likely to keep the sac intact and identifiable.[5] In most instances, the doctor is able to identify the sac and then the client is highly encouraged to return to the clinic or her Ob/Gyn for a check-up exam. If the sac is not visible, the client is required to go to a local phlebotomy lab to have her blood drawn twice in what is known as a Quantitative HCG (Human Chorionic Gonadotropin) test. As a result, women who are less than five weeks LMP and do not have insurance will

[5] The MVA is also known as a menstrual extractor. The delivery of safe, sterile abortion procedures can be prohibitive, even without the presence of moral opposition. However, abortions can be performed in almost any setting with a Manual Vacuum Aspiration Syringe. Because the MVA is not powered by electricity, it can be effectively used in more remote contexts, such as in smaller villages and towns where there is no access to a motorized aspirating machine or where there is no electricity.

often wait a week or two because of the out-of-pocket cost of the blood test and required follow-up. A Quantitative HCG test compares the pregnancy hormones (HCG) in a woman's blood sample drawn on day one and then on day two to three. Those numerical readings are compared and if the second number is less than the first, she is no longer pregnant. If the second number is higher, she is continuing to produce pregnancy hormones, and is therefore still pregnant. The greatest concern is that a client has a tubal pregnancy. These are very rare but very dangerous because when a pregnancy ruptures a fallopian tube, a woman can bleed internally.

Chemical Abortions

The chemical or mifepristone abortion (originally known as RU-486) ends a pregnancy through the use of chemicals. Mifepristone is a medication that blocks the hormone progesterone from reaching the sac, and progesterone is necessary to sustain a pregnancy. With the absence of progesterone, the uterine lining changes and the sac detaches from the uterine wall. Then a second chemical called misoprostol (brand name Cytotec) is administered to cause the uterus to contract and expel the sac. The Federal Drug Administration (FDA) approved mifepristone abortions in September of 2000. Possible complications from a medical abortion include failure to terminate pregnancy (about 4%), hemorrhaging (less than 1%), infection (0.09% to 0.6%), and death from infection of Clostrudium sordelli (less than 0.001%) (Lichtenberg *et al*. 1999:208). The Clostrudium sordelli bacteria is believed to be responsible for the death of four women in California. The deaths have been geographically isolated to California and as a result, the Center for Disease Control (CDC) has hypothesized that the Clostrudium bacteria lives in the soil of

California. The CDC's investigation into these deaths is ongoing, and the protocols for administration of the medications have been changed. For instance, the Powell Clinic no longer has clients insert the misoprostol vaginally; rather, clients administer the misoprostol at their home by placing the tablets between the cheek and gum for 30 minutes, an administration method called buccal.

Of the 2,068 women who had an abortion at the Powell Clinic in 2006, 56 women, or almost 3%, ended their pregnancy with the chemical abortion. The process has many names; a chemical abortion, a mifepristone abortion, RU-486, or the vernacular, the abortion pill. Chemical abortions make-up 13% of abortion in the United States and 22% of abortions before nine weeks LMP (Jones *et al*. 2006:8).

There are several factors that limit the number of chemical abortions provided at the Powell Clinic. First, to be effective, only women who are less than eight weeks from their last menstrual period qualify for the chemical process. After eight weeks, the efficacy of the medications drops by about 25%. After analyzing the fact-based research, the medical staff at the Powell Clinic decided it was not medically prudent to offer the chemical process after eight weeks LMP. Many of the women who come to the clinic are beyond eight weeks and are required to undergo the surgical or aspiration process. Secondly, it is recommended that a woman about to undergo the chemical process have several days free of any obligations to allow the process to happen at home. Unlike the surgical abortion that is performed in about a 5-15 minute procedure, a chemical abortion can take several days and, rarely, weeks to occur. About 75% of women pass the sac within 48 hours of taking the second dose of medication, misoprostol. Women with career and school obligations or women who are already mothers may not be able to

commit their time to the chemical abortion process. The Powell Clinic usually recommends that a client have three or four days free of obligations.

There are a total of eight forms that a client has to fill out before a first trimester surgical abortion. For the chemical abortion paperwork, there are a total of twenty forms. The abundance of paperwork is directly related to the many variables of the process. For instance, approximately 4% of clients do not pass the sac at all.

To begin the chemical process, a doctor of registered nurse gives the client the first dose of mifepristone. Mifepristone blocks pregnancy hormones, causing the sac to fall away from the uterine lining. Six to thirty-six hours later, in the privacy of her home, the client will take the second dose of medication, misoprostol. Originally developed to help stomach ulcers, misoprostol causes the cervix to soften, the uterus to cramp, and 96% of the time, expel the sac. There is usually much more bleeding involved with the chemical process than with the D&C procedure because it is essentially an induced miscarriage. For the D&C, the clinic informs clients to call our 24-hour service if they fill a sanitary pad in less than an hour. For the chemical process, it is considered normal if you are filling more than two pads in an hour. There is often severe cramping associated with the process. To aid in comfort, the provider writes a prescription for Percocet, a strong narcotic, and Phenergan, an anti-nausea medication.

The side effects of the chemical process include pain, cramping and bleeding, but this is expected as part of the process. Other less common side effects include nausea, diarrhea, and fever. As with the surgical procedure, complications are rare. These include infection, hemorrhaging (1 in 500 cases), and failed abortion. Death from the

mifepristone abortion is extremely rare – in less than 1 in 100,000 cases (Grimes 2005:161).

From a clinical perspective, women who want the chemical abortion are often the worst candidates because many of these women do not want to "have an abortion." The chemical abortion is typically a very physical process and requires more commitment in terms of time off and number of office visits. With the surgical process, women do need to rest, avoiding exercise and lifting, but can mostly return to usual activities. With the exception of a rare complication, first-trimester, surgical clients have mild cramping and period-like bleeding. It is typical for clients who undergo the chemical abortion to have significant bleeding and severe cramping.

Beyond the physical nature of the process, some women are not able to commit to the chemical protocol because it also requires a check-up exam ten to fourteen days after the initial visit. Women coming from other states or who live in distant New Mexico towns have a difficult time finding travel time and funds to get to Albuquerque. As a result, most of the women that choose the chemical process live in or around Albuquerque. Although the follow-up exam is required and scheduled at the time of their first visit, there are a number of women that are not compliant and do not show up for their exam. For instance, in 2006, out of the fifty-six chemical abortions provided, only forty-three clients returned for their exam. That is almost 25% of all the chemical abortion clients that do not return for a follow-up. The nurse calls the two contact numbers that the client is required to submit, but sometimes these numbers are not working or she not able to ever reach the client. The clinic requires an exam with the chemical abortion because of the risk of an incomplete process or a tubal pregnancy.

About 4% of women never pass the pregnancy with the chemical abortion and they are required to undergo the surgical process to empty the uterus. If a client doesn't return to have a nurse confirm by sonogram and pregnancy test that she is no longer pregnant, she risks having a late-term spontaneous miscarriage or developmental problems with the fetus.

In 2006, one woman failed to return for her required follow-up exam. When she did come back, she was 21 weeks pregnant, almost past our gestational limit. She was able to complete the procedure through a dilation and evacuation procedure. The completion of the abortion was important because misoprostol is known to cause birth defects, a fact that is repeatedly stressed to clients. Clients must also return for a check-up because a small number of pregnancies never make it to the uterus. When a tubal pregnancy ruptures, it can be fatal. The clinic wants to confirm with a negative pregnancy test that the hormones have dropped and that the client is no longer pregnant. If a woman is still pregnant at the time of her check-up exam, then she typically will undergo the surgical process. The client is re-counseled before the aspiration procedure. She has already signed consent for the surgical abortion when the failure rate of the chemical abortion is explained during the initial counsel. However, a counselor at the Powell Clinic will answer questions about the process and go over the possible risks with the surgical procedure. Many women opt for the chemical abortion because they are fearful of the surgical abortion, so preparing a client for the process is important. If the chemical abortion fails, which it has at the Powell Clinic, the client is not charged an additional fee for the aspiration procedure.

Women have a very diverse experience when it comes to the mifepristone abortion. Some women find the process simple and prefer the privacy and non-invasiveness of the process. The mifepristone abortion may be an especially good option for women who have a very difficult time with pelvic exams or women who have experienced sexual abuse and have difficulty with touch. Some clients that come to the clinic choose the mifepristone abortion because, in their mind, it is not the same as having an abortion. I have heard many women say something to the effect of: "I don't want to have an abortion, isn't there just a pill I can take."

Dilation and Evacuation (D&E) or Advanced Abortions

Eighty-eight percent of abortions in the United States are performed in the first 12 weeks after the LMP (NAF 2006). Abortions performed in the second trimester, or after 12 weeks LMP, are done through a method called dilation and evacuation. In this process, the cervix typically is dilated over time with the insertion of lamanaria. Lamanaria are sterile strips of a sea plant that are inserted into the cervical canal. The lamanaria are manufactured by a medical supply company and are called lamanaria after the plant from which it is derived.[6] Over either one or two evenings, depending on length of gestation, the lamanaria absorbs moisture and slowly expand, thus opening or dilating the cervix. The dilation and evacuation procedure requires more skill and has inherently more risks than the dilation and curettage procedure. After the cervix has been dilated to the

[6] One client came to her abortion procedure even though, in her understanding, the doctor was going to put "lumenarias" in her cervix. Lumenarias, also know as farolitos, are a traditional New Mexican Christmas light. They are brown paper bags that hold a votive candle and a small amount of sand in the bottom for weight. The fact that she came to her appointment believing that she was going to have "lumenarias" inserted speaks to the desperation of women with unwanted pregnancies.

necessary diameter, a cannula is inserted into the uterus and amniotic fluid is removed by suction. Then forceps are used to separate the umbilical cord from the placenta, causing fetal death. After the sonographer and doctor confirm that there is no heartbeat by sonogram, the fetus is extracted from the uterus with forceps. The doctor then performs a curettage of the uterus and uses the suction machine again to ensure that the uterus is empty. This is also confirmed by sonogram at the conclusion of the procedure.

Depo Provera

Abortion is an extremely time sensitive procedure - women who want to end a pregnancy are racing an exponential clock. A woman may not realize that she is pregnant for many reasons. Some women have irregular menstruation due to illness, medications, athletic activity, breastfeeding, or birth control such as the Depo Provera, as 80% of women do not get a period when on Depo Shot. Depo Provera contains progestin and can cause irregular bleeding, which usually suspends menstruation. Since Depo Provera was approved by the FDA in October of 1992, the clinic has seen many women for second trimester abortions who received the Depo Provera injection a short time after they had already become pregnant. In the first ten days after conception, a sensitive HCG urine test will not show positive because the pregnancy hormones are not yet high enough to register on a test. So the scenario is this: a woman who has conceived less than ten days ago goes to a provider for the Depo Provera injection. The provider follows protocol and runs a urine test that shows negative. However, the patient is already pregnant and doesn't suspect so because she has been told that the test was negative. Women attribute the absence of their period to the shot because they are informed that approximately 80%

of Depo Provera users do not get a period at all. She does not realize that she is pregnant until she begins to develop the characteristic hormonal effects from pregnancy (*i.e.*, sensitivity to smells, nausea, tender breasts) or, she begins to "show." For young women who have never been pregnant, differentiating between being pregnant from the side effects of a new birth control method is difficult.

With the Depo Provera injection, women are told that a common side effect of the injection is weight gain, typically five to ten pounds, and they may fail to recognize the weight gain as a sign of pregnancy. Although a birth control method that requires a medical visit four times a year definitely has benefits, feminists warn that with the ease of use that comes with an injectable birth control also comes a great potential for misuse as Depo Provera is a method that "can be used surreptitiously" (Hartman 1995:3). One mother of a young client instructed me to give her daughter the "shot." I explained to the mother that I had to get consent from her daughter even though she was only sixteen. The mother implored, "At least don't tell her it makes you fat."

Menopausal Women

Confusion about pregnancy may also arise for older women who believe they are experiencing menopause. Women have come to the Powell Clinic with a pregnancy at the very end of their reproductive lives. Some menopausal women have been farther in a pregnancy because they believe that they cannot get pregnant and their periods are absent or irregular because of menopause. Older women sometimes feel a greater degree of shame than younger women because they feel that they should have somehow "known better." The oldest woman I counseled during my time at the Powell Clinic was a 47-

year-old mother of four and was mortified to find herself having an advanced abortion. With her previous pregnancies, the last of which occurred fifteen years earlier, she had severe morning sickness and always knew she was pregnant, even before she had missed her first period. During her fifth pregnancy, she experienced no morning sickness and attributed her fatigue, absence of menses, and weight gain to menopause.

False Periods

Other women may be more advanced in a pregnancy because they have had regular periods throughout a pregnancy. It is estimated that a quarter of all pregnant women continue to get regular, monthly periods after conception. So called "false periods" can lead a woman to believe that she is not pregnant, especially women with typically light periods who assume that light spotting was a real period. Having "false periods" can ultimately delay the discovery of a pregnancy and, subsequently, an abortion decision. Some women have had normal periods throughout a pregnancy can only discover that they are pregnant when they begin to "show" or feel movement.

Diagnosis of Abnormalities

Women with severe fetal abnormalities are typically not informed about a problem until about the sixteenth week LMP, when an amniocentesis can be performed. The fact that our current technologies cannot diagnose fetal abnormalities until the second trimester can significantly delay a woman's abortion decision. Although this population of women was not included in the study sample, the vast majority of women who come to the Powell Clinic to terminate a pregnancy because of fetal indications or genetic disorders

(*i.e.*, Trisomy 18, more commonly known as Edwards Syndrome, or Trisomy 21, more commonly known as Down Syndrome) undergo advanced abortions.

Medicaid Delays

According to a study conducted prior to the passage of the Hyde Amendment (*i.e.*, between 1973 and 1977), Medicaid-eligible patients experienced no delay in obtaining abortions compared with other women, even when accounting for demographic differences. However by 1982, Medicaid abortions throughout the country were significantly delayed. On average, Medicaid-eligible women received abortions 2-3 weeks later than other women (Henshaw and Wallisch 1984:170). Some women have come to the clinic for a second trimester abortion because of problems with Medicaid. Women applying for or renewing their Medicaid are at the mercy of caseworkers and their competence.

Teen Pregnancy

Teenagers obtain nearly one out of three abortions performed in the second trimester (NAF 1996). Thirty-five states have mandatory parental notification or parental consent laws for minors. Also, many teenagers have not been educated about pregnancy and may attempt to hide their pregnancy or deny that they are pregnant even if there are physical signs. Inexperience can also cause abortion delays for teenagers, as young women are not always experienced at negotiating the health care system on their own. New Mexico does not have a parental consent law to postpone an abortion decision; however, the rural

nature of this state leaves many teenagers with no access to transportation without adult involvement.

The marginalization of teenage women also occurs when they become mothers. The CDC reports that teen mothers are less likely to complete high school and more likely to live in poverty than other teens (CDC 2006:1). Pregnant teens aged 15–19 years are less likely to receive prenatal care and gain appropriate weight than women aged 20 years or older (CDC 2006:1).

Denial

Finally, basic denial is a culprit in many late term abortions. One clinic worker explained it succinctly when she said: "If you don't want to be pregnant, it is not hard to pretend that you aren't" (Clinic field notes:01/14/2004). During my time at the Powell Clinic, several women have come to the clinic with a last menstrual period date that indicates that they are in the first-trimester of the pregnancy, yet ultrasound results determine that they are well into the second-trimester. Many of theses women may even look visibly pregnant and do not understand why the abortion procedure cannot be completed that day or why the fee is much higher than what they were quoted over the phone.

The Staff's Comfort with Advanced Procedures

Advanced procedures are in general, more physically difficult and have higher risks than first-trimester procedures. New counselors at the clinic do not assist with advanced procedures because they require more counseling skills and specialized knowledge, including specific instruments. The vast majority of complications that occur at the

Powell Clinic, although rare in general, occur during advanced procedures. The managerial staff even conducts special daylong trainings around the staff's feelings about advanced procedures. At these trainings, the Powell staff has expressed frustration with women who wait until they are advanced in a pregnancy.

Some staff members have had experiences in motherhood that give them a different perspective on second trimester abortions. Rhonda Hausen, a staff member who performed the pre-operative ultrasound on all of the clinic's clients, had her son when he was 28 weeks LMP. Her first language is Spanish, but she also speaks fluent English and German. Before working at the Powell Clinic, she worked in an abortion clinic in El Paso, Texas. When asked how she felt about advanced procedures, she said:

> When I started here, it was very tough for me with advanced abortions. It was very tough for me. When I started to do sonograms, my tears used to come down and I had to go away from the patient and then come back in the room. Now, I got used to it. Or, I changed how I think about it. Because I used to go home and talk to my sister about it. Now, I think that it is important for women to have abortions, even big ones. Every woman has the right to choose. I believe so. But sometimes it is hard. It is sad. It is just denial. I think that when they start to get big, then they realize that they are pregnant at 20 weeks. That is when their stomachs start to grow...I used to say "Why!, Why do they wait so long to come in?" Now, I realized that they start to show when they are 20 weeks and then they cannot deny it any more, especially those little kids that come here who have never been pregnant before. They come and they are very late 24 weeks, 26, 30. And I have to tell them that they are too far. It is very tough. It is very tough to tell them that we cannot help them. They cry. They beg me. One attacked me, remember? (Laughs.) Poor me. It was the beginning of me doing sonograms and she grabbed me by the neck and said, "you need to help me!" She cried and screamed. Poor thing. She was 26 weeks and at that time we only went to 20 weeks, so she was way past our limit (Rhonda Hausen, staff interview:12/06/2004).

During an interview for a visual anthropology project, *Women on the Front Line*, I interviewed Lizzie Filipo, a then 26-year-old herbology student. In 1996, she worked at

the clinic as a counselor and discussed her feelings about advanced procedures. She said:

> I still feel that it is their choice, and every woman that I've been in a procedure with, that has been that far along, I'm glad that she is not having it (the baby). For whatever reason, it is not appropriate, it is unwanted and I agree with her. I don't feel any kind of anger towards her. It is the procedure itself that disturbs me. Yes, I guess I am a little angry at her for waiting that long, but I know that that is a judgment that I shouldn't make. It is just so developed at that point. There was one patient who was an alcoholic, so she probably was pretty much numb to the idea that she was pregnant. So, I can understand in that situation, but some other people...I don't know. I still think it is her right and I want to help her through it, but it is just harder (Lizzie Filipo, staff interview:11/26/1996).

Lizzie's discomfort with advanced abortions echoes the sentiments of several staff members at the Powell Clinic. It is not that women who are in the second trimester shouldn't be having abortions; it is more an expression of regret that these women do not live in a world where they can get to a clinic in a timely manner.

Dilation and Extraction (D&X) or the Partial-Birth Abortion Ban Act

The Dilation and Extraction (D&X) abortions occur after the 26th week LMP and are extremely rare, typically limited to cases in which a pregnancy endangers the life or health of a pregnant woman or in cases of severe fetal abnormalities. Although the Clifford Powell Clinic has never performed D&X procedures, I think it is important to explain them because of the media attention given to the "Partial Birth" Abortion Act of 2003. When the partial birth abortion ban was passed in November of 2003, it was the first time in U.S. history that the United States Congress outlawed a procedure that was considered medically necessary by physicians. The bill was first created seven years prior to its passing, and President Clinton had vetoed it twice. Partial birth abortion is not

a medically recognized term. In the partial birth abortion ban, the language was vague and there was no exception for the health of the woman. The American College of Obstetricians and Gynecologists opposed the ban because, in some cases, it is the safest method of termination for a woman. Because of the extremely broad language of the bill, ACLU lawyers advised the Powells and the clinic's other doctors to document on the clients chart the method of termination (*i.e.*, dilation and evacuation where fetal death occurs within the uterus) on every advanced procedure's chart in order to avoid a possibility of prosecution. The language of the law was too general and used non-medical terms, so providers who perform second-trimester abortions were not sure, exactly, what was illegal and what was not.

The Cost of Abortion, Private Insurance, and New Mexico Medicaid

If a woman or her spouse works for the state of New Mexico, then the state insurance plan will, in almost all cases, cover an elective abortion with the cost of a specialist co-pay. A specialist co-pay is typically $15, $20, or $35 dollars. The insurance of the Navajo Nation also covers elective abortions. So, if a woman is insured through the tribe, abortions are covered. Many other private insurances in New Mexico cover pregnancy terminations. The same is not true for insurances in Texas. The state of Texas does not cover elective abortions, not for employees and not for Medicaid recipients. This is also true for most private Texas based insurance plans. Texas plans typically only cover life of mother. Because of the difficulty women have with access to abortion in Texas, the clinic staff has a saying: "Don't mess-around in Texas," a play on the state's macho motto "Don't Mess with Texas."

Although New Mexico Medicaid does cover abortions, there are still many logistical barriers to women's access. There are different categories of coverage used by the New Mexico Human Resources Department. Women who have Medicaid must change their category from the family planning category (35F) to pregnancy related (35) in order to have abortion covered. The "family planning" category covers birth control and gynecological care for women, where as "pregnancy related" covers ultrasounds, prenatal care, delivery, and abortions. This requires a woman to get a proof of pregnancy from her doctor or clinic and go to her caseworker to have her category changed. Allocating abortion services to the pregnancy related category has created a barrier for women who are covered under the family planning category. Before Medicaid Managed Care, this distinction did not exist. The process of changing eligibility categories can take weeks, depending on the experience and availability of a woman's caseworker. At the Powell Clinic, patients on Medicaid are rescheduled at least three times a week because their caseworker has failed to switch their eligibility category. Requiring women to change to the pregnancy related category also creates problems with confidentiality. When a caseworker changes a woman's category in the computer from family planning to pregnancy related, her eligibility is not updated until the following month. If a woman goes to her caseworker in the first three weeks of the month she is forced to disclose her intent to terminate in order for her caseworker to go into the computer system and retro-activate her eligibility for that month. In some cases, it can even prevent a woman from having an abortion because by the time she is eligible, she may be beyond our clinic limit. In 2006, that limit was 21 weeks LMP, the latest in the state of New Mexico. There are clinics in other states, such as in Colorado and Kansas that go beyond 21

weeks, but Medicaid eligibility does not cross state lines. A New Mexico Medicaid patient would have to come up with several thousand dollars to have an abortion in one of these clinics, and travel long distances, resources often not available to low-income women.

Conclusion: Abortion as Legitimate Medicine

Abortion provided in the context of modern medicine is a safe and generally simple procedure, especially when performed in the first trimester. There is a substantial amount of misinformation about abortion as evidenced by the expectations of women who come to the clinic. Clients are typically prepared for a three-hour appointment, and many women expect the procedure to take hours to complete. Even abortion workers' so-called advocates in the community know little about how abortion services are provided. In 2008, some members of a local pro-choice organization came to the Powell Clinic to learn about abortion procedures. Most of the members had no idea how an abortion was performed, even female members, some of whom had undergone the procedure. Although abortion is the most commonly performed surgery in the U.S., few Americans are educated about it. Much of the existing information is misinformation or half-truths. One reason is that the stories of uneventful and painless abortion procedures rarely get perpetuated. Another reason so few people know about the procedure is because pro-life activists have been successful in constructing abortion as a sadistic and painful event. Even people who identify as pro-choice don't "like abortion" and often consider it violent and gruesome. The pro-life side of the debate has successfully vilified abortion through the recurring use of the visual spectacle of the dismembered fetus. Abortion is never

characterized as a safe, medical procedure, but only as a brutal act that harms women. There is no discourse on positive abortion experiences. The cautionary tales of the dangers of abortion have many venues: gossip, anti-abortion websites, health classes. The portrayal of abortion as dangerous also happens directly outside of the Powell Clinic walls, where pamphlets that claim "You Might Die Today" are handed to women entering the parking lot.

CHAPTER 5:
Pro-life Language and the Saturday Morning Protesters

> *I believe life begins at conception. It is not just my belief, it is a scientific fact that any doctor will tell you. Before the woman has missed her first period, the heart is beating and there are brainwaves measurable at something like forty-two days. At this stage (holds up a pink model of a ten week fetus), he has brain waves for rudimentary thinking process. He can suck his thumb at ten weeks. He has fingerprints. He is sensitive to heat, to touch, to light, to sound. He absorbs nutrition. He is breathing the oxygen that comes through the umbilical cord. If you could see him on a clear ultrasound, he would look like an astronaut or a little Olympic swimmer. He is just so graceful and so beautiful. In other words, he…or she is one of us. There is a spiritual and genetic destiny for each little baby. God has a plan for each one of us.*
>
> - Paul, a pro-life protester in front of the Powell Clinic

These are the words of an anti-abortion protester responding to the question "When does life begin?" For right-to-life activists who stand outside of the clinic each Saturday morning from eight a.m. to about twelve thirty p.m., it begins at conception, the moment a sperm and an egg join to create a zygote. The moment when life begins is a common dispute among and between scientists and theologians. The commencement of life is a theory, a belief that is advanced through language. The polarizing abortion debate in the United States demonstrates the power that words provide us as we attempt to define our experiences and uphold our world-views. The claims of life's beginning are made with words, by labeling a pregnancy or a fetus a "baby," or by calling a pregnant woman a "mother." The abortion debate is, among other things, a battle for verbal control over the definitions of bodies. It is a war waged through the manipulation of

highly emotional symbols, resulting in a great deal of semantic contention and confusion. The central metaphor for the pro-abortion movement is choice and the central metaphor for the anti-abortion movement is life. In the abortion debate choice and life have become symbolic opposites as America negotiates abortion, or what Supreme Court Justice Harry Blackmun called an issue on the "raw edge of human existence" (Baird and Rosenbaum 1989:13). The pro-choice movement calls their political opponents "anti-choice," while the pro-life movement dubs their opponents "pro-death." The abortion polemic is a continual anti-dialogue, where activists on both sides of the feud co-opt their enemy's vocabulary and images.

In 1997, I produced a video for a media arts project called "Women on the Front Line: Voices of Abortion Workers" in which I juxtaposed interviews of clinic staff and clinic protesters. In this chapter, I use quotes from the protesters taken directly from this video. When I first conceived of this dissertation project, I had intended to conduct additional open-ended interviews with protesters, but the Human Subjects Review Board at the University of New Mexico was concerned that to do so would be a conflict of interest with my role as an abortion worker. However, I think it is critical for each side of the issue to step across the line and listen to each other. I include transcriptions of the video interviews from 1997 in order to provide the perspective of the protesters.

After the 2007 fire described in the introduction, the dynamics between the protesters and the clinic staff shifted. The staff moved from tolerance of the protesters to anger and fear. Also, the new clinic location, in a more public thoroughfare, has attracted more protesters. The clinic manager counts the number of protesters each day to include in the National Abortion Federation's report. Protesting abortions, or any issue for that

matter, is a very public act. In addition to deterring women at abortion clinics, presenting a visible opposition is an objective of pro-life protesters. Now that the Powell Clinic has moved from a quiet office set back in a parking lot to a major Albuquerque street, the location provides a more strategic positioning for the pro-life protesters. In 2006, the year I conducted all of the client and the majority of staff interviews, there were three or four protesters per week. There were exceptions, such as Easter Week, when there were eight protesters, the most all year. Probably because of a combination of the now more visible location and the attention generated from the fire incident, the number of protesters jumped from the "three regulars" to about thirty protesters each week. After our relocation, a group from a Catholic Church a few blocks down the street now walks to the clinic every Saturday morning.

On Saturday, February 14th, 2009, or Saint Valentine's Day, the clinic manager counted 130 protesters. Before the fire, there used to be more staff than protesters; now we are significantly outnumbered, and it feels different to staff members. The number of protesters outside the Powell Clinic fluctuates, increasing on religious holidays and the anniversary week of *Roe v. Wade*, and decreasing on cold or rainy days. Of the three regular protesters interviewed in the 1997 video, only one, Paul, continues to come to the clinic each Saturday. In 2009, along with the group that walks from the Catholic Church down the street and stands outside for about thirty minutes, three women (two White and one Hispanic), and three white men (including Paul and one with a camera) have become the regular fixtures on Saturday mornings at the Powell Clinic. In this chapter, I examine the pro-life worldview and the way in which it is promoted by protesters of the Powell Clinic.

Closed: 99 Ways to Stop Abortion (Scheidler 1985) is a field guide to shutting down clinics for the extremists of the anti-abortion movement. In this manual, Scheidler teaches the importance of controlling the language on abortion. The author advised, "[R]arely use the word 'fetus.' Use 'baby' or 'unborn child.'...'You don't have to surrender to their vocabulary...They will start using your terms if you use them" (Scheidler 1985:68). Similarly, Willkes' text for antiabortion activists urges followers to co-opt the pro-choice notion of "right to her own body" and use it when speaking about aborted female fetuses (Willke 1990:14). The appropriation of the feminist idea of the female body as a site of colonization is a powerful reversal when applied to the female fetus as a body with rights. Every day, women who identify as pro-life or who have been raised in pro-life homes and churches decide to have an abortion. Analyzing the language of the pro-life movement helps to frame the ideological perspective from which over half of all women who have abortions have come to their decision.

The Religious Right and the Reagan Era

It was during the Reagan years (1980's) that protesters became a real presence at abortion clinics, especially at the Powell Clinic in Dallas, Texas where the Christian right has been more vocal than in the primarily Catholic, live and let live, state of New Mexico. In 2006, our "sister clinic" in Texas had more protesters and daily activity than the clinic in Albuquerque. The protesters in Albuquerque only come on Saturday mornings. During the rest of the week, many of the same people, including Paul (quoted above), protest at Albuquerque's Planned Parenthood (PPH) surgical clinic. PPH was closed on Saturdays, so the protesters came to the Powell Clinic. On weekdays, the Powell Clinic is

inconspicuous and the women who enter the facility for services do so without challenge. Each Saturday, however, patients are subject to shouts and gruesome signs. This style of confrontational protesting at abortion clinics came into its own in the 1980s. Crowds began to form in front of once quiet and clandestine clinics. Women could no longer quietly exercise their constitutional right to end a pregnancy. Dr. Powell explained the shift:

> Reagan is the watershed. You can chart it. The number of hospitals that were providing abortion services was increasing [in the 1980's], the number of Ob/Gyn residency programs which included teachings about abortion was increasing, the number of doctors doing abortions was increasing. Then, it hit that divide. That is when Reagan and the Republicans made their pact with the Religious Right. Federal funding began to be withdrawn. Hospitals began to lose their federal money and they began to curtail abortions. Residency programs began to curtail training. Doctors began to be harassed, sometimes terribly. Clinics were blockaded, locks were glued (Clifford Powell, staff interview:11/15/2006).

The targeting of clinics continued through the 1980s and into the succeeding Democratic administration in the 1990s, but was definitely impeded by the Federal Access to Clinic Entrances Act (FACE act) of 1994, which prohibited protesters from obstructing or inhibiting women's entrance into reproductive health clinics. I interviewed Andrew, an elderly, white man, while standing in the parking lot outside the clinic on a Saturday morning in 1997. Andrew was one of the original "three regulars," but after the fire, he stopped coming. Andrew explained the rules established by the FACE Act:

> This is what I guess you would call private property (points to parking lot) and we are not supposed to talk to women. We are allowed eleven feet from the curb, that is legal to talk to people about abortions. But if we talk to them in front of the abortion clinic, then that is illegal, so we haven't been doing that. Of course, I walked back there a little while ago to see what was going on, but I wasn't talking to anybody (Andrew, protester interview:9/13/1997).

Even after FACE, pro-life activists continue to focus on clinics trying to make "saves," or changing a woman's mind about getting an abortion, and interfering with clinic function. For many years, the staff carried super glue solvent in purses and book bags because some mornings we would find the locks of the clinic filled with superglue. Pro-life activists have many tricks to undermine the clinic function, including placing rotting fish near the ventilation system on the roof and calling in bomb threats. On several occasions, clinic staff (including myself) has come out after a long workday only to find a nail in the side of a very flat tire. The harassment of clinic staff is the exception, however, as protesters mostly focus their attention on the clients whose opinion they believe they might be able to sway.

Life and the Cultural Construction of Personhood

It is important to consider the symbolic system of words used by pro-life activists who protest every Saturday. The "three regulars," as the staff dubbed them, would yell to women and their companions as they walked into the clinic. One protestor asked a patient if her "car was worth more to her than her baby" implying that she had selfishly chosen a nice car rather than putting her money toward supporting a child. In addition to employing verbal assaults, protesters hold up signs that say "Auschwitz, USA," "Abortion Hurts Women," "Don't get Raped Twice," and my personal favorite "Savior Baby," which evokes baby Jesus. In the past, protesters have entered the clinic property illegally, approaching cars in the parking area with pamphlets and plastic fetuses. Before the clinic moved to a more public location in March of 2008 (the fire occurred in early December 2007), they knew that women entering the medical complex on a Saturday

morning were there to have abortions because all of the other offices in the medical complex were closed. The dentist office, the vein clinic, and the yoga studio were empty. On Saturdays, the abortion clinic was a site where women who choose could be directly challenged. By focusing on the clinic, pro-life protesters positioned themselves at the physical and symbolic center of choice ideology, what one protester called "the abortuary." Unlike the even more aggressive tactics used by such organizations as Operation Rescue, these local protesters were labeled "annoying" by the clinic staff but were not considered particularly threatening. When asked why he protests at the clinic, one activist replied, "I am here for life."

The pro-life movement in the United States is founded upon a central metaphor of life. It is not a metaphor as a form of figurative speech, but metaphor in the way of understanding and experiencing one kind of thing in terms of another (Lakoff and Johnson 1980). For the right-to-life protesters, everything they do and say is understood in terms of life. Growth is life, a heartbeat is life, brain waves are life, movement is life, and they are there for life. The life metaphor of the anti-abortion movement is based on ideological tenets about personhood and the divine. The metaphor of life is a metaphor of personification. The human fetus is personified by being named and viewed as actively engaging its environment. In the anti-abortion literature that the three protesters handed out, there were several images of a fetus sucking its thumb. The literature describes the eleven to twelve week fetus as "very sensitive to pain, recoiling from pinprick and noise, and seeking a position of comfort when disturbed." These physical responses of a ten week fetus that pro-life literature attributes to the fetus feeling pain are considered by medical professionals to be basic neurological responses to a stimulus, not

at all evidence of higher thinking or a capacity to experience pain. In fact, current medical research indicates that a fetus does not have the capability to feel pain until the 28th week LMP. Research conducted by the AMA indicated that, before the third trimester, a fetus does not have the neurological pathways in the brain to allow for the "conscious perception of pain" (Lee *et al.* 2005:947). This study brings into question the regulations being proposed in such states as Virginia and Kansas that would require abortion providers to anesthetize fetuses at 22 weeks LMP or beyond before performing a procedure, especially considering these requirements increase the health risks to the woman. Senator Sam Brownback, a Republican from Kansas, introduced The Unborn Child Pain Awareness Act of 2004. He stated:

> This is the number one issue with the pro-life community. It is my hope that …once a woman would know her child is going to experience extraordinary pain in this dismemberment that she would say, 'I don't want to do this to this child" (Brownback 2004:1).

Every reference to the embryo or fetus in anti-abortion literature is saturated with life signifying words. For right-to-life protesters, life begins at conception and so does the social future of each "baby."

> It has to do with the cherishing of life, of loving God and of loving one another. Whatever that baby becomes, whether it's a physicist or a priest, whether it is a nun or a housewife, its destiny is to love and to be loved, beginning with conception (Paul, protester interview:09/13/1997).

Through language and shared ideas about life's beginnings, pro-life activists think of the fetus as a child, and begin to endow it with human characteristics such as awareness, emotion (joy and fear), the ability to feel pain, and, most significantly, citizenship. One of the protester's pamphlets called "What They Won't Tell You at the Abortion Clinic" asks beside a picture of a fetus, "What would you name her? Rebecca? Stephanie?" The

naming of a fetus serves more than a simple referential function. To name a fetus is to bring it to life. When the right-to-life protesters name a fetus, or speculate on fetuses' gender or future occupations, they have brought the fetus into their realm of personhood. A pamphlet regularly handed to the clinic clients on Saturday mornings called "Did You Know?" asks:

> Did you "come from" a human baby?
> No! You once were a baby.
>
> Did you "come from" a human fetus?
> No! You once were a fetus.
>
> Did you "come from" a fertilized ovum?
> No! You once were a fertilized ovum.
>
> A fertilized ovum? Yes! You were then everything you are today!
>
> Nothing has been added to the fertilized ovum
> Who (sic) you once were except nutrition.

For the protesters who hand out these pamphlets and the many Americans who identify as pro-life, there is absolutely no difference between a newborn baby and a fertilized ovum. God's plan has already been set in motion, so to speak. The fertilized ovum is already a member of humanity. It is a person and it is unique.

Personhood is an important concept in the analysis of the metaphor of life because it relates to ideas about societal membership and who has rights to laws and protection. Morgan argues that the concept of personhood is important in understanding the ways in which people endow fetuses and infants with meaning. Personhood is a "social birth," which gives moral status and membership into a community. It is a function of "cultural divisions of the life cycle, attitudes toward death, the social organization of descent and

inheritance, and social systems of authority and achievement" (Morgan 1989:102). A cross-cultural perspective shows that the beginning of human life and personhood are a function of whom society allows to become a person, under what conditions, and why. Personhood is a social status that can be conferred before physical birth, such as in the United States pro-life movement, it can occur at the moment of physical birth, or it can occur several weeks to even years after birth.

All cultures have different rituals of personhood. While studying in Ghana in 1993, I was invited to attend the naming ceremony of a week old infant. The Ashanti and Ewe tribes isolate the mother and child for eight days after birth. This is a dangerous and liminal time, the most probable time an infant will die. For the first week of its life, a Ghanaian baby is referred to only with his or her name-day. After a baby has survived a full week, he or she is initiated into social bonds with a celebratory naming ceremony, and only after this ceremony would the death of an infant require a funeral parade. Before this time, the infant has not yet been presented to the public, has not yet been named, and is not yet considered a member of society. In other words, he or she has not yet been conferred with personhood. It is naming, or becoming socially referential which incorporates human infants into a community of people. After surviving a week, an infant is considered a viable and potential member of the family. The cultural parameters of personhood, specifically, the beginning of personhood, are in many ways determined by a culture's infant mortality rates. Nancy Scheper-Hughes (1992) demonstrates how mothers in the Brazilian shantytown of Alto do Cruzeiro, have a different kind of "maternal thinking" with the high infant mortality rates they experience. She argues that

the notion of the individual as signified by naming is a uniquely Western notion. With infant naming patterns in Alto do Cruzeiro,

> (N)o one infant is viewed as totally unique. Infants can substitute for or replace one another. A newborn can inherit the name of an older, deceased sibling, and several children in the same family may be given a variant of the same personal name. Our firm belief that every child has a constitutional right, as it were, to his or her own individual name reflects our markedly individualistic way of thinking (Scheper-Hughes 1992:414-415).

In Brazil, like most countries in Latin America, abortion is illegal.

On the opposite end of the global spectrum is the Netherlands. In the Netherlands, where abortions are covered by the government-sponsored national health insurance system, there are two different terms for a pregnancy termination in the first trimester and in the second trimester. Anna was a thirty-two year old white woman from Amsterdam studying at an Auyrvedic institute in Albuquerque in 2006. She explained that the Dutch conceptualize a significant difference between early abortions when a pregnancy is embryonic and later abortions, and the former has no social stigma attached to it.

> For me, I just wanted to know what it was, what stage I was at, what was happening with my body. Then there are many different points of view for when the soul enters the body. You look at it from a whole different perspective. For me, I wanted to know what was happening in my body. To know what exactly what was going on. Some people will say, "You are killing a baby." But, when you look in this pile of mucous-y looking thing, you know that it is not a baby. That it hasn't formed yet. You are not killing anything. In Holland they use a different word when it's in the first few weeks than later. They call it a *vruchtafdrijvig*, which means an over-time procedure, and that helped me. When you use the word abortion right away, you have an image of these fetuses getting pulled out of your body. I think that they should use a different word when it is in the first few weeks. Knowing that the Dutch people don't use that word until later made me feel…It is not that I am in denial, it is just knowing, again, the decision of where I am at. So it helps using a different word. If

> it is this, then it is that. If it is this, then it is an abortion because then you're further along (Anna, client interview, 12/20/2006).

Viability

The pro-life protesters tell of extreme pre-mature deliveries to support the notion that fetuses can be self-sustaining, and are therefore people. Paul, the one regular who continues to come to the clinic said:

> This is the model of a twenty-week old baby. (Holds up plastic fetus). At nineteen weeks they have survived. That is the youngest an infant has survived. They kill little babies like this, little precious infants (Paul, protester interview:09/13/1997).

If a fetus can survive outside of the womb, then it is an individual, an infant, a person. The premature survival narrative argues that if a fetus can exist independently of the mother, then it should be considered independently of the mother. Through bio-medical technology, the stage of fetal viability, or the time when a fetus can survive outside of the womb, has been pushed back in a matter of a few years from thirty weeks, what most doctor consider viability, to 24 weeks. Before 24 weeks, some infants have survived, but many of these infants are not "intact," as they suffer from extensive physical problems. The post-delivery health of the earliest premature deliveries is not as meaningful for the pro-life protesters as the fact they can be sustained outside of a woman's womb.

There is a popular pro-life proverb that is chanted at marches and pasted on cars; "If there were windows on pregnant women's wombs, then there would be no more abortions." With our present technologies, there *are* windows on pregnant women's wombs. Every woman who enters the clinic is given a sonogram and bouncing sound waves creates an image of the fetus. Even before sonograms became an everyday

technology for clinics, we have been looking through the window of the womb with Lennart Nilsson's 1955 photographs of the human embryo. Not actually published until 1965 in Life magazine, Nilsson's first photographs of the various stages of the human fetus let us look into the womb with crystal clarity and witness natal development. Since published, his pictures of the fetus have been widely reproduced on pro-life literature, ultimately making the photographed fetus a cultural icon signifying life.

Through photographs inside the womb and advancements in biomedicine, which further separate the fetus from the womb, the fetus has become symbolically separate from the womb. In Nilsson's photos, the fetus appears to be suspended in space. Separating the fetus or "baby" from the body of a woman is an effective strategy to individualize a fetus and make claims of personhood more legitimate. The fetus must be seen as having a separate existence from the pregnant woman. As Paul, a protester said; "This little baby just can't wait to change apartments, he is ready to move out." To this pro-life activist, the fetus is not in or a part of the body of a woman, but in a temporary living arrangement. The fetus resides in a room, a *house*, an inanimate shell. In this narrative, the pregnant woman disappears behind the larger-than-life image of the fetus. Child rearing, women's status, social stratification, welfare, ethnicity, gender and disability discrimination, and changes in sexuality all influence our ideas about abortion. The essential difference between pro-life and pro-choice sentiments is derived from ideas of personhood and which "life" is more valued, that of the woman or the fetus. This is not to say that a choice advocate does not value the fetus or that a life activist does not value women, but one has precedence over the other.

In the language of the pro-life movement, as represented here by the words and literature of protesters, primacy is given to the personhood, or the rights of the fetus. In the hierarchy of personhood promoted by the pro-choice movement, the reproductive rights of a woman are sovereign. It is not simply the pro-life advocates of the polemic that strategizes through language. The pro-choice side is also invested in controlling the language. Inside the walls of the clinic, the terms "tissue," "pregnancy," and "fetus," are used to refer to what pro-life language calls a "baby." The naming of a fetus is a definite strategy in the pro-life movement just as the avoidance of naming a fetus is a strategy of the pro-choice movement. The war of words between pro and anti-abortion advocates is a symbolically rich encounter as both sides promote their different truths about the organization of the world. The language of both the pro-life and pro-choice movement is about defining the parameters of life, and we all have a stake in this.

Where "Saves" Happen

Diego is a Hispanic man who was in his forties in 1997, and he would come to the old clinic about twice a month. He would sometimes bring his young son. Diego said,

> This is outrageous exploitation of women that happens here. We have had many saves, and we support them, all the way through, not just through the pregnancy. We have clients that, for over twelve years, we have helped the families. A society that allows that, blood sacrifice to the devil, is what abortion is. They have sophisticated names today, but abortion is the killing of a child. You ask any four-year old child (points to his son) if they want to kill their brother or their sister, they would look at you like you were crazy. I don't care if they are from China, where they're from, they would look at you like you were crazy. Once we become educated, we become sophisticated and the definition of sophistication is worldly wisdom. There are a lot of people walking around with big degrees, sophisticated people, but they are walking, talking killers is what they are. A society that allows that will be destroyed. We are in the last days of

> Rome in the United States and this is the worst abomination on the face of the earth (Diego, protester interview:09/13/1997).

When a protester is able to successfully sway the decision of a woman to continue a pregnancy, it is called a save. In my many years of abortion work, women rarely change their decision once they get to the clinic. The majority of "saves" occur long before a woman gets to the office, when a woman cancels her appointment or is a "no-show" as it is called in the Powell Clinic vernacular. Although many women cite financial reasons for terminating a pregnancy, there are usually several other factors contributing to a decision, so the offer of financial assistance does not usually tip the scale in an abortion decision.

Patients' Feelings about Protesters

Most of the clients at the clinic never saw a protester during the time I was doing the interviews. The Powell Clinic provided abortions Thursday through Saturday and every other Wednesday. Protesters only came on Saturday mornings, so only approximately one-sixth of the patients are subjected to the signs and constant yelling across the clinic's parking lot. Because of the FACE Act, it is illegal for protesters to enter the clinic property. They set up on the public sidewalk and attempt to stop vehicles from entering the parking lot with the offer of a pamphlet, small plastic fetus, and plastic rosary. It is often very upsetting for women that do come on Saturdays and are confronted with the protesters. When confirming a Saturday appointment, the staff at the clinic warns clients that there will be protesters outside. The old clinic site was sometimes difficult to find and, ironically, patients were often able to locate the facility more easily by seeing the

protesters out in front. Clients had different reactions to their presence. Some women yelled back. Some women cried. Some women asked the staff if it was legal for the protesters to be there. Some tried to ignore their presence all together. Once in the clinic waiting room, the protesters could not see the clients nor their family and friends. Because they had to stand out on the street, their yells were muffled and almost inaudible in the waiting room. The Powells have been very sensitive in the design of their facilities, trying to make them feel less clinical, more comfortable, and very safe. Since the Powell Clinic has moved, it has become more difficult for women who come to the clinic on Saturdays and are smokers. They have to endure the protesters yelling and grisly signs when they step outside of the clinic to smoke.

When Elizabeth came to the clinic, there were no protesters, but she remembers taking a friend to the Planned Parenthood clinic. Elizabeth said:

> I took my friend to the Planned Parenthood and there are these crazy people there. They were crazy. They were chasing the car and falling down on their knees. They had escorts in the parking lot, like ten feet away from the door. They held an umbrella. Why would you … I don't understand how you can see someone who is clearly having an emotional time and at their weakest moment, and try to badger them and manipulate them and make them feel insecure. I find it totally distasteful (Elizabeth, client interview:02/21/2006).

For a short time after the fire, the Powell Clinic had patient escorts outside the new clinic which was much more open and accessible than the previous location. However, the presence of the escorts made protesters more aggressive in their tactics. The Powells decided that having patient escorts created greater conflict. When the clinic stopped using escorts, the number of incidents between patients and protesters decreased. As Dr. Clifford explains, having patient escorts plays into exactly what the pro-life protesters

want: engagement. The Powell Clinic asks patients with Saturday appointments not to engage with the protesters in any way. Without two clashing sides, most days, including Saturdays are calm at the Powell Clinic. One client described what she had expected:

> At the pregnancy center, they just think that this is such a horrible place, and it's not. They first told me that there are all these protesters and they will be banging on the window. I am like, yeah right, it is peaceful here. It is really comfortable, it is quiet and they have music. But, it can't be wonderful unless you are really ready for it (Kim, client interview:05/16/2006).

One participant was asked her opinion of the protesters. She replied:

> Yes, I do, a very strong opinion. (Laughs). When I went to Planned Parenthood, they do have protesters out there and a guy was chasing me down the street when I was leaving. I went in there just to make an appointment and this guy was harassing me. I just don't think a guy should be able to make the decision or have any say in it. It should all be a woman's rights. A guy doesn't know what a woman goes through, so they shouldn't be able to make the decision (Hillary, client interview:12/20/2006).

In 2006, two of the "three regulars" were white men. Like many clients, Hillary views abortion as a woman's issue. One client said about the male protesters, "get a uterus, then you can have an opinion" (Clinic field notes:2/24/2005). Even though the protesters are primarily passive, many clients are still disturbed by their presence and express feeling judged.

Some women who come to the Powell Clinic have pro-life activists in their family. When asked about how she was raised, Luz, a twenty-three year old Hispanic woman from a small town twenty miles south of Albuquerque said:

> My Mom used to protest. (Laughs). So, we aren't supposed to do this. That is why I told her there was something wrong with the baby. She would disown me if she found out what was going on (Luz, client interview:11/14/2006).

Even though her mother once protested, Luz chose to end her unintended pregnancy.

Anna, a thirty-two year old student from Amsterdam said:

> I wasn't raised with a particular religion or, or anything. I also think that because we are European that we are more grounded to just look at the reality of what situation we are in. It is one thing to see the billboards that say "abortion stops a beating heart" and all this heaviness, but those people who are standing outside, and I remember when I drove here to get it done, and there were these people standing outside, and, maybe they have the right intention, but who are they to … they are not going to have to take care this child, they are not going to have to pay for it, so it seems so silly to judge when you are not in that person's body. You don't have to live with that decision. (Anna, client interview 12/20/2006)

Staff Attitudes Toward Protesters

Each staff member has a different relationship with the protesters. Before the fire, they were usually considered annoying. Manuelita, a Hispanic counselor and part-time midwife, likened the protesters to annoying flies. Other counselors had stronger feelings. Lizzie talked about how the protesters make her upset her to the point where she felt like running them over with her car. She said:

> Especially when they stop a patient, I get really angry. Well, first of all they are men, and they have no place telling women what to do with their bodies. It is just another sign of our patriarchal society. If men got pregnant, there would be no question if they could get abortions. They could do whatever they want. It is just another way to control women. They don't take into account, most women that come in here, it is a very difficult decision…These people (the protesters) are just so ignorant. "Oh, stop the killing." Especially, when they compare it to Auschwitz or something like that. I just want to run them over. (Laughs.) And that is obviously not a solution. It really angers me. Religion is one thing, or trying to convert someone to your own religion. Fine, if you don't believe in abortion then don't have one, but don't try to stop some fourteen-year-old girl whose life will be changed forever if you stop her out there. The other thing is, they tell a lot of lies. Tell the truth. If you are really going to give her money, tell the truth. They don't do anything for these women. All they want to do is deter these women and scare them. If you are religious, they are more effective because they bring God into it. They have a big giant Virgin Mary out there. They have pamphlets and little

> dolls of eight week fetuses out there and it doesn't even look like a fetus at eight weeks, it is just tissue. They have to tell lies, because they couldn't be convincing in any other way (Lizzie, staff interview:11/17/1996).

It is generally accepted by both sides of the abortion debate that the other side is disseminating lies. One of the pamphlets that I have found crumpled up in the waiting room of the Powell Clinic warns women of the physical effects of abortion:

> Possible physical effects from abortion: intense pain, excessive bleeding, infections, shock, coma, death, loss of other organs, breast cancer, peritonitis, pelvic inflammatory disease, uterine perforation, blood clotting, menstrual problems, stillbirths, tubal pregnancy, sterility, insomnia, vomiting, gastro-intestinal problems, frigidity, weight loss/gain (Project Defending Life).

Interestingly, this same grocery list of physical ailments (with the exception of breast cancer) is also associated with childbirth but occur at a much higher rate.

Crisis Pregnancy Clinics

Since 1998, a new frontier of the prolife movement has emerged in the creation of Crisis Pregnancy Centers, or CPCs. These faith-based centers disseminate misinformation about abortion and its relative risks. It is currently estimated that there are over 4,000 CPCs in the United States as compared to 1,800 abortion clinics. (Kashef 2003). A 2006 study conducted by NARAL called the Waxman report found that of 23 CPCs telephoned by a researcher posing as a pregnant 17-year-old, twenty (87%) provided false or inaccurate information about the risks associated with abortion. CPCs tell women that having an abortion increases the risks of breast cancer, although the American Cancer Association has rejected the link between abortion and breast cancer. CPCs also told researchers that abortion causes mental health problems and can lead to Post-Abortion

Stress Syndrome (PASS). PASS, not recognized by the American Psychiatric Association, is the emotional damage women allegedly experience after having an elective abortion and its promoters categorize it as a form of post-traumatic stress disorder. Studies done with large populations, adhering to the scientific method, and that are non-anecdotal have all indicated that there is no evidence of negative emotional impact from an abortion. In 2008, Johns Hopkins University reviewed 21 studies, analyzing the experiences of over 150,000 women. This research team concluded that there is no difference in mental health between women who have had abortions and women who have not (Charles *et al*. 2008). Pre-existing conditions in a woman's life, such her relatonship to the pregnancy, absence of social support, pre-existing depression, and conflicting beliefs about abortion increase the likelihood of experiencing negative feelings after an abortion. However, studies indicate that there is not long-term negative impact for women's mental wellbeing. Adler (1990) determined that emotional distress is greatest before the termination. One 18 year-old client I interviewed said:

> So at the Birthright, they asked me what I was going to do, and I said that I didn't know. They started saying, "Oh, but babies are so cute, and that it is wrong to have an abortion," and this and that. They said, "don't kill you baby, it already loves you." But, they don't know. They are all older and don't know what it is like for me. I know babies are cute, but I been kind of depressed since I had my son. It is just so hard. If I had somebody, like the baby's Dad, who would help me. Like, if he would watch the baby sometimes and buy some diapers, I would have had it. But, I can't do it all by myself (Audrey, client interview:04/04/06).

CPCs Use of Ultrasound

CPCs, with government funding, have begun to purchase ultrasound machines. These are not used for medical diagnosis and care, but as a means of persuasion. A client named

Kim went to a CPC because they offer free pregnancy tests. She did not request an ultrasound, but was shown a pregnancy (that she eventually terminated) by the staff of the CPC.

> This last time, I went to a crisis pregnancy clinic over in the South Valley [a neighborhood in Albuquerque]. They were like, "we are so happy for you" and "are you going to have this baby." I said I was thinking about abortion. I was pretty set on my decision. They were like, "Oh my God, come into this room, and let's do a sonogram on you." They did like sonogram and they showed me it and were like "this is your baby!" I pulled out the pictures of my three kids and was like, "Yea, well these are my babies too." I was like, "are you going to come to my house and help me take care of all my kids (Kim, client interview: 05/16/2006).

Another client had a negative experience with a CPC in Albuquerque. She had just found out that she was pregnant and felt confused about what to do. Seeking guidance and information, she looked through the Yellow Pages and found the number for a local organization called Birthright. Camille explained:

> I just looked in the Yellow Pages. The first place I called was Birthright or something like that. I spoke with the lady and she seemed older, and what I would call ignorant. The things that she said to me, I was just not comfortable with that. So, I went online and I researched every possible thing that you could think of: what happens, what doesn't happen, what size is it, everything…She asked me where I was in the pregnancy and I told her and she said that that was really too late. I called her at night and then she had called me back. She wanted me to come in the next day and talk to her. I was like, no, I'm not going to do that. I did not get a good feeling. Even when you go on websites, they don't tell you that they are pro-life. Then when they are giving you descriptions of what is happening during an abortion, it is very detailed and, actually exaggerated. The more you read, the more you wonder what is accurate (Camille, client interview:04/25/2006).

Camille suspected that the information she was given from the CPC worker was inaccurate, and she did research on her own to find out more information about abortion. On a regular basis, women will call the Powell Clinic having first

contacted a CPC, and they will express their anger or bewilderment with the misinformation they were given by these religiously based organizations.

Mental Health Argument in the Abortion Debate

Pro-life advocates argue that abortion is emotionally damaging to women and that choosing an abortion will cause mental health problems for women.

> A lot of women that are thinking about abortion, they think it is a quick fix. It may get rid of the problem, which is the child, but actually, in the long run, it is detrimental to their mental and physical health. There are a lot of women who are suffering from post-abortion syndrome. Many women have mental problems, physical problems from having an abortion. In the long run, it is much better to have the baby. Even if she doesn't want it, she can have it adopted out. Usually, women, after they see the baby, they love the baby. We follow up with all of these women that we have been helping and I have yet to see one who regrets having the baby after the fact (Andrew, protester interview:09/13/1997).

Even people who identify as pro-choice assume that abortion is always an emotionally traumatic experience for women. During a speech commemorating the passage of *Roe v. Wade* in 2005, Hillary Clinton described abortion as a "sad, even tragic choice to many, many women." The literature handed-out by protesters at the clinic speaks of a "Post Abortion Stress Syndrome." Research conducted on unintended pregnancy has demonstrated that there is no increased risk of depression for women who abort compared to women who continue a pregnancy. In a longitudinal cohort study with a sample size of approximately 1,000 British women, researchers found that women who had abortions had a lower rate of depression than women who continued unwanted pregnancies because of the positive impact on income, education, and family size (Schmiege and Russo 2005:5).

The literature on the psychological impact of unwanted pregnancies has found an increase in the likelihood of depression during pregnancy (Orr and Miller 1995). Women who carry unwanted pregnancies to term are also more likely to suffer from depression during the first two years after delivery (Najman *et al*. 1991). Beyond the literature, the many women who have sought abortions, regardless of legality or risk, brings the greatest indictment of the negative psychological impact of unwanted pregnancy.

When investigating unwanted pregnancy, which is estimated to be 57% of all conceptions in the U.S., researchers have typically focused on the physical health and socioeconomic status of the resulting children (Brown and Eisenberg, eds. 1995:14). Because unwanted pregnancy causes a negative effect on women's mental health, New Mexico's Medicaid patients are able to have abortions covered as "medically necessary." The Powell Clinic has never been denied payment on these terms, and Medicaid patients with unwanted pregnancies agree wholeheartedly with the "negative impact" statement. According to the clinic manager,

> When a woman calls and asks if Medicaid will cover abortions, I say 'they will cover it if you believe that to continue the pregnancy would cause a profound negative impact on your mental health.' Ninety-nine percent of the women say, "well, yea, I have three kids and the youngest is five months old, and I just can't do this. There is no way" (Jill Rue, staff interview:12/06/2004).

Psychiatric criteria for abortion emerged from the medical community in the late 1950s and the early 1960s when many women's pregnancies were compromised by Thalidomide and the rubella epidemic (Luker 1996:81). "Many of them [doctors] believed they could perform abortions for fetal indications on the grounds of maternal

mental health rather than eugenic considerations and as part of an argument based on the possibility that a woman may commit suicide if denied an abortion" (Luker 1996:55).

In contrast to the research on the mental aspects of unwanted pregnancy, numerous researchers have determined that there are rare instances of negative psychological response after an abortion. According to the Institute of Medicine, "it is quite clear that abortion has few if any long-tern negative consequences on a woman's medical or psychological well-being" (Brown and Eisenberg eds. 1995:80).

The Adoption Option

The protesters offer financial assistance in terms of clothes, diapers, and food to women who change their minds about having an abortion. The vast majority of clients, many who drive hours to get to the clinic, have already made their decision. A woman rarely comes to the clinic *only* because she lacks material support for a baby, although finances are a common factor in an abortion decision. The Saturday morning protesters will yell out "someone will love your baby" and promote adoption over "murder." However, with the physical realities of a pregnancy, adoption is not a very private option for women. Jacki explained during her interview why adoption was not a possibility for her. She said:

> Going through nine months of pregnancy, putting my body through all this and then maybe possibly falling in love with the baby. I wasn't going to take that chance. I could say, OK, I'm giving this kid up for adoption, but what about my son? What is he going to think when he sees my stomach all huge, and all of the sudden he will wonder where is my brother or where is my sister. I just didn't want to go through any of that stuff (Jacki, client interview:08/22/2006).

Like Jacki, Kim felt that the physical signs of pregnancy prevent adoption from being a legitimate option for her. Kim expressed that giving a baby up for adoption was viewed as shameful in her community. At least with abortion, she could keep her unintended pregnancy a private matter and avoid public scrutiny. Kim said:

> People sit there and say they could have the babies and give them up for adoption, but it is not just that easy. You still go through the whole pregnancy and you get big and everybody knows. That affects your life. And then to be like, I am giving this baby up for adoption. People will judge you. The people in that community would wonder where her baby was and find out she gave it up for adoption and think she was a bad person. Either way, abortion, adoption, have the baby and don't take care of it right, you are a bad person. Quit making women feel so bad about themselves (Kim, client interview: 05/15/2006).

"Junk Mail"

In early January of 2006, the clinic sent out a mailing to gynecologists throughout New Mexico and west Texas containing clinic brochures (in English and Spanish) and a brochure request card. A week later, the clinic received a brochure request card from a doctor in a small town in northern New Mexico that had the following bible passages taped to it:

> Please send _____ copies of the clinic brochure to:
>
> "YOU SHALL NOT MURDER"
> Exodus 20:13 Deuteronomy 5:17
>
> LUKE 17: 1 Jesus said to his disciples: "Things that cause people to sin are bound to come, but woe to that person through whom they come."
>
> MARK 15 "The time has come," he said. "The kingdom of God is near. Repent and believe the good news."

> ACTS 2: 38-39 Peter replied, "Repent and be baptized, every one of you, in the name of Jesus Christ for the forgiveness of your sins. And you will receive the gift of the Holy Spirit. The promise is for you and your children and for all who are far off—for all whom the Lord out God will call."

I wonder what happens to women with unwanted pregnancies who go to this doctor? What options are they given? Does he prescribe birth control? Being curious, I looked in the yellow pages and found that he is the only Ob/Gyn listed in the town.

In October 2006, the clinic received a card with a picture collage of beautiful children on the front. Inside was written:

> Today the staff of Lutherans For Life
> included your staff in our daily devotions.
> Our prayer is that you will embrace the sanctity of life
> and drop your sword against the unborn child,
> much as the Centurion who stood at the foot of the cross
> of Christ became horrified at the crucifixion of an innocent man.
> God offers you peace and forgiveness.
>
> *That is our prayer for you as well. Yours in Him, LFL Office*

Before I began doing research, the clinic manager would throw these letters, which she calls "junk mail" in the trash. I became interested in the pro-life rhetoric and asked the manager to save the letters for me. The clinic manager must go through the mail first as a security precaution. She looks for Anthrax or other hazardous materials and then gives them to me. Between 2002, when I first began to collect the letters and pamphlets sent to the clinic by pro-life organizations and individuals, and 2009, I have compiled two bulging binders of pro-life documents.

On a YouTube video posted December 30, 2007, Reverend Donald Spitz, an anti-abortion activist discussed the arson of the Powell Clinic. He stated that Mr. Sanchez, one of the two men charged with the crime, should be commended for his actions. Rev. Spitz called the Powell Clinic an "abortion mill." According to Rev. Spitz, this girlfriend was coming to the clinic to have "Mr. Sanchez's child killed, his son or daughter put to death." The Reverend asks, "What was he supposed to do?" He stated, "[t]hey should put the baby killing abortionist and the people that work for him in jail," "[t]hey are contract killers," and that "God's judgment will come to America."

A blogger on the site The Daily Kos wrote on December 8th, the day after the clinic fire,

> [A]bout the death threats they get. My local PP director has gotten many, reported them, and none have been tracked down. Whereas I am pretty sure similar threats to elected officials would have entirely different results. Truly disturbing (Sanuk on Sat Dec 08, 2007 at 05:46:44 AM PST).

Other Bloggers on the site in dialogue about the fire were upset about how little national attention was given to the event. One blogger from New Mexico wrote:

> The point of this diary is not to argue abortion rights but rather to point out how little national attention this story received. I guess on one hand it is good that stories like this don't make it to the national limelight because every right wing extremist, insurgent, or terrorist will be burning down abortion clinics and possibly hurting someone (NMDan on Sat Dec 08, 2007 at 05:37:39 AM PST).

Ultimately, the difference between the staff at the clinic and the protesters outside, between pro-choice and pro-life, is based on two different ways of ordering the world. For abortion workers, gender equality is dependent on the right of a woman to control her

reproduction. For the pro-life activist, the fetus is human and deserving of all the rights and privileges of humanity. The fetus is an unborn citizen deserving of protection.

Conclusion: Across the Picket Line and into the Clinic

The pro-life protesters who stand in front of the Powell Clinic each Saturday morning try to deter the women entering the facility by warning them of the dangers of abortion and offering them financial support to raise the child. What the protesters do not understand is that, although women do decide to terminate a pregnancy for financial reasons, there is usually a multiplicity of reasons that women choose to end a pregnancy. The naive promises of diapers and a car seat will rarely succeed in changing an unwanted pregnancy to one that is wanted.

CHAPTER 6
Alternative Narratives and the Conditions of Choice

We sat across from each other in the small but comfortable mauve-themed counseling room on a cool morning in late September. She was a Hispanic woman in her mid-twenties who was born and raised in the South Valley of Albuquerque, New Mexico. It had been two and a half weeks since her first-trimester abortion, and she was feeling "fine" with no cramping or bleeding. She had returned to the clinic for her post-abortion check-up to be sure that everything "really was OK."

"Tell me what you think about choice and your decision to have an abortion?" I asked her.

"I didn't have a choice." she replied quickly. "I had to have an abortion. I still live with my grandma and mom, and my youngest is only eight months old. I didn't really want to have an abortion, but I couldn't have another baby. We barely get by as it is."

As I busily scribbled her response on my yellow note pad she stared out the large, tinted window and thoughtfully added, "There are only so many pieces in the pie"

- Dori, client interview on 02/07/2006

Theorists such as Lopez (1997) and Petchesky (1984) have deconstructed the concept of choice; however, they did not do this ethnographically, at the site of the abortion clinic. As this vignette demonstrates, some women I interviewed at the Powell Clinic discuss their position as an absence of choice, with aborting the pregnancy as their only option. The concept of choice is not compatible with the desperation they feel. For women choosing abortion, motherhood seems "equivalent to a 'death of self'...a complete loss of control over their present and future selves. It shatters their sense of who they are and will become...the choice of abortion becomes one of self-preservation" (Swope 1993:32).

This chapter will present the alternative narratives that women employ when discussing an abortion decision and the relations between intendedness and wantedness. Pro-choice women, pro-life women, and women who identify as neither or both create abortion narratives to describe the context of an unintended pregnancy. Clients do not feel that "choice" applies to abortion because choice implies options, and for many women, that is not the reality of an abortion decision.

Women Turned Away – A Decisive Absence of Choice

Abortion is ultimately about unwanted pregnancy. Because of economic constraints, health concerns, educational demands and a myriad of other reasons, unintended pregnancies often become unwanted pregnancies. A pregnancy may be unintended, but, approximately a third of all pregnant women who did not intend to become pregnant will continue the pregnancy to term. This outcome is not always because a woman did not want an abortion. Every week, the Powell Clinic sends away women who are beyond the doctors' gestational limit of 22 weeks LMP. Although we rarely know what happens to these women who are turned away, I would imagine that most of them are condemned to have an unwanted child. The other clinics that offer abortions farther into a pregnancy are located in Wichita, Kansas[7] and Boulder, Colorado, and are inaccessible to women with an advanced pregnancy who are on New Mexico Medicaid. Medicaid coverage does not extend beyond state lines, even if a pregnancy has severe fetal abnormalities or is the result of rape or incest. These women have no other options but to pay over $6,000 for a procedure. In 2003, white, twenty-four year old, single Holly Lewis was about to

[7] As of May of 2009, the Wichita clinic was closed indefinitely due to the assassination of the clinic owner and director, Dr. George Tiller.

enter medical school at UNM. She was a sonographer at the Powell Clinic and remarked about more advanced pregnancies:

> If the fetus were two millimeters bigger, then she couldn't have this [procedure] and she would have to have the baby. Two millimeters. That is all. It is like a grain of rice. It is a lot of power. When it gets down to the limit, it gets really weird. I mean, what if my ultrasound was a little fuzzy? What if it was a little clearer? That would make a difference between having a baby or having an abortion. I'm kind of uncomfortable with that (Holly Lewis, staff interview:3/14/03).

Women who are beyond the clinic's gestational limit are given information about prenatal care options, adoption agencies, and told about New Mexico's safe haven law. To address infant abandonment and infanticide, the safe haven law protects women from legal prosecution if they drop off their newborn at any hospital within 90 days of delivery.[8] What happens to these women and their lives after they are turned away is an unknown at the Powell Clinic. We may soon have some insight into these outcomes.

In October of 2008, the clinic began to participate in the Study Of Unintended Pregnancy (SOUP) conducted by the University of California San Francisco. SOUP is an investigation of the experiences of women who have abortions as well as women who are denied an abortion because they are beyond a clinic's gestational limits. There are 25 clinics across the U.S. participating in the study. Clinic workers recruit women to participate in the SOUP after they have undergone a sonogram and found to be beyond

[8] Safe haven laws address infant abandonment and infanticide. They began in Texas in 1999 with the "Baby Moses law." Infant safe haven laws have been enacted to encourage women in crisis to safely give up their newborn to designated locations where babies are protected, given medical care, and placed for adoption. Safe haven laws are important because they allow the mother to remain anonymous and to be exempt from prosecution for abandonment or neglect. Approximately 47 states have enacted safe haven laws but there exists a wide range of time frames. As mentioned above, New Mexico's safe havens accept infants up to 90 days old. In fifteen states, the safe haven time limit is 72 hours. In 2008, Nebraska made headlines when it passed a safe haven law that was not limited to newborns but included all minors (under 19). The unintended result was parents abandoning disabled children and children with behavioral problems at Nebraska hospitals.

the clinic's gestational limit. Women who agree to participate are given a cell phone for interviews provided by the University of California, San Francisco (UCSF) and are compensated monetarily for their time with gift cards to national retailers. It will be very interesting to see the results of this longitudinal study and have a perspective on how a denied abortion impacts a woman's mental health, physical health, and socioeconomic position. When the nursing staff tells a client that she is beyond the clinic's limit, it can be devastating for all parties involved. Sometimes staff members cry when they cannot help a client, especially those with the most compelling stories, such as rape or incest. For the staff of the Powell Clinic, it is the women who are beyond the gestational limit that do not have a "choice" as they are condemned to carry an unwanted pregnancy to term.

"Between a Rock and a Hard Place"

Intendedness and wantedness are fluid concepts when it comes to pregnancies and their meanings in women's lives. There are situations in which a pregnancy is intended and wanted, but because the circumstances surrounding the pregnancy shift, the pregnancy becomes unwanted. These women have come to the clinic to terminate an intended pregnancy. A boyfriend or husband wanted the woman to conceive and together they tried to do so, then the male partner leaves or, in some cases, was incarcerated. I clearly remember one very sad woman who was terminating her intended pregnancy because her boyfriend had been deported back to Mexico and her household had lost its only source of income. I recall another client who decided to terminate her pregnancy because her husband had died suddenly in an accident. When such circumstances arise, the woman

who was happy about being pregnant must then decide if she wants to raise a child on her own or consider adoption. At the time of her abortion, Marsha was a twenty-eight year old woman with three children aged from two to eleven. She is Native American and she lived in a pueblo about thirty minutes north of Albuquerque. Her pregnancy was not intended, but was wanted for a time until her circumstances changed. When she first informed her fiancé, they were both excited about being pregnant and were planning to have a child together. Then her fiancé "changed," accused her of cheating on him, and left her. If she continued the pregnancy, she would be the single parent of four children because in her family, adoption is "not an option." She had an abortion when she was 15 weeks LMP.

> Well, I knew that I couldn't take care of another baby on my salary and I get really sick when I am pregnant. Always throwing up and I was starting to miss work. I just can't do that. I had a fiancé and at first he was happy about it and then he changed. He was saying that it wasn't his and that he wasn't going to help me. I kept calling his mom's house, but he either took off or she was covering for him because he was never there. I told him that I didn't go out [cheat] on him, but he just wanted to get out of his responsibility. It really made me mad because he knows I don't go out. I called his phone and left a message that I was going to get rid of it, and he never did anything (Marsha, client interview:01/24/2006).

Marsha's story shows the complex and shifting meanings of pregnancy and the reflexive relationship of intendedness and wantedness.

Not all unintended pregnancies are unwanted, and not all intended pregnancies are carried to term. In other instances, a woman may be informed that there are developmental or genetic problems with her pregnancy, and this changes the pregnancy from wanted to unwanted. In essence, it was a healthy child that was wanted, not a sick or disabled child. However, the vast majority of women who come to the clinic for

abortion services have an unintended *and* unwanted pregnancy, from the moment of conception.

When women have an unintended pregnancy that becomes an unwanted pregnancy, choice is already taken away because their choice would have been not to become pregnant in the first place. Women who consent to intercourse are not consenting to parenthood, even if they are not on birth control. Luker (1973) argues that when women make decisions about contraception, they are trying to attain many goals, only one of which is avoiding a pregnancy. Women making contraceptive decisions may be aware of the likelihood of pregnancy, but they are not risk-taking based on actual statistics. For women who decide not to use contraceptives, the chances are either zero (not pregnant) or one (pregnant): either they are or they aren't, positive or negative. In this cost-benefit model, it is a 50/50 chance with each decision.

Because women with an unintended pregnancy do not feel that they have many options, very few of the clients that come to the clinic use the political language of choice when discussing their abortion decision. This may seem to be at odds with the clinic's philosophy, which is firmly grounded in the politics of choice. However, the Powell Clinic staff believes that being pro-choice also includes supporting the choices of women who do not view their decision as politically invested. Jill Rue has worked at the Powell Clinic since 1988. During the research project in 2006, Jill was the clinic manager but was a counselor for many years beforehand. She said about choice at the clinic:

> We talk about choice a lot. How do we allow women to make choices without putting our own attitudes towards those choices? It is a constant struggle to support choice, because it is challenged in so many ways. It is strange to me, and it still is after so many years that women come here to the clinic and they feel that they have no choice. They come through our

> doors and they say that they have no choice, that they can't have this pregnancy for whatever reason. In reality, they are making a choice because they are able to come here to have an abortion. So many women who come here to have an abortion have not thought about it in a political sense. They don't think about being pro-choice or pro-life. They are just dealing with their individual lives. We get some women who are more, and this is a judgment, more educated about choice and have some idea about the feminist movement. But that is definitely not the majority of women who come here (Jill Rue, staff interview:12/6/04).

There are exceptions to this absence of choice ideology among clients. There are women who talk about their abortion decision as a choice, but as Jill explains and the counselors have noted, these women are few and far between. If a woman feels that she cannot have a child and she cannot go through adoption, what other choice is there if she has an unintended pregnancy? A week after the fire, the clinic received a card in the mail at our "temporary headquarters," as we called it. Inside the thank you card was written:

> A year ago, you and your terrific staff helped me with a difficult decision to end an unplanned pregnancy. I recently read about the fire and wanted to express support, sympathy, and anger over what happened to you. Your courage in doing this work is deeply appreciated by those us (the majority!) who believe in the right to choose. Thank you for helping me when I so needed you. Enclosed is just a little to help you when you need it – sorry it's not more, but it comes from the heart.

Inside was a ten-dollar bill. The staff got several other personal cards from previous clients who had heard about the fire, but this one was the most appreciated by the Powell staff. For this woman, the right to choose was very real in her experience.

Degrees of Choice and Women's Agency

Although atypical, some clients, particularly women who identified as pro-choice before their abortion, talk about having a choice. Only one participant identified as pro-life before her abortion decision felt that she had a choice. Candice, a 37 year-old Native

American women with three children in 2006, was asked how she feels about choice. She responded:

> I think everybody in life has choices. It really is. Life is a choice. It comes to us to make that choice, and for us to have that, we come to a decision. You have to set your ducks in a row. You have to. If there is something there that is going to be permanent, you have that choice. You have to make that final decision. If you rely on just words and religion, then you are stuck. Life is a choice. Today, I feel good. I don't feel stuck. Like today I made a choice to come here and make sure that I am OK, and I chose to talk to you about it. Everything is a lesson (Candice, client interview:02/07/2006).

Candice had a more existential view of choice than the political banner version of the pro-abortion movement. In Candice's vision of choice, life is saturated with choices every day. Her abortion decision was just one element in a long succession of choices that includes her choice to come to the clinic for a post-operative examination and to talk to me about her abortion decision.

Except for Candice, the other participants that believed they had a choice had either been raised in a pro-choice household or had, at some time, been positively exposed to feminist ideals. Dorothy also identified as pro-choice before her abortion. At the time of the interview, she was eighteen years old. When she was sixteen, her political awareness of abortion began when she saw the movie Dirty Dancing (1987), which is set in 1963. In this classic film, a minor character has an illegal abortion and suffers complications. From this movie, Dorothy began to think of abortion as something necessary and a woman's right. She had already decided when she first became sexually active that she would have an abortion if she became pregnant unintentionally. Dorothy said:

> I do believe that women should have a choice, it is one of our American rights. We have choices, that is why a lot of people come to this country. To not be able to make our lives less difficult or change a mistake that we have made, honest mistakes, then we are definitely cutting down on the American dream in some way. I am definitely pro-choice even though I am not registered with any party or anything, but I am definitely pro-choice (Dorothy, client interview:03/07/2006).

Dorothy views choice as a right of American citizens. In her worldview, choice is a very patriotic issue, part of the American dream. She had been raised in a pro-choice home and believes that choice is intrinsically linked to her freedom. In March of 2006, when she returned for her postoperative exam, Dorothy was a few months from graduating from high school and was planning on going to college. Her parents are pro-choice and both supported her decision to end the pregnancy, although her mother would have preferred she had the baby. She felt that she had options with the support of her family and she said that they had left the decision up to her. She identified with choice because her abortion decision was something that allowed her "life to go in two different directions completely" (Dorothy, client interview:03/07/2006).

Like Dorothy, Mattie was raised in pro-choice household. Mattie was a 26 year-old woman who identified as both Hispanic and Native American. She grew up in Albuquerque and is attending graduate school at UNM. She terminated her first pregnancy when she was six weeks from her last menstrual period. Mattie was raised by her single mother. She said:

> I was raised that it was defiantly your choice. I have friends that don't believe in that and I respect that. They call me and they say, "What am I going to do?" I tell them that it is really up to you. The only person that is going to deal with it for the rest of your life is you. If you can't live with the fact that you had an abortion then that is not the right decision for you. But, I have my Mom too. She always said, "You don't have to have kids."

> I was raised that it was your choice. If I was raised by my Dad, it would be a different story (Mattie, client interview:02/07/2006).

Mattie decided to terminate her pregnancy because she did not feel stable enough to be a good parent, but also, she was concerned about passing on her genetic disorder. She viewed her decision as a catalyst to get her life in order and to better herself. Mattie wanted to be sure that in the future, if she has another pregnancy, she would have more options available to her. Mattie explained:

> I am just trying to move forward and get my life together so that when I get pregnant again, I won't have to make the same choices. Or, I'll have more choices I guess (Mattie, client interview:02/07/2006).

Even though she was raised pro-choice and identifies with that political ideal, Mattie still felt that her abortion decision was made in the context of limited choices. Mattie understood choice as a continuum where she had less choice with the pregnancy she just terminated than she will have, hopefully, with future pregnancies. As a continuum, the context of one pregnancy allows for more or less choice than for another pregnancy.

Kim was an 18 year-old Hispanic woman from Albuquerque and she had a similar understanding of choice as a continuum. In chapter one, I discussed how the state had promoted Kim's abortion by using the custody of her children as leverage. When she terminated her pregnancy because she was told she had to or she would not get her children back from the state, she felt that choice had been taken away from her. With her second termination, the decision occurred more on her terms, so she felt that she had more choice. I asked Kim if she felt that she had a choice with her first abortion and she explained, "No. It was like, do it or don't see your kids. I guess this one I had more of a choice, but I still feel like I did it for my kids" (Kim, client interview:05/16/2006).

With this abortion decision that was not explicitly subject to the coercive element of the state, Kim felt that she experienced a greater degree of choice. When pregnant with her youngest child, Kim came to the clinic with her then boyfriend to have an abortion but she changed her mind. At the time she lived in southern New Mexico and she drove five hours for her appointment. She had young twins and had already terminated a pregnancy in order to regain custody of them from the state. In her words, it occurred like this:

> We went all the way from Hobbs, and I went to the back and they took blood from my arm and then they did a sonogram and everything, but I didn't see it. When I went to talk to the counselor here, I was like, I am sorry, I can't do it. I just can't. It was too emotional for me. She was like, OK, that is fine. We won't do anything that you don't want. I was like, what am I going to tell him? He is going to have a big old fit and then leave me here and I'm not going to have a ride home. She said, "that is OK, we can just tell him that we can't do the procedure today." I was like, Oh my gosh. That made me feel good because they weren't like, you have to do it. I was like, dang, that is crazy (Kim, client interview:05/16/2006).

When Kim came to the clinic over three years before this interview took place, she expected the clinic workers, like her state-assigned counselor, to push her toward terminating her pregnancy. When the sonographer told her that she did not have to have an abortion that day, she was surprised that it was *her* choice, unlike with her previous experience. Kim returned home, broke-up with her boyfriend, and had her third child. When Kim returned to have her second abortion when her youngest son was three, she knew the decision could be made under her terms. In comparing her three pregnancies and their different outcomes, Kim had different levels of control over these outcomes. In other words, Kim experienced differing degrees of agency. It is critical to view women as agents in their own reproduction, not simply passive victims of social and economic constraints. However, that is not to say that women's reproductive choices are not

subject to their socioeconomic situations. Women strategize within the context of these limitations.

For Mattie and Kim, the degree of agency, or choice they had fluctuated with each pregnancy. When interviewed, Camille was a 26-year-old Hispanic woman from Albuquerque and she felt disenfranchised around her first abortion decision. Three years later, she was in a different place in her life and choice played a different role in her decision:

> With my first abortion, I felt like I did not have a choice. I was too young and I would have been disowned by my family because I wasn't married or anything. I was so against it and I felt like I was forced to do it because of my family. I knew how they would react if they found out I was pregnant and unmarried. So, I didn't feel like I had any choice then. But now that I am married and have a house, the decision was a little harder (Camille, client interview:04/25/2006).

Camille's story lays bare the degrees to which choice can resonate with an abortion decision. With her second abortion decision, Camille was in a more legitimate place to become a mother. She felt she had more choice during her second termination because of her more stable life situation. However, having more choice made aborting the pregnancy more difficult for her than when she didn't have a choice. Experiencing less coercion from social stigma and familial ostracism, Camille had more choice and, ultimately, more responsibility for her choice. From Camille's analysis of her experience, having more choice caused her greater distress, the opposite of Kim's explanation in which she felt better emotionally when she had a greater degree of choice. Perhaps acknowledging that one has a choice creates greater accountability for a decision, and having an abortion without financial or social constraints becomes less morally acceptable.

By and large, women do not see their abortion as a political act and do not identify with choice or the pro-choice movement. While experiencing an unwanted pregnancy, women rarely take the leap to think of abortion in a political sense, possibly because it is such a deeply personal moment. According to Dr. Roberta, in the first few years after legalization, women would speak of their abortion decision in more positive terms than they do today. In the first few years after *Roe v. Wade*, women having abortions would talk to the counselors about their hopes and dreams for their future and their love for the children they already have. It can be distressing for the clinic staff after they provide the excellent care that a woman deserves only to hear her declare unabashedly that she is voting for a pro-life candidate in an upcoming election. Dr. Sara Dunn, a doctor working in the abortion field since *Roe v. Wade*, explained that she had difficulty understanding how women can avoid thinking about their abortion in a political context. When I asked if women thought of their abortion as a political act, she said:

> None of them. It would be really nice if they did, but it never gets to that level. It is like, I am here by myself and this is an event that is happening to me. I feel like, most of them have never watched the news, never read the newspaper, never had a clue about anything concerning abortion. It has taken till now for people to quit asking me if it is legal. You might get a few people who are better educated, a little more intellectual, who will say, "Thank you for doing what you are doing and making this a choice." There are people who say that, but frankly, they are college graduates and probably aware politically of what is going on all over the United States, and know who the president is, and all that stuff. (Laughs). Not to belittle them, I mean, they are smart enough to get to a clinic for an abortion they know they need. But, on the political side, it just doesn't happen for most women. It has taken me a long time to understand it, because of the way I am and the way I think, but a lot of women just don't think that way (Sara Dunn, staff interview:04/08/2006).

For Dr. Dunn, personally, abortion is and has been an intensely political issue. Protesters have stationed themselves in front of her house near Dallas and a giant picture of her has

been hung from a highway overpass with the words "Murderer" above it. She is also on the Nuremberg Files (as is Dr. Powell), an incendiary pro-life web site that lists the names, addresses, physical description, and family members of abortion providers and promotes their assassination. On Dr. Dunn's file, she has been dubbed the "Blood Red Rose of Texas." The established goal of the Nuremberg Files is to "record the name of every person working in the baby slaughter business across the United States of America."[9] Dr. Dunn has been targeted by pro-life groups and has been seen as a questionable character in some parts of her community. Because she lives it every day, for her, abortion has always been saturated with politics, and she deeply identifies with choice.

No Choice

In comparison with the women who felt they had a choice, most respondents that I interviewed did not identify with choice or feel they had a choice. When asked if she thought choice applied to her experience, Amanda, who was a 19 year-old Hispanic college student at the time, explained:

> I don't feel like I had a choice. I couldn't take care of a baby right now and adoption wasn't an option because I couldn't hide it from my parents. This was the only thing I could do. I know it isn't right, but I had to do it. Someday, I will make it up to the kids I will have. I will be a really good mom (Amanda, client interview:01/24/2006).

She did not feel that she had a choice when it came to her pregnancy because she had only one option and having only one option precludes choice. She did not identify as

[9] In 1999, a federal jury in Oregon ruled that the Nuremberg Files violated racketeering laws and FACE laws and was ordered to pay restitution of 107 million dollars. When the site shut down, The Nuremberg Files was put back on the web on an Dutch Internet site which promotes free-speech by hosting banned political websites : http://www.xs4all.nl/oracle/nuremberg/aborts.html

either pro-choice or pro-life. In 2006, Kristina was a twenty-two year old Navajo woman from northwestern New Mexico. She didn't feel she had a choice either:

> I didn't have a choice. My doctor told me how dangerous it would be (to continue the pregnancy) and I knew I had to do this. I didn't want to. I never would do it if it was guaranteed that I would be OK (Kristina, client interview:01/24/2006).

Another client named Janet, then a twenty-six year old woman with four young children, said:

> I didn't have a choice. I wish I did have a choice, maybe it wouldn't have been so hard (Janet, client interview:02/03/2006).

I asked Nuria, a black woman from Las Cruces who was twenty-one year old in 2006, if she felt as if choice applied to her abortion decision or not and she replied:

> Not really. It was just such a bad time for his family and for my family that it just had to be done. I mean, don't get me wrong, I really want to have babies with him, but we are still really young (Nuria, client interview:05/16/2006).

Marisol was a twenty-nine year old mother of three children from Chihuahua, Mexico. She was undocumented and a single mother with three children. She said, when asked about her abortion decision, "*Muy clara. No hay opciones*" [I was very clear. There were no choices] (Marisol, client interview:12/20/2006). Dori didn't have a choice either. When she had an abortion, she was twenty-five years old, single, and had three children. Her oldest was seven and her youngest was less than a year old. Dori said about her abortion, "I didn't have a choice. I had to have an abortion. I still live with my grandma and mom" (Dori, client interview:02/07/2006). Erlinda was 18 years old in 2006 when she terminated her first pregnancy. She was attending a technical school in Albuquerque. She is Navajo and she grew up in northwestern New Mexico. She

explained her abortion decision simply: “I felt like I had to” (Erlinda, client interview:11/14/2006).

A more detailed typology of the alternative narratives employed by women to make sense of their abortion experiences appears later in this chapter. However, these examples demonstrate how, for some women, choice plays no role in their conscious abortion narrative. Dr. Roberta Powell reflected on the conundrum of choice:

> I think that choice is a deliberately ambiguous term. I also think that it is a fact of life that we all want to have choice, not just choice around pregnancy but choice in general. We resent it terribly when we don’t have choice and we are often overwhelmed when we do. I think that most human beings have a very ambivalent relationship with choice and choices, and I don’t think that abortion is any different (Roberta Powell, staff Interview:11/15/2006).

The concept of choice is multidimensional. Its absence can cause resentment and its presence can create confusion. It may be human to want to determine our destiny while simultaneously fearing accountability. Whatever the origins, the clinic staff is unanimous in the assessment that clients seldom invoke choice. Doctor Powell goes on to explains why, at the very nexus of its practice, choice is not invested in most abortion decisions:

> I think that most patients don’t talk about “choice.” I think we take whatever we have and what is available to us in this world largely for granted. It just is. Therefore, it is unseen and unnoticed. It is something that we don’t put into words. Yeah there are lots of fancy terms for this, whether it is the Gestalt or the Paradigm or whatever. It is the fabric and we don’t think about it or talk about it or put it into words because we have little reason to. So, no, I don’t hear women, real women in the throes of this important life decision, I don’t hear them talk about choice (Roberta Powell, staff interview:11/1/5/2006).

When women are making a very personal decision, it is not surprising that most women do not step back and discuss the metanarrative of abortion. Several of the client

participants stated that they had never really thought about being pro-life or pro-choice. For these women, the discourse of choice was not at all present in their interviews or abortion decision. Even for women who identify as pro-choice, choice can be a empty notion. Sarah is a thirty-four year old massage therapist from Taos. She is White and was raised in New England. She was single and had lived in New Mexico for almost six years. Sarah doesn't think that choice applies to abortion decisions. She says

> I think actually…Well, it is a conversation that needs to be left out of it because there is no politics in this choice. The choice is between the individual and God. There is nobody else that can make judgment on that, and I feel very strongly about that (Sarah, client interview:11/14/2006).

Making Sense of Abortion Decisions: Alternative Narratives to Choice

When a woman feels that she has no choice regarding a pregnancy, she may resort to an alternative narrative to explain her circumstances. During counseling sessions and through formal interviews, I became aware that when women talked about their abortion decision, there existed a particular set of narratives or tropes that framed women's understanding and verbalization of their experience. These alternative narratives include the career/school narrative, the economic narrative, the unpartnered narrative, the economic fitness narrative, the child spacing narrative, the infidelity narrative, the drug use narrative, the health indications narrative, and the failed contraception narrative to name a few. When asked about their abortion decisions, respondents had alternative narratives to choice. These narratives are not mutually exclusive. Most of the respondents had a primary narrative regarding their abortion decision as well as a secondary narrative. In other words, there were multiple ways in which women made sense of their abortion experience; however, there was always a principal framework

utilized when reflecting on an abortion decision. About 24% of clients (13) employed a primary alternative narrative and had no secondary narrative. Women who employed the health indications or rape narrative would often *not* have a secondary narrative. Many women who use the economic survival narrative had child spacing as their secondary narrative. Clients who discussed their abortion decision based on a career/school narrative would also regularly talk about not feeling financially ready for a child (economic fitness).

Narrative	Primary Narrative	Percent of 55 Clients	Secondary Narrative	Percent of 42 Clients
Career/ School	Client Number 2 Client Number 7 Client Number 10 Client Number 11 (no secondary) Client Number 13 (no secondary) Client Number 16 Client Number 17 Client Number 26 (no secondary) Client Number 29 Client Number 31 Client Number 37 Client Number 39 Client Number 47 Client Number 52 Client Number 53	Total number of clients: 15 or 27.3%	Client Number 3 Client Number 23 Client Number 41 Client Number 45 Client Number 50 Client Number 54	Total number of clients: 6 or 14.3%
Economic Survival	Client Number 1 Client Number 8 Client Number 9 Client Number 14 Client Number 19 Client Number 32 Client Number 34 Client Number 36 (no secondary) Client Number 43 Client Number 44 Client Number 54	Total number of clients: 11 or 20.0%	Client Number 12 Client Number 22 Client Number 37 Client Number 49 Client Number 55	Total number of clients: 5 or 11.9%

Figure 6:1 Alternative Narratives Employed by Clients

Health Indications	Client Number 3 Client Number 6 Client Number 18 (no secondary) Client Number 24 Client Number 42 Client Number 51 (no secondary)	Total number of clients: 6 or 10.9%	Client Number 40	Total number of clients: 1 or 2.4%
Unpartnered	Client Number 30 Client Number 41 Client Number 45 Client Number 48 Client Number 49	Total number of clients: 5 or 9.1%	Client Number 1 Client Number 14 Client Number 15 Client Number 28 Client Number 39 Client Number 43 Client Number 47 Client Number 52	Total number of clients: 8 or 14.5%
Child Spacing	Client Number 12 Client Number 15 Client Number 22 Client Number 50	Total number of clients: 4 or 7.3%	Client Number 5 Client Number 8 Client Number 9 Client Number 10 Client Number 19 Client Number 32	Total number of clients: 6 out of 42 or 14.3%
Age Young	Client Number 20 (no secondary) Client Number 21 Client Number 23 Client Number 35 (no secondary)	Total number of clients: 4 or 7.3%	Client Number 16 Client Number 25 Client Number 27	Total number of clients: 3 or 7.1%
Economic Fitness	Client Number 25 Client Number 27	Total number of clients: 2 or 3.6%	Client Number 6 Client Number 17 Client Number 21 Client Number 24 Client Number 31 Client Number 38 Client Number 42 Client Number 53	Total number of clients: 8 or 19.0%
Age Old	Client Number 28 Client Number 40	Total number of clients: 2 or 3.6%	Client Number 7 Client Number 34	Total number of clients: 2 or 4.8%
Infidelity Her	Client Number 5 Client Number 46 (no secondary)	Total number of clients: 2 or 3.6%	Zero	
Rape	Client Number 4 (no secondary)	Total number of clients: 1 or 1.8%	Zero	

Figure 6:1 [continued] Alternative Narratives Employed by Clients

Coercion	Client Number 38	Total number of clients: 1 or 1.8%	Zero	
Addiction or Drug Use	Client Number 33 (no secondary)	Total number of clients: 1 or 1.8%	Zero	
Infidelity Both Partners	Client Number 55	Total number of clients: 1 or 1.8%	Zero	
Failed Contraception		Zero	Client Number 2 Client Number 29	Total number of clients: 2 or 4.8%
Infidelity Him		Zero	Client Number 44	Total number of clients: 1 or 2.4%

Figure 6:1 [continued] Alternative Narratives Employed by Clients

Career/School Narrative

The career/school narrative was the most commonly employed narrative. Fifteen, or over 27% of the 55 clients interviewed utilized the career/school narrative as the primary circumstance for the abortion decision. In a career/school narrative, a woman decides to terminate an unintended pregnancy because the timing conflicts with career or educational obligations. Many women expressed wanting to start a family or add to their family in the future, but educational or work commitments made the pregnancy unwanted at the time. Other women didn't want to have more children because doing so would set them back in their career. Candice was a 37 year-old Native American woman who lives in Albuquerque. When I asked her about her decision, she explained:

> When I made that decision I thought about my career and having to start all over again when I've already raised my children. My youngest is

> eight. So, my life is actually moving along. But, who is to blame but me. I made that choice to end it because I wanted to get on with my life (Candice, client interview:02/07/2006).

For Candice, her career was important to her in terms of her personal worth and the wellbeing of her family. Another client was both working and attending school. Camille, whose secondary narrative was the failed contraception narrative, was close to graduating when she became pregnant, and she felt that having a baby would prevent her from being successful in school. She said:

> I am in school right now and I am really close to finishing. My husband is in school too and we are both working, and this was just absolutely the wrong time to have a baby. Neither of us are ready. We definitely want to have kids in the future, but we are buying a house and money is really tight right now…In a way, my family is depending on me. I am the first one in my family to go to college and there are a lot of expectations of me. So, I asked the nurse at the student health clinic and she told me about this office (Camille, client interview:04/25/2006).

Nuria was a 21-year-old junior at New Mexico State University located in Las Cruces in May of 2006. She said:

> Well, actually, one of the reasons I came in at first was because my boyfriend he plays football. Now, is not just a good time for him and his family. They depend on him to kind of bring them up, if that makes any sense. He's responsible for his family. Also, because I am going to finish school in December and I want to pursue my Masters. I know we were irresponsible but it wasn't a good time (Nuria, client interview:05/16/2006).

Nuria and her boyfriend do want to have a family in the future, but Nuria had educational goals, which would have been deferred if she had a child. Anna was a 32-year-old Dutch woman who was studying at a holistic school in Albuquerque. She said:

> At first I didn't even think about terminating the pregnancy. I am 32 and I am in a very loving relationship, so it is not like I am sixteen and I have to finish school, although school is one of the reasons I ended up not being able to do it. I moved here to go to the Auyrvedic institute. My boyfriend

> who lives in Amsterdam came to visit and, you know, it was just bad timing. That sounds so, as if it were just a light thing. But, I had to look at the bigger picture. I will be in school for another six months, and this is a school that I have been wanting to go to for a few years, and it took me a lot to be able to move here and do this school (Anna, client interview:12/20/2006).

Erlinda was an 18-year-old Navajo woman from Albuquerque who had dropped out of school in the 10th grade and, at the time of our interview, she felt that she was just getting her life on track.

> Well, I'm eighteen years old and I started at Job Corps. I just knew that if I was pregnant and I had the baby that it would be hard to get where I want to be in life (Erlinda, client interview:11/14/2006).

As a policy, Job Corps does not accept pregnant women and the Powell Clinic has seen many young women from Job Corps who want to complete their training but would be unable to do so if they continued the pregnancy. Young women trying to improve their lives through job training or education can be sidetracked by a pregnancy at any time. At the Powell Clinic, I have spoken with several women athletes who would lose their athletic scholarship if they were to continue a pregnancy. Also, women solders come to the Powell Clinic, aware that if they were to continue a pregnancy, they would be promptly discharged. Nicky, a twenty-five year old white woman decided to terminate her pregnancy because her music career was just gaining momentum. She and her boyfriend were planning to move into a new house and the band they had formed had begun to gain a following. Nicky felt that if she were to continue the pregnancy, it would really set her and her band mates back as they may never have the same chances for success that they had when she became unintendedly pregnant.

Beatrice, a 24 year-old Hispanic woman who was attending UNM, also used career/school as her primary narrative, commenting that having a child would "totally ruin all of that" (Beatrice, client interview, 02/14/2006). Like Beatrice, Elizabeth believed that continuing her pregnancy would postpone or possibly end her educational goals. Elizabeth, a 27 year-old white woman who was a junior at UNM, had already put off her college education when she had her daughter. When asked why she terminated her pregnancy, she replied:

> I want to graduate from college because I didn't go back to school until after I had my baby. I just didn't want to put everything off again. I want to have some sort of control over what I do next, instead of like, pregnancy is going to pop up here and there and that's just the way it is going to be for me. And that is what is going to dictate my actions. I want to make a better life for me and my daughter (Elizabeth, client interview:02/21/2006)

Dorothy, an 18 year-old white woman, was a senior in high school when she terminated her pregnancy and employed the career/school narrative. When I asked her what went into her abortion decision she said:

> School. I'm still a kid. I'm not stable enough and I don't have money saved up, and that is probably a good thing to do. (Laughs) And, just basically the stage I am in my life. It is something that I was able to go through it and it wasn't painful, just some cramping. I feel lucky because I think most people wouldn't have known what to do and gone ahead and had the kid and had so many complications because of it. I see girls at my school all the time dropping out because they're pregnant. So now they aren't going to graduate from high school and they are having a kid (Dorothy, client interview:03/07/2006).

Dorothy had witnessed other women in her high school drop out when they became pregnant. She did not want that to be her path in life. When she spoke with me, Dorothy felt that having an abortion had afforded her a new lease on her

future and she was not condemned to motherhood before she was ready. She continued by saying:

> I'll be able to get a lot accomplished and be able to look back. Or, maybe I wouldn't have anything accomplished and still be in the same boat, but at least I won't have a kid I can't take care of. (Laughs). At least I have the opportunity. I definitely feel more appreciative and more aware of the things going on around me – everything and everyone (Dorothy, client interview:03/07/2006).

Both Madeline and Lenora said that having a child would have thrown off their educational objectives and undermined their career paths. They viewed their abortion decision as essential to their financial futures. The career/school narrative is ultimately an economic narrative, along with economic survival and economic fitness.

Economic Survival Narrative

Abortion is commonly an economic decision. The abortion rate among women living below the federal poverty level ($10,400 for a single woman with no children) is more than four times that of women 300% above the poverty level (44 vs. 10 abortions per 1,000 women) (Jones *et al*. 2002:229). The economic survival narrative is the second most commonly employed narrative at the Powell Clinic, and I would imagine it to be a familiar narrative in other abortion settings. Eleven, or 20% of participants draw on the economic survival narrative as their primary narrative. New Mexico is a poorer state with over 18 percent of residents living in poverty (Persons Bellow Poverty in New Mexico 2008). In fact, many of the women who come to the clinic are single mothers who may already have young children. For single mothers, it is difficult to see the daily

struggle for the children they already have. In reflecting back on her abortion decision, Pauline explained:

> A lot went into it. I already have three kids. My baby is two and my second oldest is twelve, and I have a sixteen year old. I have one going through all the stages. I got a teenager, an adolescent, and a baby. I just couldn't do it now. It wasn't something planned. Financially there is no way I could do it. If it just took love and caring, I would have no problem with it. But, it takes money, and making sure there is enough food, and making sure that you don't run out of money before the end of the month. I can hardly make the ends meet now (Pauline, client interview:06/13/2006).

For Pauline, her abortion decision was based primarily on her limited resources. She loves her kids and enjoys being a mother, but her resources where already stretched thin. She did have a boyfriend, but he did not help her financially. Secondarily, Pauline felt she was too old to have another child. Also, Pauline's pregnancies were very hard physically and she had suffered three miscarriages. When asked about choice, Pauline stated:

> There was only one option that was realistic for me at the time, so, whether or not that is a choice, I don't know. Like I said, the Higher Power gives us choices…I know that that little bean inside of you is a potential life and it could have a spirit or not. Who is to say if the Higher Power has decided that. But, sometimes that spirit may not be ready to come into being, or maybe the mother is not ready to bring it into being. Either way, it ends. (Pauline, client interview:06/13/2006).

Another client stated that even though she believed abortion was a sin, she could not afford another child.

> I think abortion is a sin against nature, but I had to do it. I just couldn't handle another right now. If we had more money, I would have never thought to do this. I never thought of it with my first two. But now we are just barely getting by (Carrie, client interview:02/14/2006).

When making an abortion decision, many women who come to the clinic and are already mothers (31 or 56% of respondents), dedicating resources to the children they already have. Some are working mothers who have to pay more for childcare than they do for rent. The economic realities of adding a child to a family can be the proverbial straw that breaks the camel's back. Fifteen of the respondents (27%) had two or more children and of these fifteen, more than half (eight clients) construct their abortion decision using the economic survival narrative.

Health Indication Narrative

Health indication was the third most common primary narrative with 6 clients (almost 11%) utilizing it. Carrying a pregnancy to term can be very dangerous for women with high blood pressure or diabetes. Forty-two percent of New Mexico's population is Hispanic and 10% is Native American, two groups that have higher rates of diabetes than Whites. More than 120,000 or 9.2% of New Mexicans suffer from diabetes (Rineer-Garber 2009:1). Also, a woman who is a borderline diabetic can become fully diabetic with a pregnancy, called gestational diabetes.

Women who have undergone cesarean sections during previous pregnancies can also have riskier pregnancies because of uterine scaring. In considering health indications, women who have cervical dysplasia cannot undergo treatment when pregnant. If a woman has an abnormal pap test and discovers that she is pregnant, she either has to postpone treatment of the cancerous cell or terminate her pregnancy.

Annie was twenty-years old and lived in Santa Fe. She was a Hispanic woman and she expressed the ambiguous nature of choice. She didn't feel that she had a choice because continuing the pregnancy would have postponed treatment of cervical dysplasia:

> I did have a choice, but in a sense I didn't feel like I did. I would want to be there for my baby's life. I wouldn't want to be dead. With what I have, if I would have waited too long it would have spread. What made it hardest was when I went to an ultrasound and I saw the baby move - that made it like a million times harder (Annie, client interview:12/20/2006).

Annie's choice was taken away by the health risks she faced if she continued with the pregnancy.

Lena was a 25-year-old woman from a small town approximately three hours south of Albuquerque. She was single and had two children, ages six and four with her long-term boyfriend. She identified as "Spanish" and her family has lived in New Mexico for many generations. She completed high school and worked as a secretary. She paid the cash fee of $395 for her abortion.[10]

> I thought it was wrong and that you should never do it. I was raised in a real strict Catholic family and it is a real sin to kill a baby. I never thought I would do this, but I really didn't have a choice. My doctor in Roswell is against this too, but he said I should do it for my health and the health of the baby. He said it would be too hard with me being so sick and all. So, I looked in the phone book and my boyfriend brought me up here (Lena, client interview:04/04/2006).

Mattie terminated her pregnancy because she didn't feel ready to be a parent, but primarily because of the fear of passing on a very rare genetic disease that she has. Her mother was pro-choice but she pushed Mattie toward terminating the pregnancy because of the genetic illness. Mattie said:

[10] In 2006, abortions in the first 12 weeks form the last normal period were $395. In 2008, the cash fee was $425.

> Part of it was my Mom saying, "You shouldn't have kids and blah, blah, blah." You know, I have a disease and there is a likelihood that my child will have the disease. That is part of that and if I were to have a kid and the kid got the disease, and me knowing that (Mattie, client interview:02/07/2006).

Mattie's wanted to have children, but she feared passing on the debilitating disorder. She expressed that she felt guilty about having an abortion, but said that she would have felt more guilt if she had a sick child.

Economic Fitness Narrative

During the interviews, many clients, particularly those who used the career/school narrative, expressed that they wanted to be more financially stable before having a child. The women who understood their abortion decision in terms of economic survival did not envision a near future where they would have the resources to have another child. The economic fitness narrative differs from the economic survival narrative in that in the fitness narrative, the respondent is working towards the goal of becoming financially prepared to have a child. None of the women who used the economic fitness narrative (primarily or secondarily) had children. These women did want to be mothers in the future, when they would be more financially prepared for motherhood.

Alma, a 19-year-old, single, Hispanic woman from Albuquerque's South Valley had dropped out of high school in the 11th grade. She was morally opposed to abortion but then she became pregnant and felt as if she was not financially prepared to have a child. She wanted to have children in the future, but felt that she needed more time to become economically fit. She said:

> Honestly, growing up, when I first heard about getting pregnant and everything, I always said I would never have an abortion. But, when you have to, you have to. There are a lot of young girls out there who are having kids who shouldn't be having kids. They aren't financially ready or anything. Like me, I don't have no high school education and I am already fixin' to be twenty. I still have a lot of things that I want to do, and I won't be able to do it if I had the baby. But mostly, I ain't ready, money wise. I want to have a car and a house and be able to take care of a kid. Right now, it would be wrong. I want to have all the money I need to be a good mother, and someday I will (Alma, client interview:04/11/06)

Like Alma, Lorena employed financial fitness as her primary narrative. She was a 21 year-old Hispanic women from Albuquerque. She was single and when we spoke, she was a sophomore in college. Lorena said:

> [T]he only thing the drawed (sic) me to have the kid was that was that feeling a little bad about doing it and also the cuteness of having the kid. Logically, I couldn't afford it. I am way too young. I'm just not ready and I can barely pay my own bills. I definitely didn't want to do that to any kid…. I really feel like if I brought a kid into my life right now, it wouldn't be a good thing. I have all of these goals that I want to reach in my life. I want to be financially stable for my kid. I just wasn't. There are just so many kids, and so many problems, and I don't want to just add to that. I'm thinking that I want to adopt if I do have a kid. Take care of the kids that are already brought into this world (Lorena, client interview:(05/25/06).

Although the economic fitness was the primary narrative for only two respondents, it was the most commonly utilized secondary narrative with 8 respondents (19%). I would argue that economic fitness is most commonly a secondary narrative because it imagines a future condition and does not invoke a present reality.

Unpartnered Narrative

Not exclusive of the economic survival or fitness narrative, and very much situated within financial considerations, is the unpartnered narrative. Some women also find

themselves ill prepared to care for a child because they are unpartnered and have no financial support from a spouse or boyfriend. Of the 55 participants I interviewed, 48 of them (87%) were not married at the time of their abortion. Pauline believed in the natural instinct of women to care for children, and she was puzzled by her boyfriend's ability to abandon his children.

> Which, you would figure that the man would be there. How come the men don't get that nurturing instinct like women do. But, he just wasn't there for me. You got to take care of the kids, you got to make sure there is food on the table, you got to make sure that the house is clean, you got to make sure that the laundry is done. It is a non-stop job for woman. A man can just stop working and go off and do whatever and not have to worry about the kids. A woman can never just take off and leave her kids. That is my biggest thing. I wish he could understand the emotional detachment (Pauline, client interview:06/13/2006).

Pauline had three children she is raising on her own. Having another child without help from a partner was out of the question for her. Likewise, Marisol, an undocumented woman from Mexico couldn't have another child without the support of a spouse. I asked her to talk about her decision to have an abortion, and she said:

> Bueno. Soy sola y tengo tres ninos. No puedo tener otro nino mas porque yo soy sola. No tengo esposo. Es muy dificil. [Well, I am single and I have three children. I couldn't have another baby because I am single. I don't have a husband. It is very difficult.] (Marisol, client interview: 12/20/2006).

Marisol has three children and is single. She could not have another child because, as a single mother, it was difficult for her to work and support her family while pregnant.

Beyond the economic hardships that arise from single parenthood, some women fear the social stigma that comes from having a child out of wedlock. One client, Tiffany, explained during her interview that she had to have an abortion because she

could not have a child if she was not married. It was simply unacceptable in her family. Tiffany was a white twenty-five year old woman from Albuquerque. She said:

> I guess I felt like I had a choice. I didn't have any monetary restrictions or anything. On the other hand, when it came to my family, I really didn't feel like I had a choice because no one in my family could have a child outside of marriage. It would just be unthinkable (Tiffany, client interview:08/22/2006).

Tiffany explained that she wants to be ready when she starts a family and that includes being married.

Jacki told me that her decision was ultimately based on the fact that she had no husband. Jacki was a 34 year-old Navajo woman living in Albuquerque when she was interviewed. She was just recently divorced from her abusive husband who had left her alone to care for their young son. She said that there was no way that she could raise another child on her own. If she was still married, it would have been different.

> It was unintended. I am a single parent already and my son's dad doesn't pay an active role in his life. This was an accident. I didn't plan on getting pregnant. I had just got off my birth control because I was having a bad reaction to it. There are a number of things. I am single now. I am in school. I am trying to build my career to try to make a better life for myself and my son. It wasn't an easy road for my son and I. We struggled quite a bit. Knowing that and also thinking about having to go through all of that all over again, I couldn't do it. Especially now. I am a little better off that I was, but there was no way that I was going to raise this kid alone, again. I have no idea where the Dad is at. I wasn't going to take the time to go look for him and find him (Jacki, client interview:08/22/2006).

Although her primary narrative is the unpartnered narrative, Jacki views her abortion decision as a complex array of conditions that made adoption or having a child an impossibility.

Child Spacing Narrative

The Child Spacing Narrative is firmly rooted in the economic survival narrative. When discussing an abortion decision, women who have a young child will often describe the pregnancy as happening "too soon" after their previous pregnancy. As discussed with the failed contraception narrative, the minipill, which is given to breastfeeding women, has a significantly higher failure rate than other contraceptives. Breastfeeding or LAM (Lactational Amenorrhea Method) has long been considered a natural form of birth-control by anthropologists, but many women who rely on it are not aware that you can ovulate if you are not continually breastfeeding (at least every four hours during the day and every six hours at night) and that it can only be relied on for six months (PPH 2008).

Tanya's narrative surrounding her abortion decision was based on the fact that her daughter was so young when she became pregnant again. Even though she was married, she felt too overwhelmed by caring for her single daughter. Tanya said:

> Actually, I thought it [abortion] was wrong. Seriously. I mean, everybody thinks its wrong, but then again if it benefits you and what you are going through, I think it is better. I think a lot of people around you think it is wrong, but when the person that is doing it goes and does it, they understand it more than the person that hasn't got it done. I didn't like it in the beginning, but I think that it bettered me. I have one baby that is fourteen months right now. She is a pain in the butt. She gets into everything. So, I am going to focus on her (Tanya, client interview:02/07/2006).

Sylvia was a twenty-two year old woman from a small town just south of Albuquerque. She was a sophomore at the University of New Mexico when she became pregnant with her daughter and dropped out to be the child's full-time caregiver. She and her boyfriend decided to end a second pregnancy because they already had a baby. She

expressed that she wanted to wait a while until her daughter was older before she had another baby.

> Well, first of all, I have a fourteen month old right now. Me and my boyfriend, who is the dad of the baby I have now, we talked about it. [Then] we talked about what would be the good things and the bad things. We looked at both sides, you know. We both decided that we weren't ready for another baby. We want to give Sierra, my daughter, her time to be a baby. Mainly to take care of her. That is the main thing. It would be hard. We aren't financially ready yet either. We live with my parents and are looking to get a place, and there is just no way we could do it (Sylvia, client interview:04/11/2006).

Veronica was an eighteen year old, single mother of a small child when she became unintentionally pregnant. The primary reason she terminated her pregnancy was because of her young son. She said:

> Actually, I have a son who is nine months and I can't handle another one. So, that is basically why I made that decision (Veronica, client interview:12/20/2006).

One client explained to me that she spent as much on childcare for her son as she did for her rent. There were just not enough resources for her to have two young children in daycare at the same time. Women who are already mothers have competing identities when having an abortion.

Age Narrative: Too Young or Too Old

Fifty percent of U.S. women obtaining abortions are younger than 25; women aged 20–24 obtain 33% of all abortions, and teenagers obtain 17% (Jones *et al.* 2008). Thirty-seven of the 55 (67%) respondents were 25 years old or younger, making them typically more financially unstable and economically ill prepared for parenthood. Four participants (7%) utilized the too young narrative. One client, Cindy, was 19 when she

had her abortion and she explained that the primary factor in her decision was that she was too young to be a good mother.

> Well, I shouldn't have got pregnant to begin with, but I did. I got pregnant and I didn't know. My body wasn't feeling it. The first thing that I thought was that I am too young. I am only going to be twenty in August. I felt like this wasn't the time for me, that it wasn't the time for my boyfriend. (Cindy, client interview:04/11/2006).

Cindy wants to be sure that she can provide for her child when she has one. Couched within the "too young" narrative is the economic fitness narrative. But Cindy felt that it was not just her lack of financial stability, she also expressed that she was emotionally unprepared, a circumstance of her young age. Cindy went on to say:

> Don't get it through your head, don't let people tell you that you are killing a baby, because they don't know. When I was getting my check-up I was like, I'm never going to do this again. I want to just take care of myself and focus on my school and my boyfriend so I can be a good mom some day. I know what I did, and nobody can change my mind. If a friend came to me and said, what should I do, I would say that I would support her either way (Cindy, client interview:04/11/2006).

Cindy viewed her abortion as a new start for her life, a step towards becoming financially and emotionally ready to become an able parent, but at 19, she felt ill equipped. Janine, a Hispanic woman from Espanola, New Mexico, also felt that she was too young and still a kid herself. When I asked her what went into her decision to have an abortion, the 18-year-old, recent high school graduate said:

> Strict Father. (Laughs) And, of course, I just wasn't ready. It was not something I could handle right now. I can hardly take care of myself. I am still a kid. How is a kid supposed to raise a kid. Doesn't work (Janine, client interview:07/18/2006).

It was not just economic considerations that lead Janine to end her pregnancy. She felt she lacked the knowledge and experience to have a child because of her young age.

On the opposite end of her reproductive life, Rita felt that she was too old to have another child. When older, a woman's age may be couched within a health indications narrative. For example, women who are what the medical community considers "of advanced maternal age" have higher risks with pregnancy. A woman is considered of advanced maternal age at age thirty-five. Two clients used their perceived advanced age as their primary narrative. Tammy was a 34-year-old Hispanic woman who identified as pro-choice before and after her abortion. She was single and the mother of two children. She felt that she was "too old" to have another child.

> Bottom line, I am too old. My oldest son is fifteen and he is just about to move out of the house. I didn't want to start all over. So, that was my final decision. You know, and not being married, and I struggle with my fifteen year old because his Dad was only with us until he was five. I had him for ten years on my own. I know the struggle. For women my age…I don't know, just evaluate the situation. You have to figure out what will be the best for you and your child (Tammy, client interview:04/25/2006).

As this passage suggests, Tammy's secondary narrative is the unpartnered narrative. Rita was a forty-two year old Native American woman from a Pueblo north of Albuquerque. She was single, had three children and had a high school diploma. This was her first abortion and she was seven weeks from her last menstrual period. She received a clinic loan to pay for her abortion, and she works as a waitress in a restaurant.

> My age. There is no way that I could start all over again. I have a three-year old, thirteen, and twenty year old. It would be very difficult for me right now. There is also that I have a very difficult delivery with my last one. I bled out pretty much. That was really scary. I just couldn't do it (Rita, client interview:08/29/2006).

Her last pregnancy was physically very difficult and she could not work and have a high-risk pregnancy. For Rita, the age narrative and the health indications narrative intertwine.

Infidelity Narrative

Women who have been unfaithful to a partner and are fearful that someone impregnated them other than their boyfriend, fiancé, or husband utilized the infidelity narrative. Tanya was a 19-year-old Hispanic woman from a small city south of Albuquerque, New Mexico. She had one young daughter and was married at the time of her interview. Her highest level of education was the eighth grade. When asked about her decision to have an abortion, she said:

> I cheated on my husband with a black man and then I had sex with my husband just a few days later, so I can't tell who I got pregnant from. I asked that lady who did the ultrasound if she could tell me when it happened, but she said she couldn't because they was too close together (Tanya, client interview:02/07/2006).

Like Tanya, Luz couldn't continue the pregnancy because she was too stressed to continue the pregnancy without knowing who the father was. She said: "Well, I am married and it wasn't his. I just couldn't deal with thinking it might be that other guy's" (Luz, client interview:11/14/2006).

Coercion Narrative

Patricia was an 18-year-old white woman from Albuquerque. Her mother raised her not to "kill a child." Her mother was an addict when she was young, and her father was out of the picture. When we spoke, she had a 13-year-old brother that she raised while her mother was going through "hard times." She discovered that she was pregnant when she

was in jail and originally had planned to have the child with her boyfriend. She was told by her probation officer that if she had a child that she would be kicked out of her foster care home.

> Honestly, I didn't have a choice because I'm on probation and I'm also in foster care. I didn't have a choice. I was twenty-one weeks and they said that if I had come in even a week later that it would have been too late. So, I really didn't have a choice. With foster care, they would have kicked me out. I would have been in a shelter being pregnant and then had the baby and who knows what would happen. I wouldn't have a job or nothing. I would be kicked out into the street. I couldn't go back and live with my Mom because she is really struggling. I'm already five months into the program and I only have a couple months to go, and I get released into the life I could live. Or, I could have had this child and had nothing (Patricia, client interview:07/18/2006).

In Patricia's case, the state of New Mexico was the coercive element in her abortion decision. Parents, boyfriends, and husbands can also push a woman toward terminating a pregnancy, diminishing choice. I had one nineteen year old client that said she did not want to have an abortion but was told that she would be kicked out of her sister's house if she didn't. We offered information on resources but she decided to proceed with a pregnancy termination even though she felt as if her sister was "making her." In her case, she chose to have an abortion over being kicked out by her sister.

Addiction or Drug Use Narrative

The addiction or drug use narrative describes a situation in which a woman has been using alcohol or drugs while pregnant.

> I didn't have a choice because of the drugs I was using and that I didn't know I was pregnant. If it was a healthy pregnancy, then I probably would have continued with it. But abortion can be a good thing. I don't think it should be a method of birth control (Chantelle, client interview:05/16/2006).

Chantelle's narrative tells us that her primary reason for aborting her pregnancy was that her cocaine use may have harmed the pregnancy. When she was using, she was unaware that she was pregnant. Counselors at the clinic are trained to refer women with concerns about drugs and alcohol to a genetic counselor who would be able to tell her the actual risks associated with use at a certain time in a pregnancy. Very rarely does a client want to consult a genetic counselor. Women who terminate a pregnancy and employ the use narrative typically have more than one reason for doing so, but drug and alcohol use is the primary narrative or the most important grounds for their decision.

Rape Narrative

Because of under-reporting, social scientists can never be truly sure of sexual assault statistics. From working at the clinic for many years, I know that rape is commonplace. Although difficult to determine because not all women disclose a rape, the clinic will usually see at least one woman every week whose pregnancy was a result of a rape. One week in October of 2008 was particularly unusual when the clinic had four clients who had been raped, one a thirteen year old girl. This was later discussed by the staff at the monthly staff meeting as an exceptional and very sad week. Very few of the women who come to the clinic and disclose that they were raped will press charges against their rapist. For some women the rapist is a relative or a family friend. According to New Mexico Crime statistics, 1,094 forcible rapes were reported in 2006 (New Mexico Crime Statistics 2008: 39). Janet didn't have a choice because she was raped:

> Some women decide to have an abortion just because they don't want the baby. I had to because I was raped. I didn't have a choice. I wish I did

> have a choice, maybe it wouldn't have been so hard (Janet, client interview:02/03/2006).

Janet, a Navajo woman who was 26-years-old when she was assaulted by someone she knew. When asked about her decision, she said:

> This doesn't fit with my beliefs. My heart tells me one thing and my head tells me another thing. My heart tells me that I shouldn't have done this, but I was raped by a friend of my brother. I did not want to hate the child. It is not its fault. For me, that is the greater sin. All of my babies have the same dad. He doesn't help me for anything, and they just get upset when he comes around, but I still like it that they are true brothers and sisters. They all look alike and they feel like they belong together because they are full Native. The man that raped me was Hispanic, and I don't want to be constantly reminded of what happened (Janet, client interview:02/03/2006).

Janet never told her family what happened to her:

> I have seen that man who raped me too and that was really hard. My brother still don't know what happened and I am afraid to tell him. I am afraid he might shoot his friend. He has a real bad temper and he can just fly off the handle. If I told him that this man forced himself on me, then he would probably kill him. He is very protective of me and my sisters (Janet, client interview:02/03/2006).

Before she was raped, Janet thought abortion was absolutely wrong, even in cases of rape. She identified completely as pro-life.

> I thought it was wrong in every circumstance. I thought that there was no good reason that anyone would have an abortion. Even if it was rape. I thought that two wrongs did not make a right. But, then when I thought about having the baby and having to explain to my kids why their little brother or sister looks different or why I didn't want to hold it. I knew I just couldn't have a kid that I didn't love (Janet, client interview:02/03/2006).

Janet continued to identify as pro-life after her abortion. She was the only respondent that disclosed that she had been raped. One client stated that her sister had an abortion

because she had been raped. Another client was talking to a woman in the waiting room of the clinic who had been raped. She stated:

> I started talking to another girl in the waiting room and she was raped by a friend. What if she had to have that baby? That would be so messed up (Camille, client interview:04/25/2006).

Gamma Hydroxy Butyrate (GHB), or the Date Rape drug, has a salty taste and is a naturally occurring chemical in the body in low levels. It causes a person within fifteen minutes of ingestion to become comatose for four to six hours, and after twelve hours, it is no longer detectable in the body, so it makes it very hard to prosecute GHB rape cases. I have counseled over a half dozen women who believe they many have been drugged and raped, but with no recollection; the pregnancy was the only proof.

Failed Contraception Narrative

According to the CDC, the failure of oral contraceptive pills or condoms was the most common reason for women becoming unintentionally pregnant and terminating a pregnancy (Strauss *et al*. 2006:20). Half of all women who have abortions in the United States reported using contraception the week they conceived (Guttmacher 2003). Some women used the product improperly (*i.e.*, missed a pill) and some women had failure even though they were compliant. Many women had difficulty using their contraception prior to its failure. One client, Jacki, whose primary narrative was the unpartnered narrative, stopped her pills because they were making her nauseous and she had made an appointment to see her doctor. But, before her appointment, she became pregnant. Beatrice said "I really went back and forth. I've been with the same guy for nine years. It was just irresponsibility. I got off the pill and was irresponsible (Beatrice, client

interview:02/14/2006). For some women, taking a pill every single day, at the same time each day can be a real challenge, especially for busy moms like Lucinda. Lucinda was shocked that she became pregnant when she was on the pill.

> I couldn't believe I got pregnant because I was on the pill. I have never been a really good pill taker. I got pregnant with my first one on the pill, but of all the times for it to happen (Lucinda, client interview:12/20/2006).

Another client named Nicky explained that she had been using protection and that her pregnancy was unintended. She said:

> It wasn't planned. I was actually taking birth control when I got pregnant. It was really unexpected. We want to have another kid, but just not yet and we felt that, at this point, if we did that, it would be hurting everybody. Eventually, it would probably work out, but at this point, everything that we have just gotten together would fall apart again (Nicky, client interview:02/14/2006).

Another client, Camille, forgot to take her pills with her on a trip and became pregnant as a result. She said:

> I was on birth control and everything, but we went to Las Vegas for Valentine's and I forgot my to pack my pills. Yeah, it is really frustrating because I am religious about taking my pills and then we used a condom and it obviously didn't work. My whole family is really fertile (Camille, client interview:05/24/2006).

Along with inconsistency of use, birth control does not always work, even when it is used properly. According to the U.S. Food and Drug Administration, the effectiveness of condoms is about 89%, usually failing due to breakage or slippage (Nordenberg 2007). If used perfectly, the pill is 98% effective, however, studies show that the pill is about 92% effective when factoring in user failure (Nordenberg 2007). Women with migraines or who are breastfeeding are often prescribed a progesterone pill or the minipill, which has a lower effectiveness than a pill with estrogen. The minipill is about 87% effective,

significantly less effective than pills that are not progesterone only (Feminist Health 2008). I have been through abortion decisions with many new mothers who were breastfeeding and on the minipill. The IUD, both the non-hormonal (10 year) and hormonal (5 year), is over 99% effective. The Depo Provera contraceptive injection is 97-99.7% effective. The contraceptive patch, brand name Ortho Evra, is 99% effective with perfect use. However, if a woman weighs more than 198 pounds, the effectiveness drops significantly to only about 92% (Feminist Health 2008). Some women also have difficulty with skin irritation with the patch and become pregnant when they are unable to switch methods in a timely manner. The Contraceptive ring is over 99% effective when used as directed, but New Mexico Medicaid does not cover the patch or the ring because, as newer products, they do not have a generic version. As a result, women who are not good pill takers and are on Medicaid have fewer options.

It does not matter how compliant a woman is with her birth control, all forms of contraception have *at least* a 1% failure rate.

> I am a sophomore at UNM and me and my boyfriend used protection and everything but the condom busted. I even used that pill, the morning after one, but it didn't work. I didn't want to have anything happen to the baby because of the morning after pill, so we talked and decided this was the best thing. We are both young and need to finish school (Amanda, client interview:01/24/2006).

Condoms are the least effective form of contraception and many women still do not know about Plan B or the morning after pill. A common story heard at the clinic is that a woman called her doctor for a refill for her birth control, but that she was denied a refill because she needed an annual exam and there was not an

available appointment for several months. Women, especially those who live in rural areas, are at the mercy of an overloaded healthcare system.

Fetal Abnormalities and Fetal Demise, Excluded Narratives

It was recommended by the Human Subjects Review Board that I exclude women undergoing an abortion because of severe fetal abnormalities or fetal death. These women's abortion decisions were perceived to be less elective than women who had no diagnosis around fetal health. It is often a much more emotionally traumatic experience for these women because most of them wanted to be pregnant, so I agreed with the Board's recommendation to exclude this population. This population of women would be primarily absent from my data because the women who come to the Powell Clinic with fetal health indications typically return to their doctor or specialists for follow-up care. As a result, conducting interviews at post-operative exams effectively excludes these women.

Most of the fetal anomaly clients who come to the Powell Clinic are at least 16 weeks LMP into a pregnancy. It is at this time in a pregnancy that an amniocentesis can be safely performed to screen for chromosomal anomalies and neural tube defects. Women who have fetal health indicators that are undergoing abortions consider their situation as non-elective even though private insurance companies categorize an abortion as elective unless the fetus is dead.

In her rigorous ethnography of the practice of amniocentesis in New York, Rapp (1999) interviewed women who had terminated a pregnancy after receiving a positive diagnosis for a chromosomal anomaly. What Rapp found was that women who had

abortions because of an "abnormality" saw themselves as having legitimate reasons for terminating a pregnancy. Rapp writes:

> I was forced to recognize the *cultural* judgment that many women with positive diagnoses make about their own circumstances. They considered themselves to be appropriate mothers, and therefore, tragically, appropriate aborters. While they often expressed compassion for teenage girls "in trouble" they did not want to be identified with them in any social sense (Rapp 1999:237).

I have talked with women who are, according to clinic vernacular, "anomaly" or "demise" clients, that didn't want to sit in the communal recovery room with the "other women." Women who have fetal health indications have expressed their anger toward women at the clinic who are, in their reference, "throwing away" a perfectly healthy baby. Other clients with fetal health indications have expressed that they felt better about their decision because of all of the other women at the clinic. During counseling sessions, choice rarely applies to women with diagnosed abnormalities when they are talking about their decision. I do remember one client who invoked the concept of choice when she was speaking about women in her church who she imagined would never make the "choice" to abort a pregnancy with a fetal abnormality.

Some women come to the Powell Clinic who have fetal abnormalities and when intrauterine fetal death has occurred. At hospitals such as Presbyterian and Lovelace, women whose fetus has died can be delivered over hours or days by the use of misoprostol, the same medication used with Mifeprex for chemical abortions (see chapter 4). Women who do not want to deliver a dead fetus and are informed about their options can go through a process at the Powell Clinic that typically involves a multiple day procedure. If a woman is less than fourteen weeks from her last menstrual period, a

standard dilation and curettage can be performed in a ten to fifteen minute procedure. However, when it comes to fetal abnormalities, most diagnostic tests such as amniocentesis cannot be safely or successfully performed before sixteen weeks from the last menstrual period. As a result, the vast majority of women who come to the clinic with diagnosed anomalies are advanced procedures, requiring multiple days.

Conclusion: A Multiplicity of Narratives

Kristina was a 22-year-old Navajo woman in 2006 that worked in Albuquerque while her mother and maternal grandmother cared for her three children. Her husband worked in a mine in Arizona during the week and was also away from the children during the weekdays.

> I thought of it like murder. You are killing a growing being, a life. But, I could have died if I had it. My doctor told me I had a fifty-fifty chance of dying. I have to be here for my kids, because they aren't going anywhere. And being in school. I am just barely getting a foundation for my life. I have been a stay at home with my Mom for five years. I started having my kids when I was young. I got pregnant with my first when I was fifteen. Now that the youngest is 2, I can be here in Albuquerque while my Mom and grandmother raise my kids. It hurts me not to see them every day, but I am getting a foundation for my life so that I can get a good job. A guy can get a hard labor job and live paycheck to paycheck. A woman can't do that. To make any money I have to have an education so that I can provide for my kids. I don't want them to not have all the things they want and deserve just because I started having them so young. I look at this like the baby was a sacrifice. Sometimes you have to make sacrifices even if it hurts your heart (Kristina, client interview:01/24/2006).

In her narrative, Kristina has many layers to her abortion decision. Health indications narrative is her primary narrative, but she also invokes the economic survival narrative. Like many of the women who come to the clinic, Kristina had moral conflict with

abortion. Women saw it as "not right to do." Because it is morally prohibited for many, those women who do come to the clinic for a termination typically have more extreme life situations that make continuing a pregnancy something close to impossible for them. Women who believe abortion is wrong and do not have economic constraints or are married would be better able to adhere to their belief system because they have more resources and social acceptability, ultimately permitting them to continue a pregnancy.

> Well, I have always thought that it was wrong. I was born and raised Catholic and then eventually converting to The Church of Christ. It was a strong hit in my life. I totally went against anything I like doing in my life. Like, having a personal relationship with the Lord. I feel like I completely went against how I see myself. Now, when people see me, even though they don't know what I'd done, I think that they see me differently. It still feels like a let down of others (Candice, client interview:02/07/2006).

To remind you about the context of her abortion decision, Candice was a 37 year-old Native American from Albuquerque. She was the single mother of three children from ages 20 to 8, and her highest level of education was the tenth grade. Candice felt that she disappointed people in her life, including herself. By having an abortion, she defied her Christian beliefs. She said that she is coming to terms with having done something that she had always been adamantly against.

Camille was raised in a very Catholic household, and abortion was among the most prohibited sin when she was growing up in a small, rural New Mexican town. She described her experience as a young girl:

> I was against it too. I was a little kid. What better did I know? They tell you that women are killing their innocent little babies and that it makes God cry in heaven, of course you are going to be against it. I remember crocheting little booties; blue and pink. I'm not even really sure what they did with them come to think about it. It had something to do with

> stopping abortions. I used to think that girls that did this were horrible and selfish (Camille, client interview:04/25/2006).

When women make an abortion decision, they are stepping outside of their normal, every-day beliefs and practices. Women who have abortions create narratives to explain their abortion decision. Women do not come to the clinic and say "just because I need one." Women's abortion decisions are framed by their life situation. For many women, logistical constraints trump moral beliefs when they have an unintended pregnancy. Even women who do not have a moral objection to abortion make their decision to end a pregnancy in terms of their ability to provide for a child or their parental readiness. Pro-choice women, pro-life women, and women who do not identify as either create abortion narratives that describe the context of the pregnancy. No matter how they identify politically, women who terminate a pregnancy are making a very personal decision and the concept of choice is inapplicable when women feel they have few options.

When women feel that they have no choice when having an abortion, they make use of alternative ways of expressing a decision. Although women's narratives are diverse, they are all situated within the United States' early twenty-first century ideas about motherhood and legitimate reproduction. The abortion narratives that have been presented in this chapter are not monolithic and they are temporal, changing through time. Nellie, a twenty-four year old white woman from Albuquerque in 2006, had numerous reasons for having an abortion, demonstrating how a woman's relationship with a pregnancy is shifting and compounded. She said:

> First of all, it was health. I didn't know I was pregnant for so long and continued bad habits, drinking and smoking cigarettes and things. I didn't

> even really know I was pregnant until I went to the doctor because I was bleeding a lot. Then, when I found out I was pregnant, it was more of a health issue because I knew it wasn't normal bleeding. Then it turned into a financial thing because I lost my job the day after I found out I was pregnant. So, I have somebody that is there. I do have a really awesome guy, but it is all the aspects, the health and the financial stability. I didn't even have health insurance myself. There are so many things that go into it. So, that is why (Nellie, client interview:04/11/2006).

Nellie had an abortion because she could not afford another child and because of health concerns. So did Polly. She said:

> My back hurts all the time and I can't eat 'cause everything makes me sick. I am just barely feeling back to normal and eating good. It hits me hard. I can't work good and I got my kids depending on me. I may feel like laying in bed all day, but I don't got that option. If I don't work, my kids don't eat. It is that simple. I help out this woman who is eighty-nine and she can't really cook or anything because she has kind of lost it, in her head. She would leave her stove on and stuff like that. So, I take care of her during the day and then I work the register at a gas station from three to eight, and then when I get home at night I take care of my kids and help my Mom with my grandmother who is real old too. How am I supposed to have a baby? I just couldn't. It would make everyone suffer. Just because of a bad decision I made, I couldn't let my whole family suffer (Polly, client interview:12/20/2006).

Polly's narrative incorporates elements of economic survival, being unpartnered, and health indications. She had multiple reasons for terminating her pregnancy and she never thought she would have an abortion, but her circumstances changed drastically.

> I had my oldest when I was seventeen. I never thought about having an abortion. I thought I was in love and that he would take care of me. You know, the whole storybook fairytale that you believe when you're young and stupid. Before my son was even two years, he took off back to Mexico. I think he has another family there. That is what his friend told me. He would send money back and he said it was to his parents, but I knew he was lying. Stupid, macho guys. The government can't do nothing to get me child support because nobody knows where he is. Don't get me wrong, my sons are my life. I would do anything for them. They are such beautiful little angels and I never regret that I have them (Polly, client interview: 2/20/2006).

Although Polly talked about many reasons for terminating her pregnancy and verbalized many interdependent narratives, a few weeks after her abortion procedure, she identified as pro-life.

CHAPTER 7
Pro-Life Women Who Have Abortions

"Do you identify as pro-life or pro-choice?" I asked.

I say I am pro-life. At my church, we used to pray for all of the souls of the aborted babies. I think, somewhere, people are praying for my baby's soul.

- Janet, a Navajo woman and mother of four children

There seems to be a philosophical incompatibility between identifying as pro-life and having an elective abortion. This chapter examines the views of women who identified as pro-life before their abortion and continued to identify as pro-life at the time of their post-operative exam. Of the fifty-five women I interviewed at their post-operative exam, thirty (54%) identified as pro-life before their abortion and eleven (20%) participants still identified as pro-life two to four weeks afterwards.

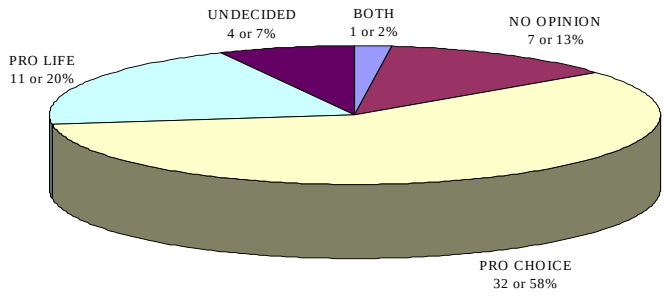

Figure 7: 1 Participants' Political Identification After the Abortion

Women who are Pro-life Before and After an Abortion

Before working at the Powell abortion clinic, I imagined that all women who have abortions were pro-choice, or at least did not identify as pro-life. I learned that pro-life women also have abortions, and they continue to adhere to this belief system after a pregnancy termination. Abortion researcher Petchesky writes:

> How women act to resolve an unwanted pregnancy is not in itself expressive of their consciousness; we cannot comprehend their reasons and their understandings from their actions alone. In sorting through the available evidence of what women who undergo abortions usually think and feel, we have to untangle the frequent contradictions between what women *say* and what they *do* (Petchesky 1984:368).

Before working at the Powell Clinic, I did not expect such a profound discrepancy between what women say and what women do. Admittedly, as a private issue, I

imagined that few women discussed their abortion experiences outside the clinic. When women did talk to me about their experiences, over half defied the belief system they had before they became pregnant, and one in five continued to adhere to a pro-life identity. For some, especially pro-choice feminists, it may seem incongruous for a woman to have an abortion while simultaneously stating that she identifies as politically and morally against abortion. Often, these women understand their abortion experience in terms of the specificities of their own pregnancy, and they view that as different from their moral beliefs about abortion. In these cases, their personal reasons for ending a pregnancy are and remain distinct from their moral perspectives. A pro-life identity has largely to do with believing that a pregnancy is a child. As these women's interviews testify, the monikers of pro-life and pro-choice subsume the vast ambiguities that exist within their belief systems and everyday practices.

Shifting Politics

According to a CBS/New York Times Poll, in 1993, about half of all women between 18 and 29 agreed that abortion should be available to all women. Only a little more than a decade later in 2005, the number dropped to 28% (Polling Report, Inc. 2008). What occurred from 1993 to 2005 that so many young women no longer identified as pro-choice? The pro-choice downturn really began in 1992, the same year that *Planned Parenthood of Southeastern Pennsylvania v. Casey* was decided by the Supreme Court. The case was ambiguous for some because the decision upheld *Roe v. Wade* while simultaneously allowing for greater restrictions to occur at the state level. The *Casey* ruling made the pro-choice movement somewhat complacent because it was

characterized as a comfortable middle ground (i.e., it supported *Roe v. Wade* but imposed restrictions that *Roe* had not). After 1992, there was a significant drop in donations to PPHs across the U.S. By that time, most pro-choice women supported parental notification laws in the cases of minors seeking abortions and opposed government funding of abortion; the "pure" pro-choice woman was obsolescent (Saletan 2003:139). Young girls in 1993 were adult women by 2005, and they were more pro-life than their age group had been twelve years earlier (Dominus 2005:203). Interestingly, from 1993 to 2005, the actual rate of abortion in the U.S. only experienced a slight decline. Researchers at the Allan Guttmacher Institute attribute the decline to increased restrictions such as enforced waiting periods, a decrease in providers, and Targeted Regulation of Abortion Providers Laws (TRAP Laws) (Guttmacher 2006). In 2005, women whose politics were shifting to the right and who were assuming a more pro-life stance were still becoming pregnant and terminating pregnancies at a rate comparable to twelve years earlier. How do the increased numbers of women who identify as anti-abortion negotiate the ideological terrain associated with deciding to terminate a pregnancy?

According to the above-cited CBS/New York Times poll, support of legal abortion has been dropping among women ages 18 to 29 since 1993. In that year, 49% of women polled said that abortion should be "generally available," and 19% of women said that abortion should be "not permitted." Of the remaining respondents, 30% said there should be "stricter limits" and 2% were unsure. (Polling Report, Inc. 2008). In 2005, some 12 years later, 28% of women believed it should be generally available and

30% of women believed abortion should not be permitted. 40% believed in stricter limits and 2% were unsure (Polling Report, Inc. 2008).

U.S Women Ages 18-29	Generally Available	Stricter Limits	Not Permitted	Unsure
In 1993 N=1113	49%	30%	19%	2%
In 2005 N=1155	28%	40%	30%	2%

Figure 7:2 Views on Abortion for Women 18 to 29 in 1993 and 2005
Source: CBS News/The New York Times Polls
(See Appendix G for Statistical Significance)

In this turning tide toward pro-life, the abortion rates in the United States has also declined, but only slightly, from 1992 to 1996, by about 3.4% a year, although now the rate of decline is slowing (Guttmacher 2003:3). It is difficult to demonstrate that the decline in the abortion rate reflects the shifting political views, especially because, as this research demonstrates, pro-life women continue to have abortions. Some pro-choice organizations, such as NARAL and NOW (National Organization of Women), argue that the drop in the abortion rate is due primarily to reduced access to abortion services. There are fewer abortion providers today and there are more restrictive laws, such as mandated waiting periods and parental consent requirements for minors. Further, the abortion rate is not declining for all populations**.** Although the national rate fell from 1997 to 2003, it rose for poor women (Guttmacher 2003:3). For example, the abortion rate among women living below the federal poverty level ($9,570 for a single woman with no children in 2006) is more than four times that of women above 300% of the poverty level (Finer and Henshaw 2006). Because, as I argued in chapter 6, abortion is so often largely (though not exclusively) an economic decision, economically

disadvantaged women continue to have a disproportionately high rate of pregnancy termination.

The exact percentage of women who have abortions at the Powell Clinic and continue to identify as pro-life is difficult to determine. However, the 20% represented in the sample of clients I interviewed is supported by anecdotal evidence from the staff. Women who are pro-life have always had abortions according to staff and doctors who have worked in pregnancy termination for the last twenty years. Lola Samuels, a long-time counselor at the Powells' clinic said:

> I continued to be amazed by how many pro-life women have abortions. We see it all the time. She is the woman who hates everyone in the waiting room and feels like everybody there are murderers and terrible human beings, yet they are going to go ahead and do it. That has expanded my understanding of choice. Supporting a woman and providing her with a safe and hopefully physically comfortable abortion even though she thinks I am the devil for working at an abortion clinic. Being pro-choice means even supporting women who will vote for Bush and say they are against abortion, but that their situation is special (Lola Samuels, staff interview:3/22/03).

Contradictions abound at a clinic where a pregnancy represents a crisis. Parents who have raised their daughters to be pro-life sometimes bring to them to the clinic to have an abortion. I observed several such scenarios at the clinic where a very young girl refused to have an abortion because she believed it is murder, just as her parents and church taught her. In some instances, parents have been irate with the clinic staff when they refuse to perform an abortion on their minor daughter who will not give consent. They feel they know what is best for their daughter and never imagined that an abortion clinic wouldn't just perform an abortion at their insistence. During one of the clinic's monthly staff meetings, Dr. Roberta told the story of what she described as an elderly white

"socialite" from Dallas who brought her African American maid to the clinic for an abortion, which the employer paid for in cash. While her maid was having an abortion, this elderly woman began to pass out pro-life pamphlets to the young, white women in the waiting room. In Dr. Powell's retelling, the woman was quite irritated and did not understand why she was asked to leave the waiting room. People from all walks of life may identify politically or religiously as against abortion, yet may seek abortion services for themselves, a family member, or even an employee.

The clinic staff regularly discusses this phenomenon during what we call "supervision" or the time during the monthly staff meeting when counselors talk about particularly difficult or interesting clients. Counselors might bring up a client who was upsetting because she believes abortion is equivalent to murder. On one occasion, Lola, a counselor, was distraught because she had counseled a woman who was very clear that she wanted an abortion but admitted that she protests at PPH twice a week and had every intention of continuing to do so. Dr Dunn recognizes the divergence between women's belief systems and their abortion decisions in her statement:

> I really like doing abortions. I feel significant. I feel in some ways that God wanted me to. I can relate to women. In Dixon (TX), we did one of the Alan Guttmacher surveys with our patients, and half of them said they were Born Again Christians. We are talking about this huge conflict between people having abortions and the way they were brought up (Sarah Dunn, staff interview:04/08/2006).

Some staff members feel "frustrated" by the phenomenon of pro-life women having abortions. Samantha, a counselor, jokingly called women who are pro-life and have abortions "terminally unique" because, according to her, they are unable to imagine that other women having abortions might also have a valid reason. Samantha said:

> They are what I like to classify as terminally unique. They are not like the other one point five million women who have abortions every year. Their reasons are unique. Their situation is different. My hope is that something within them will change. That they would be able to take their experience and teach one or two other people that there are different ways to look at choice. It is my hope that they feel kindness and respect here at the clinic, and that they can carry that with them to other people. Whether or not that is happening, I really don't know (Samantha Pullman, staff interview:12/06/2004).

Although she joked about it, it was at the same time distressing to her:

> My fear is that they leave here and they don't tell anybody and they act like it has never happened. My fear is that they go back out there and pick up their signs and do their own protesting, even though they themselves have had an abortion (Samantha Pullman, staff interview:12/06/2004).

Samantha and the other staff at the clinic believe that it is important to provide good services to pro-choice and pro-life clients alike; however, it can be frustrating to the staff when clients unabashedly announce they are voting for the pro-life candidate in an upcoming election.

Political Versus Personal

In a study of the relationship between women's abortion experiences and political consciousness, Stewart and Gold-Steinberg (1996) found that illegal abortions (*i.e.*, considerably more frightening, painful, and potentially dangerous) were more likely to bring about political awareness in women than legal abortions (*i.e.*, far safer and more comfortable). Their study found that legal abortions were more personal and less political for women. According to the researchers, women who experienced illegal abortions:

> [S]uffered much more anxiety, particularly about being hurt, molested, arrested, and dying. These anxieties were associated with feeling

> identified with other women, which was in turn associated with political activism. This set of relationships did not hold true for women who had experienced legal abortions (Stewart and Gold-Steinberg 1996:294).

If this is the case, it validates Samantha's fears about pro-life women, who come through the clinic but continue to be politically active in favor of the pro-life movement and pro-life candidates, especially because it is the philosophy of the Powell Clinic to provide the most physically and emotionally comfortable experience possible. Throughout the many years of his practice, Dr. Powell has been on the forefront of pain-control among abortion providers and members of the National Abortion Federation (NAF). His techniques include a combination of pharmaceutical and metaphysical approaches. As described in Chapter 4, Dr. Powell and his staff of four other physicians administer a synthetic morphine (Fentanyl) and anti-anxiety medication (Versed) intravenously immediately before a procedure. During the process, counselors stand beside a client, employing guided imagery and relaxation methods. Depending on the wishes of the client, the counselor may explain what is happening during the process (*i.e.*, "the doctor is dilating your cervix now") or, they might engage in general conversation. A small number of women fall asleep with the medications, and, at the other end, especially during advanced procedures, a small number of women do have more severe pain. The staff does its best to alleviate all pain and anxiety through whatever methods and techniques they deem appropriate to the individual.

Very few women who come to the clinic for a first trimester abortion describe the process as painful. Many patients have even deemed the procedure "too easy." If painless procedures subvert political activism, Dr. Powell has created an army of complacent women. As an ordained minister, it is Dr. Powell's spiritual and

philosophical belief that women deserve to have the least painful experience possible. When Dr. Powell and I discussed the findings of Stewart and Gold-Steinberg with respect to the political inertia of abortion receivers, he said he found the results interesting and expressed regret that more women were not politically involved with abortion. He responded: "It is not my job to politically educate women, it *is* my job to care for them and respect them" (Clinic field notes:3/12/2007).

Dr. Powell provides abortions to women who identify as pro-life because he and his staff maintain that it is an important part of being pro-choice: allowing for contradiction and disagreement. The staff of the Powell Clinic regards a clinic in Texas that requires women to work in a pro-choice workbook and "counsels" women regarding their political opinions as an imperfect model. The former manager of the Powell Clinic, Lily McEvans, told me about a woman doctor from Arizona she met at a NAF conference. The doctor told her she refused to provide an abortion for a woman who said that she was going to vote for George H.W. Bush in the then upcoming presidential election. The Powell staff found this doctor's actions deplorable. According to the Powell philosophy, women who have religious or political views that differ from the staff's still deserve to receive a safe and caring procedure as a fundamental human right. In fact, protecting choice for pro-life women is considered a pillar in the Powell Clinic ideology.

Dr. Clifford explains how a woman who identifies as pro-life can have an abortion without changing her world-view:

> They are desperate. It is hard for them to shift to decide that abortion is moral just from that. It is a big shift, a big philosophical shift. It is easier to think, I need to have this abortion. They feel their need as very intense.

> They don't necessarily transfer that to empathizing with other women's needs. They may not think, oh, these other women have reasons like me. They often don't get that step. They may need it, but the Church says it is bad. The President says it is bad. Who are they to say it is good. It is bad, but I need to do it for me. My reason is sufficient, but I hear about all these bad reasons that women are doing it. They can rationalize it for themselves (Clifford Powell, staff interview:11/15/2006).

For Doctor Powell, women who terminate a pregnancy do so in a moment when they are under extreme duress. This may not be a time that easily translates into empathy for other women's situations. Furthermore, when a woman terminates a pregnancy, she may have different personal feelings about abortion, but she returns to the life where she first learned to be pro-life. Women may continue to identify as pro-life because after a termination they continue to live in the same family structure and political environment. It is a reality for many women that their abortion experience is never shared or discussed. Women often need to maintain their privacy with their family and close friends and suddenly identifying as pro-choice could significantly compromise a woman's privacy.

Returning to a Pro-life Environment

Pro-life women typically come from pro-life homes. Dr. Powell discusses women who have abortions and the realities of the lives to which a pro-life woman returns:

> They go back to the life they had. Are they going to go to a different church? Are they going to have a different family? No. They still have a family that is actively anti-abortion. They still have a church where the Minister is anti-abortion. Because they have had an abortion, they are not going to say "Hallelujah, God wants us to have an abortion if we need one." They are not going to do that. They are going to go back to the only life they have. The only way they can go back to that life is to slip back into that culture and those beliefs. That duality is too hard, so they go back to it. Even women who don't have those strong prohibitions, they are still bombarded with the idea that abortion is wrong (Clifford Powell, staff interview:11/15/2006).

In March of 2006, Audrey, then 18, had an abortion. She was a single mother with a one year-old son and she had dropped out of school in the 11th grade when she became pregnant the first time. Audrey identified as "Spanish," and no one in her life knew about her pregnancy. She lived with her mother and grandmother. When she was asked if she was pro-life or pro-choice, she stated: "In my house, you got to be pro-life. If my Mom or Grandmother knew I had an abortion, I would be out on the street. They would take my son and throw me out. It would not be good" (Audrey, client interview: 04/04/2006). Like many of the women who come from a pro-life household, Audrey could not identify as pro-choice without jeopardizing her privacy and safety. Many of the women who continue to identify as pro-life said that having an abortion is something that they never wanted to do. Polly was a twenty-five year old single mother of two children from Northern New Mexico who, given her situation, didn't feel that she had a choice regarding her pregnancy. She stated:

> I guess I would still say pro-life. I am the same person. I still think it is wrong and that it is a sin. I really didn't have a choice. I did what I had to do in the situation. Like I said, I didn't want to do it. It still is hard to think about and how if God is going to punish me or not. If he does, he does. I did the only thing that I could do. I couldn't see my kids suffer anymore. I told my counselor that I wished it was illegal so that I couldn't do it at all. It was really hard for me to do it when it is so against what I believe (Polly, client interview:12/20/2006).

Some women who feel that they do not have a choice continue to identify as pro-life because abortion was not something they chose to do. In this perspective, not having any options takes the decision away from a woman. Having a choice means having realistic alternatives: enough resources to care for another child or not having become pregnant in the first place. When a woman views her situation as one with no alternatives, she can

still view abortion as morally wrong as it is *not* the decision that she wanted to make. Ultimately, there is no contradiction between being pro-life and terminating a pregnancy if a woman thinks that her life circumstances left her with only one path. Lucinda, then a 23 year-old Hispanic woman with a young daughter, terminated her pregnancy because she had a brief affair with a co-worker. Because ultrasound measurements are not absolutely accurate, she was uncertain if the pregnancy was from her boyfriend or co-worker, so she decided to have an abortion. Lucinda stated that she "didn't really have a choice." Although she had an abortion, she continued to identify as pro-life. She explains: "I believe that abortion is wrong and a sin. But, sometimes one sin happens and then you only have one way to make it right" (Lucinda, client interview:12/20/2006). For Lucinda, her affair was wrong, and so was the procedure that resolved it.

The term "choice" implies that a woman has several alternatives, the traditional triad of parenthood, adoption, or abortion. Women who terminate a pregnancy do not regard parenthood and adoption as legitimate possibilities for them. Pregnancy has very profound social consequences for a woman as she physically changes and becomes socially identified as a future mother. In reality, adoption is rarely "anonymous" for a woman when it comes to her family and community. A client named Amanda had considered adoption, but she knew that her parents would inevitably discover that she was pregnant. Even though Amanda identified as pro-life, adoption was not a possibility for her because her family would see her pregnancy and demand that she raise the child. Before her decision, Amanda was "disgusted" by women in her hometown that she knew had abortions. When asked if she was pro-choice or pro-life three weeks after her abortion, Amanda said she was "both."

The Value of the Pregnancy/Fetus

Women can identify as pro-life and have an abortion because the fetus or pregnancy continues to have value to them. For these women, to value the fetus is to be pro-life. Of the 11 clients that continued to identify as pro-life afterwards, all but one were already mothers. Although the Institute of Medicine estimates that almost 60% of all pregnancies in the United States are unintended, health care providers commonly assume that a pregnancy is a wanted and joyous event (Brown and Eisenberg eds. 1995:1). Women are shown ultrasounds and given prenatal appointments without any discussion of wantedness or her intentions. It is the cultural script of Motherhood. It is often women who have been subjected to such assumptions that have the most emotional difficulty with their decision to abort. The fetus has already gained some elements of personhood through being imagined as a future child through such "kinning" mechanisms as naming, sexing, or receiving a sonogram picture. When a woman begins to see her fetus (or yolk sac if she is before 10 weeks LMP) as a member of her family, then deciding to terminate the pregnancy because of life circumstances can cause a woman grief and emotional pain. Nicky was a 25 year-old white woman who has terminated two unintended pregnancies and identifies as a pro-life Christian. She was raised in an actively pro-life household and her grandmother works at crisis pregnancy center in Albuquerque. When asked about her abortion decision Nicky said,

> It is kind of hard, because I believe that even if a pregnancy is unplanned that it happened for a reason. I feel like, I do believe that when a baby is conceived that God knows that baby. I believe that, even when we do this, that it still ends up in a good place. You are not just throwing something away. I *do* believe that babies are alive, but I wouldn't have done it if I

> was farther along than seven weeks. I think at nine weeks they feel pain, and there is no way that I would have done it. So I have my own limit (Nicky, client interview:2/14/07).

Nicky didn't morally agree with abortion because she "believes it is alive." In this passage from her interview, she refers to the bible verse "Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet of nations" (Jeremiah 1:5). Although the word abortion is never mentioned in the bible, this verse is used in pro-life literature to argue that abortion is a sin in the eyes of God. Although Nicky identified as pro-life, it is fetal pain that is her standard for personhood. According to Nicky, if she had been nine weeks, she would not have had an abortion because she believes that it is at this point in the pregnancy that the nervous system is functioning. It is when a pregnancy can feel that it deserves protection.

A discussion of the value of the fetus can be very uncomfortable for individuals who work in providing abortions. Dr. Powell's philosophy is one that values both the woman and the pregnancy, and for some of his colleagues, this is a very dangerous stance. When asked about the value of the fetus in the abortion debate, Dr. Powell said,

> This is another divide that ought not to exist. On the anti-abortion side, they give the fetus or embryo ultimate value to meet their cause. It is a person at the time the sperm and egg unite. It is a person entitled to all rights and privileges of a person and of equal value to any other person in our society. On the other hand, you have the people on the other side that support abortion, and they feel that if they give the fetus any value, then someone has got to represent that fetus…To them it is easier to say that the fetus has no value because it is not a person. I think that both of those positions are wrong. I am in the minority, I will tell you. I have been going at it for a lot of years trying to get people to think about the position, and I don't know that I am making a great deal of headway (Clifford Powell, staff interview:11/15/2006).

Like Nicky and other women who come to the clinic and identify as pro-life, Dr. Powell believes that the fetus does have value. Again, it is a matter of whose value is greater. When a woman is pregnant as a result of rape or if her life is in danger from a pregnancy, she is more innocent and therefore, of equal or greater value to the fetus. However, a woman who is pregnant because of "carelessness" is not innocent, unlike the fetus, and therefore can be perceived as having a lesser value than the fetus.

The valuing of the fetus can translate into fetal rights as the state can have a vested interest in the fetus as a potential future citizen. In July of 2001, the Department of Health and Human Services (HHS) under the Bush administration proposed that "an unborn child may be considered a 'targeted low income child' by the state and therefore eligible" for coverage by Medicaid. State Children's Health Insurance Program or SCHIP extend Medicaid benefits to a fetus (Saletan 2003:266). I have seen women come to the clinic with a Presumptive Medicaid (a category for pregnant women) form issued by the public health department which lists the women's name, her other children if she has any, and "unborn child" on the last line or, "baby" followed the client's last name. The date of birth column across from "unborn child" contain either "unknown" or the expected due date (also known as the estimated date or confinement or EDC) based on the applicant's last menstrual period or sonogram results.

Health Indications

Women who have abortions because of health problems often feel disenfranchised when it comes to choice. Several women cite health as the sole reason they are terminating a pregnancy. Kristina, a 22 year-old, Navajo mother of three children stated: "I didn't have

a choice. My doctor told me how dangerous it would be and I knew I had to do this. I didn't want to. I never would do it if it was guaranteed that I would be OK" (Kristina, client interview:01/24/2006). Gestational diabetes, pregnancy related hypertension, and many other conditions put women at risk. Lena, also discussed in chapter 6, was a 25 year-old "Spanish" woman with two young children, suffered from severe bronchitis. Heath indications was her primary narrative. It was Lena's doctor's opinion that it would be in her medical interest to terminate this pregnancy. Lena identified as pro-life but because of the strong medications she has been on for her condition, she feared for the health of her pregnancy and its normal development. In her belief system, a woman must have a "good reason" to have an abortion. She was raised to be against abortion and identified as pro-life after her procedure. She "didn't want to do it." Because Lena felt that it was not her decision, there is no conflict for her continuing to identify as pro-life. Women who have health contradictions with a pregnancy are more likely to involve their pro-life family in the process because they have a "good reason" for having the abortion.

The Powell Clinic has a very close relationship with a paranatology clinic that refers women whose pregnancy has been diagnosed with a fetal anomaly or fetal demise (death). These situations are often very different from other patients because these were wanted pregnancies and there can be much more grief involved for these women and their families. As previously addressed, I was prohibited from interviewing clients with a known fetal anomaly or demise. However, I have counseled many of the women with anomalies or demises. Many, but not all, of the women who came to the clinic for a "non-elective" abortion are very clearly in the pro-life camp and are often offended by the other women who are there "by choice." Similarly, Lena was offended by what she

perceived to be the nonchalant attitude of other women in the waiting room. She said, "There were so many girls and they didn't seem like they even cared. They just throw it away like it was nothing" (Lena, client interview:04/04/2006).

When the staff of the Powell Clinic is making an appointment for a patient referred by the paranatologist, the staff is told to always "warn" the woman that the facility is an abortion clinic and that she does have the option of going to a hospital for the procedure. This is usually not an option for women who have healthy pregnancies, as most hospitals will not perform a termination unless there is a health concern. Dr. Powell was contracted to provide all of the elective terminations for Lovelace insurance patients because Lovelace stopped providing abortions in their hospitals due to bad press and staff protests. One exception to this rule is the University of New Mexico, which opened an abortion clinic in 2007, but the clinic is not located *in* the UNM hospital. This clinic is technically a part of UNM hospital but it is physically separated from it. If there is a diagnosed health concern, then a woman can have the procedure performed in a hospital. However, operating rooms are hard to book, and some women are told that they will have to wait upwards of weeks for their appointment. Some women with health indications reluctantly decide to come to the Powell Clinic for services because they can usually get an appointment within days of calling. The staff of the Powell Clinic works hard to accommodate the special needs of pro-life women with anomalies or demises by offering ceremonies and burial by a funeral home to aid in the grieving process. However, for the staff, women with anomalies are considered part of the broad continuum of choice. Lola, a long-time counselor at the clinic said:

> A good example is women with a fetal demise or fetal anomalies. This is a wanted pregnancy. Their doctors, as soon as that fetus is sick, wash their hands of them, and send them to us. The poor woman is like, no this is my baby. I wanted this baby. I have all of this grief about this. And, we are able to show them compassion and grieve with them. When they come to an abortion clinic, they assume that we won't recognize their grief. But we do, and they are surprised and really grateful. I think so. Before abortion, women with fetal anomalies were forced to carry these pregnancies to term, to deliver, usually a very difficult delivery. They would deliver a dead baby or one that would only last a few hours or weeks. So, of course these women have a choice (Lola Samuels, staff interview:3/22/03).

Although clients with a fetal anomaly or with a health complication do not feel that they had a choice, the staff of the Powell Clinic sees it as very much invested with choice. From this perspective, it is women who are forced to go through a dangerous pregnancy or whose only option is to deliver a unhealthy baby that do not have a choice.

For both pro-life and pro-choice women alike, there are times in a pregnancy when having an abortion is acceptable and times when it is not. These boundaries of acceptability are based on ideas of personhood. Personhood can be endowed when a fetus feels pain, can be felt moving inside the uterus (quickening), or even when gender can be determined. During her interview, Lena said:

> If you are in a situation like me, then, yeah, it is OK. But if I weren't so early in the pregnancy, I couldn't have done it. If it was more formed or bigger, I just couldn't have gone through with it. So, when I came up here and they told me I was early, I was relieved. Otherwise, I wouldn't have done it. You know, because, it is like a baby, all formed and what not (Lena, client interview:04/04/2006).

If her pregnancy was "formed" then Lena believes that she could not have proceeded with the termination, even if continuing the pregnancy would be dangerous to her health. Lena identified as pro-life before and after, but her pro-life position was only negotiable past a certain point in the development of her pregnancy.

Explicating a Contradiction

The Romantic poet John Keats' concept of "Negative Capability" came to mind when reading the interviews of the eleven women who continued to embrace the pro-life identity. This is when we are "capable of being in uncertainties, Mysteries, doubts without any irritable reaching after fact and reason" (letter from John Keats, December 21, 1817). Keats believed that people should be able to live comfortably with contradiction and open-endedness and accept that not every thing can be resolved. Keats' "Negative Capability" is a literary concept for humankind's ability to live contentedly with mystery and ambiguity. This letting-go, so to speak, is not unlike the ability of pro-life women to live comfortably with contradiction of an abortion decision. For women who identify as pro-life after having had a pregnancy termination, one might anticipate conflict or moral confusion. However, many of the participants who continued to identify as pro-life after their abortion were not heavily conflicted about their decision to end a pregnancy. For instance, Lenora was a twenty –four year old Native American woman who lived in Albuquerque. She was single with one child in July of 2006. Although she identified as pro-life, she felt that she had made the right decision. Lenora said:

> I am for the pro-life, but sometimes this just has to happen. I think it is up to the person. If you can't take care of the child, you don't want it to suffer. You have to do what is best for the baby. If you can't support it, you shouldn't bring it into the world (Lenora, client interview:07/18/2006).

If one were to read Lenora's statement without the first sentence, it might be assumed that Lenora was pro-choice, but that is not how she identified. Similarly, Marsha had an

ambiguous relationship with abortion. Although she identified as pro-life, she could understand why some women would end a pregnancy. Marsha said:

> I guess I would say that I am pro-life. It is a baby and it has a soul. But, I also understand why sometimes girls got to do it. It is like, you can't watch your other ones suffer every day. I think it is wrong if you have money and you have an abortion just because you don't want to do all the hard work. I never rest with my three. It is constantly something that I got to do or take care of. Now the oldest one wants all of the newest sneakers and clothes. I can barely keep up as it is (Marsha, client interview:01/24/2006).

Dori was less sympathetic to other women's decisions than Lenora or Marsha. She was a twenty-five years single mother of three children. She said:

> I was pro-life, and I guess I still am. I don't agree with this. I think it is one of those necessary evils in life. I think it is horrible how many girls do this and act like it is no big deal (Dori, client interview:02/07/2006).

Erlinda also identified as pro-life after her abortion, but also said it depended on the person's situation. She said: "Sometimes I regret it and sometimes I am OK. I believe it was the right decision, but I feel like I messed up (Erlinda, client interview:11/14/2006). Erlinda felt that abortion was "wrong" but also "necessary."

We will never know if the 20% of women who continued to identify as pro-life will ever have a shift in their perspective. Camille did not begin to identify as pro-choice until some time after her first abortion, which occurred three years prior to her second termination at the Powell Clinic. When asked when she became pro-choice she replied:

> It was sometime after my first abortion, and it wasn't right away either. I wasn't OK with my decision at first. I was upset for a while and felt like I was being punished for having sex before I was married. I wouldn't let my boyfriend touch me. I would see my nieces and nephews and cry. Thank God my boyfriend was there for me through the hard times. Then I started to feel better after a couple of weeks. I wasn't so sad. A couple months later, some girl in one of my classes started saying things like, "women who have abortions are selfish" and "abortion is the same as

> murder." I just sat there stunned and thought, I used to say those exact same things and really believed it too. I thought, "she is so ignorant." Then I thought, what if I was six months pregnant right now. I would probably have jumped off the parking garage. Not really, but it hit me how it was absolutely the right thing for me to have done. I knew I wasn't a murderer (Camille, client interview:04/25/2006).

The Staff's Relationship with Pro-life women

> At the clinic, we are really good at seeing a patient, and recognizing that that is that person's life and we have to respect who they are, where they are at. You know. Respect that woman who comes in and says that she is pro-life and that she had picketed clinics, and she probably will again. Yet, she wants an abortion, and it is our responsibility to care for her with all of our skill and attention. That is really hard (Lola Samuels, staff interview:03/22/03).

Even though it can be frustrating for the staff of the clinic to see pro-life women have abortions, the clinic's philosophy holds that these women too deserve to be treated respectfully. Some of the staff have come from conservative homes and understand the pressure that women feel. Dr. Dunn grew up as a minister's daughter in an extremely conservative home and this has given her greater empathy for women who have religious conflicts with their decision. She said:

> I think the more I got into I realized that I had something unique that a lot of other doctors performing abortions didn't have, and that was growing up in that background. And, how does one ever know what God's plan is for you, but it just seems like I was in the right place at the right time to help all these women who felt so much like sinners. To be able to say to them, "I grew up in a very strict Christian family and I believe that God is a loving and forgiving God." When they would ask me if they were going to Hell, I would say that I didn't believe that. They could talk to me about it, back then even more so than now. Now, I would probably say that I'm not even sure that there is a Hell (Sarah Dunn, staff interview:04/08/2006).

For Dr. Dunn, growing up as a minister's daughter, which we both have in common, has helped her relate to women who come from pro-life homes. Dr. Dunn, like all doctors at

the clinic, meets individually with the client before the procedure. Dr. Dunn always takes a little extra time with the patients and asks women about their lives. Patients seem to be more at ease after they have met with her. She will often tell patients that she is a minister's daughter and a Christian. Pro-life clients can relate to her because she is also bridging two worlds.

> Sometimes I say, "do you believe in a loving and forgiving God?" And they say "Yeah." And I'll say "You know, God doesn't expect us to do more than we can. He gave us a brain and he intended us to use it. He wants us to take care of the children we have and take care of them well. I just don't believe in a God that would punish people by giving them this burden." That is the kind of what I say to them. I at least try to say a sentence or two about it, and I have no problem telling them about my background: A minister's daughter, and evangelical Christian father. The way I was brought up is that everything is black and white. But, as you get older, you do discover that there are grey areas, and, the farther you go in life, the greyer everything gets. (Laughs.) You look back at this and see it differently (Sarah Dunn, staff interview:04/08/2006).

Whether or not women shift their political perspective, many of the staff members talk about changing things through kindness. A woman may get an abortion and continue to identify as pro-life, but she may remember the kindness and respect she was given during her very personal journey at the Powell Clinic. Dr. Powell explains how clients change through a positive abortion experience, although it might not manifest into a political consciousness:

> I think more often I see women who even if they struggle, and even if it never shows up in an obvious political action, I think most women are changed. Whether they were pro-choice, indifferent, or anti-choice before. Living the experience does make a difference in ways that I don't think we have good words for or good ways of measuring, or good ways of tracking. But we see it. We see it and we feel it (Roberta Powell, staff interview:11/15/2006).

How do women really conceptualize their abortion experience as a political act? Many women did say they identified as pro-choice, where as before their abortion experience, they were pro-life. Almost a third of all participants shifted their political identification from pro-life to pro-choice, or at least to undecided. But it should be considered that the respondents were asked question about their political identification at an abortion clinic. Outside of the clinic, some of these respondents may have identified as pro-life in their everyday lives.

CHAPTER 8
Conclusion: The Future of Abortion Rights

> *Our strategy should be not only to confront empire, but to lay siege to it. To deprive it of oxygen. To shame it. To mock it. With our art, our music, our literature, our stubbornness, our joy, our brilliance, our sheer relentlessness – and our ability to tell our own stories. Stories that are different from the ones we're being brainwashed to believe.*
>
> -Arundhati Roy's speech Confronting Empire, presented at the World Social Forum in Brazil, January 27, 2003

The stories of women who have abortions deserve to be heard and the ways in which they conceptualize abortion decisions are both valid and diverse. What many of these stories do have in common; however, is a sentiment of the absence of choice. A central project of feminist anthropology is the inclusion of women's voices. Because of the shame women in the United States are expected to feel about pregnancy termination, and indeed often do, they rarely share abortion experiences with close friends, let alone social researchers. Working at the clinic provided me with the unique opportunity to ask women how they look back at their abortion decision. I wonder how they will consider it throughout their lives. I learned about choice ideology from the clinic staff through in-depth interviews and through working with these exceptional and brave people. Outside the Powell Clinic, the protesters exercise the freedom of speech guaranteed to them by the constitution. I absolutely respect that right; however, I have seen the line between

free speech and harassment crossed many times since the fire.[11] The Powell Clinic is now a more public site because of its notoriety from the fire and the more centralized location attracts a greater number of protesters, a few of whom employ more aggressive strategies than before. The few protesters that are confrontational get most of the attention from staff and clients, but the majority of the protesters are there to quietly voice their beliefs and they do respect the laws. Some stand vigil quietly on the sidewalk, with bright red tape across their mouths. The site of the clinic is exceptionally invested with meaning. Before *Roe v. Wade*, abortions were clandestine events in the United States performed out of the public eye. After *Roe v. Wade*, abortions became safer, but there was a place to directly challenge abortion: the clinic. With legality and the ghettoization of abortion services (*i.e.*, not performed in hospitals), abortion clinics have become a site of contestation and contradiction, where pro-life women have abortions and the political concept of choice has little resonance for the women exercising it. Since the mid 1980s, the U.S. abortion debate has been verbalized almost exclusively in the language of choice and life. As we can see, the choice and life paradigms abridge women's everyday experiences and, ultimately, obstruct a discussion of the practice of abortion.

In this chapter, I discuss participants' views on the legality of abortion in the U.S., specifically the 2006 legal battle to outlaw all abortions in South Dakota. I outline how choice fails as a paradigm for abortion rights and I offer up an alternative paradigm; the

[11] In February of 2009, an interaction between a client and a protester turned into a scuffle and both called the police. All the police could do was give the protester, a white middle-aged woman, a warning even though she had been seen breaking the law by entering the Powell clinic parking lot. During the conflict, the client was distraught and was terrified that the police would arrest her. At the old clinic location, protester and client confrontation very rarely occurred because the clinic was set back from the public road and far away from the protesters.

reproductive justice model of abortion rights. I describe a reproductive justice model and how it is similar to the choice model, but more significantly, how it differs. I also discuss the future of abortion services for women in the United States and outline policy recommendations for improving the health of women and families through the universal legalization of abortion.

A Question of Legality

During many of the client interviews I conducted, I asked participants an open-ended question about the abortion legislation being debated in South Dakota. In March of 2006, then Governor of South Dakota, Mike Rounds, signed a bill that would effectively illegalize abortions in the state. South Dakota voters rejected the abortion ban by 55% in early November of 2006. I thought that the battle in South Dakota would be a current and revealing topic and provide an excellent segue into clients' opinions about legality. I asked clients if they identified as pro-choice or pro-life, but there were so many gray areas in the responses. What about the legal status of abortion? If passed, the ballot measure in South Dakota would have outlawed "elective" abortions with no exception for rape, incest, or life of mother.

For most of the women who come to the clinic, abortion is not discussed openly in their homes. On occasion it was whispered about. During counsels, many clients have told me that their mother or sister revealed to them that they had an abortion as they were on the way to the clinic for their abortion. In the day-to-day, most women do not think about abortion politics unless they are an abortion clinic worker. For the staff of the clinic, their work is saturated with political acts and they have a consciousness of choice.

They regularly discuss access issues, national politics, and abortion rights. Abortion reflects both their livelihood and their principles. Women who come to the clinic for services do not always view abortion in a political context because it is such a deeply personal experience, one few clients expect to encounter. They never thought about abortion before they had one, and they may not think about abortion much afterwards. There are very few counseling groups for women for abortion, so women, when they do think about abortion, are probably processing their experience alone. Abortion is not in the forefront of every woman's consciousness. Many women who come to the clinic, especially women under thirty, do not know that abortion was illegal in the United States before 1973. They are not aware that before *Roe v. Wade*, women who were harmed by illegal abortions filled Ob/Gyn wards. The single client that did mention the health impact of illegality had taken a Women's Studies class where she was exposed to feminist views. Of the clients interviewed, 12 of 55 (almost 22%) either had no opinion or were undecided about identifying as pro-choice or pro-life.

When I asked, Alma, who was a nineteen year-old Hispanic woman, if she identified as pro-choice or pro-life she said:

> No. I never really thought about it because I thought I would never get pregnant. I thought, No, I will never get pregnant. Not me, not me. So, I never really had a decision on it. (sic) When it came down to it, I had to. A lot of my friends are against it, but that is them. When they seen everything I was going through, now they don't say nothing and are supportive about it…I have two older sisters and they have both had abortions because they were too young to have babies. I heard about it in school, I heard about it on the news, I heard about it all over, and I never really had an opinion, until now (Alma, client interview:04/11/2006).

Alma thought that abortion can be a good option for women and should be legal and accessible, but she did not identify as either pro-choice or pro-life. If she had to "choose"

one, she said that she is more on the pro-choice side. The ambivalence that women have about identifying as pro-choice or pro-life is reflective of the ambivalence that they feel about abortion *and* their own decision. Although the issue of abortion and abortion rights may seem inextricably linked to having one, for some women, they are not. Although she did not identify strongly as pro-choice, when asked about a possible abortion ban in South Dakota, Alma said:

> I think that they should leave it alone. I think that it should be legal to have this because, like I said earlier, there are going to be girls out there doing drugs. Why you going to have a baby like that when you can just have an abortion and go on with your life and get on birth control. Like for me, for my own sake, I couldn't have no baby right now. If it happens like an accident and they don't want to have a baby, nobody is going to take care of their babies but them. Whoever is going to make it illegal, are they going to go and take care of these girl's babies? No. I don't think that they (politicians of S.D.) should do that (Alma, client interview:04/11/2006).

Alma believes that women should be able to have abortions because sometimes women use drugs during pregnancy or they aren't ready to be mothers. She wants to know if the South Dakota lawmakers are going to take care of the unwanted babies that would invariably result from such a ban.

When asked if abortion should be legal or illegal, Kim had a very strong opinion. She expressed that if abortion was made illegal, then she would go to Mexico. Kim said:

> That would be so crazy if the government just came in and said, all of you women have to leave, this is illegal now. I would be, like, I need to go to Mexico. (Laughs.) I think I would have. If it was illegal, I would go to Mexico. Sometimes it really has to be done (Kim, client interview:05/16/006).

When Sylvia talked about the possibility of illegality in the U.S., she had a very similar response to Kim. Sylvia said:

> I hadn't heard that. (Pauses). I don't think it would be a very good idea. Everyone has different reasons. Every woman has a different situation and there are different reasons, different situations. Sometimes it has to be done (Sylvia, client interview:04/11/2006).

For Sylvia, there are valid reasons that a woman decides to end a pregnancy. For her, it is situational, and a total ban would not allow consideration of the different reasons women have when aborting a pregnancy. Another client, Shaundra, said that she would fight the State of New Mexico if it tried to make abortions illegal.

> If that were occurring in our state, I would definitely stand with people that are pro-choice. It is my body. There are already too many children in the world that are unwanted. You should not bring a kid into this world if you are not going to love them the way they deserve to be loved. It is just unfair. It is unfair to you, to the child, to society. If something like that were to happen, I would definitely be involved (Shaundra, client interview:05/16/2006).

Shaundra felt that making abortion illegal is "unfair" to both women and the children who are unwanted. Shaundra identified as pro-choice, but would only be moved to action if the legislation affected abortion access in New Mexico. The women in South Dakota who faced these restrictions were on their own.

When asked about the ban, some clients talked about the negative consequences to both women and children if abortion was made illegal. Cindy believed that if abortions were illegal, infanticide would increase and desperate women would discard their babies. She said:

> I believe that if they make it illegal, that they are just going to have all of these babies floating around. That is what I believe. I don't mean it in a mean way, but it is true. All these young girls, what are they going to do, these twelve, thirteen, fourteen year-old girls who can't get a job? Their parents can only help them for so long. What are they going to do? It shouldn't be illegal. (Cindy, client interview:04/11/2006)

Cindy had two abortions; one when she was eighteen and another a year later. She knew of the desperation a young woman feels when she has limited options. Another client, Tammy, believed that if abortion was made illegal in South Dakota, that women would attempt to end a pregnancy through unsafe means. Similar to the situation before *Roe v Wade*, Tammy thought that if abortions were illegal in the United States, women would attempt to end a pregnancy on their own. Women would suffer and die. She said:

> Yea. There will be a lot of dead women. Women will try to do this illegally and it is not going to be safe. They are not going to have a place like this where they can go…I think people would try to get abortions on their own and get infections and start dying (Tammy, client interview:04/25/2006).

Shaundra, Cindy, and Tammy were all attending college at the time of the interviews, but none had taken a course in feminism. Ruth had taken a feminist theory class while pursuing her bachelors in History and she had a more economic, world systems model of abortion rights. When asked if she had an opinion about illegalization, she said:

> I do. I think that when the government steps in and starts to regulate a very personal decision, they are overstepping their bounds. When I look at other countries where women are second-class citizens, women don't have the right to decide what happens for them reproductively. If the U.S. goes down that road and starts to take reproductive rights away from women, it will make us into second-class citizens. That is just one step away from bringing our nation down, economically and socially, to a third-world country (Ruth, client interview:07/18/2006).

According to Ruth, making abortion illegal would economically marginalize women and, in turn, be detrimental to the U.S. as a world power. Another client, Annie, identified as pro-choice, but she thought that there should be more restrictions on abortion. At the time of her interview, she was working in Santa Fe at the capitol building and she interacted with politicians on a daily basis.

> Well, I work with politicians. That is my job. A lot of them are men, so I guess they really don't understand the decision a woman is faced with. I don't think that they should be able to decide. It is a personal choice. But, I think that there should be a law depending on the circumstance. If you got pregnant just because you are stupid and irresponsible, then you should deal with the consequences (Annie, client interview:12/20/2006).

Annie decided to end her pregnancy so that she could begin treatment for early-stage cervical cancer. Because she could not start treatment until her pregnancy was "resolved," she decided to terminate. Annie differentiated herself from women who are "stupid and irresponsible," or women who decide on abortion without health indications. Annie believed that these women should not have access to abortion because they have "no good reason" (Annie, client interview:12/20/2006). Although she identified politically as pro-choice before and after her abortion, she believed that women who do not have a good reason should not be able to access abortion services. When asked about South Dakota, none of the women believed that abortion should be completely outlawed. Interestingly, some clients who identified as pro-life thought that abortion should be legal and without restriction and some women who identified as pro-choice thought that there should be some kind of restrictions in place.

Dr. Roberta Powell, who had been fighting for the legality of abortion since she was a young woman in the 1970s, reflected on the state of abortion in the U.S:

> I think it is actually a right that is largely being taken for granted, not only by younger women and people who have grown-up with legal abortion, but lots of my peers. People who are not involved in the women's movement, but supported abortion rights. A lot of people who believe that the right is safe. It is not. I see the continual eroding of and undermining of the right to abortion that especially affects the poor and the disenfranchised. I have seen nothing to make me believe that that is going to change, so I am fearful. I really believe that at some point in my life I was going to move on to something else, but after thirty years, abortion

> has yet to be on secure ground for me to move on (Roberta Powell, staff interview:11/15/2006).

Many in the abortion providing community are fearful of the future of abortion rights because the anti-abortion movement has strategically shifted its focus from legality to restriction. *Roe v. Wade* may not be overturned at a national level, at least not during the presidency of Barack Obama, but state restrictions continue to create barriers for economically marginalized women seeking abortion services.

The Graying of Abortion Providers

Women's access to abortion in the U.S. is threatened not only by legislation, such as occurred in South Dakota, but by a very real phenomenon termed the "graying" of abortion providers. For abortion activists, this is one of the most pressing issues for women's access in the future. The young doctors, who bravely started to provide abortions around the time of *Roe v Wade* (1973), like Dr. Powell and Dr. Dunn, are aging and retiring. Fifty-seven percent of abortion providers are 50 or older (NAF 2005b). Many clinics across the U.S. are currently relying on elderly doctors to function. A doctor who works at the Powells' other clinic in Texas suffered a brain aneurism in 2008, and the clinic's ability to provide services was significantly compromised during his recovery.[12] Another of the older doctors at the Powell's clinic in Albuquerque became very ill with cancer in 2003. The clinic manager, Jill Rue, explains what happened at the Powell Clinic and at clinics all over the U.S.:

> We have had the experience of losing one of our most skilled providers of advanced abortions. Here is one man who would cover three different

[12] In the case of other medical services, there is typically a safety-net of other practitioners within the same specialty to takeover a sick or aging doctor's case load.

> cities in the southwest providing advanced abortions, and one man's illness has devastated, essentially, millions of women's options. It is very horrifying. There is a movement through Medical Students for Choice, and there are young doctors interested in learning how to do abortions, but they don't necessarily want to become abortion providers. It is dangerous work and it is difficult to find young doctors who are dedicated to providing abortion. We have two other providers who are in their sixties. So we have one young provider in her thirties that is replacing three other providers. That is shocking, but that is what is happening. We are replacing three with one. Think about what that does for women's choice (Jill Rue, staff interview:12/06/2004).

If there are no providers, then the question of legality is moot.[13] From 1982 to 2001, the number of abortion providers in the United States dropped by 37% (Finer and Henshaw 2003a:23). The future looks especially grim for second trimester abortion services as dilation and evacuation (D&E) procedures are very rarely taught in medical schools. According to a study of NAF providers in 2002, most second trimester abortion providers (63%) are 50 year old or older (O'Connell *et al.* 2008). The tenuousness of advanced abortion services was made tragically clear with the May 2009 murder of George Tiller, one of three late-term abortion providers in the United States. I had the pleasure of meeting Dr. Tiller, a soft-spoken and gentle man, who was both a friend and student of Dr. Powell. His death lead to the permanent closing of his Kansas clinic, and an already difficult to access procedure has become out of reach for many women in need.

Because of the successful terrorization of abortion providers by pro-life extremists, few young doctors are willing to face the risks associated with becoming an abortion provider. That small number of doctors that are willing to enter into a life

[13] As of February of 2009, The Powell clinic had hired two new providers, one in her mid-thirties and another in his mid-forties and they both perform second trimester abortions.

riddled with threats of violence and state scrutiny[14] may have difficulty finding training. Twenty-six percent of Ob/Gyn residency programs trained all of the residents in abortion procedures and 14% of Ob/Gyn residency programs have absolutely no training for residents (Finer and Henshaw 2003b:9). There are some important programs oriented towards training new physicians in abortion care. One such program, the Kenneth J. Ryan Residency Training Program in Family Planning and Abortion, is a national program, based out of the Bixby Center of the University of California in San Francisco. Since 1999, its mission is to provide training opportunities in abortion and contraception for residents in obstetrics and gynecology. In 2009, there were 49 programs in 26 states, as well as two programs is Canada (Bixby Center 2008).

There is also the more recent Center for Reproductive Health Education In Family Medicine (RHEDI), established in 2004. RHEDI provides funding to U.S. family residency programs to integrate a rotation in abortion and family planning. Dr. Powell called RHEDI, the "most important thing since *Roe v. Wade*" because the program requires family planning residence at participating medical schools to opt-out of contraceptive and abortion training rather than pursuing training if they have a personal interest (Clinic field notes: 04/22/2009). Ultimately, the goal of RHEDI is to normalize abortion services for future doctors. The Powell Clinic participates in a voluntary abortion study program with the UNM School of Medicine and on many Thursdays (both before and after the fire), a medical student observes at the clinic for one or two days.

[14] Only two months before his murder, a Wichita jury acquitted Dr. Tiller of 19 criminal counts. Dr. Tiller was accused of performing illegal abortions because it was charged that he did not comply with a Kansas state law requiring a second, independent physician to approve a late-term abortion. Beginning in 2006, then pro-life Attorney General of Kansas, Phill Klein, began what has been called a "legal crusade" against Dr. Tiller.

Both female and male medical students are exposed to the counseling and medical aspects of the clinic. After being briefed by the head nurse regarding privacy policies, the Powell philosophy, and expectations, a medical student typically will observe sonograms, abortion counsels, the process of the provider meeting the patient, and abortion procedures. The Powell staff asks the consent of the client to allow the medical student to observe. Some women, especially if it is a male student and it is her first gynecological experience, say that they would be more comfortable without the student present. But, most clients consent to have the student observe. The Powell philosophy stresses the importance of compassionate care. The primary objective of having medical students is to expose these future doctors not to a medical procedure, but an ideal of respect for women that they may bring to their practice, which probably will not involve abortion. Very few of these medical students go on to provide abortion services, most probably because of the intense controversy of the issue. Of the fifteen medical students I asked if they thought they might go on to provide abortion, only one said yes, but she also made it clear that abortion would be a small part of her practice. The future of abortion services in the United States is dependent upon new doctors learning abortion techniques *and* providing abortion services, and this is not occurring at a maintainable rate. Medical Students for Choice (MSC) has more than 4,000 members at over 100 campuses to educate and involve a new generation of physicians in providing abortions.

Other levels of medical providers, such as physician assistants, nurse practitioners, and nurse-midwives were the great hope of the future for expanding abortion access, especially with the FDA approval of Mifeprex abortions. However, this potential pool of abortion providers has been effectively stifled through state laws that

prohibit midlevel providers from performing abortions or administering Mifeprex abortions.[15] Most states have passed legislation that prevents midlevel providers from providing abortions. Although midlevel providers can prescribe or administer other medications, in many states they are restricted from administering chemical abortions. Today, most states have a "physicians-only" provision in their abortion laws (NAF 2005b). In Texas, midlevel providers are prohibited from providing all abortion services. In New Mexico, midlevel providers are prohibited from performing surgical abortions but they may, under the direction of a physician, dispense Mifeprex and misoprostol for a chemical abortion. However, this does little to expand providing because "under the direction of a physician" requires that a physician be physically present, i.e., in the building. Without providers who are willing perform abortions, abortion access in the future will be as it was before *Roe v. Wade*, a safe option for only the privileged. In this future, women may truly have no choice.

How Does Choice Fail?

Choice ideology in the U.S. is problematic in three critical ways. First, it ignores the social inequalities that women are subject to when seeking to control their reproduction. Freedom to choose an abortion has become synonymous with a legal abortion, but freedom to choose does not address the access issues women face: money, transportation, education, and a dwindling pool of providers. Choice ideology is modeled on an autonomous, classless, raceless, ageless, woman with many options. By promoting a

[15] In Montana, a physician assistant, Susan Cahill, was only one of three providers in the state, beginning to perform abortions in 1977. In 1995, the state of Montana attempted to stop her from providing abortions, claiming that she was not qualified to do so. In the Fall of 1999, after appealing a previous verdict, Cahill won her case against the state (Armstrong *v.* State of Montana 989 P.2d 364 [Mont. 1999]).

shared right for women as a homogeneous group, women on the margins are dismissed. In the pro-abortion movement in the United States, women of color, low-income women, rural women, and women with disabilities are disenfranchised by the notion that they are free to choose among a set of alternatives.

Second, when women are terminating a pregnancy, they rarely invoke the language of choice and may perceive an abortion decision as devoid of choice. Even women who identified politically as pro-choice and came to their decision with a feminist consciousness said they had no choice. The political framing of pro-choice versus pro-life veils the ways in which women understand and talk about their abortion experiences. Women use alternative narratives to configure their abortion decisions because they feel that having an unwanted pregnancy takes their choice away.

Third, choice ideology is culturally based and does not easily translate into other belief systems outside of a western capitalistic society. Choice ideology is founded on Enlightenment assumption that the rights of the individual are preeminent. In many cultures of the world, the rights of the husband, the family, the community, or the state trump the rights of a woman, especially when reproduction is involved. When discussing abortion in a global context, it is critical that anthropologists, as well as policy makers, and activists, consider the diverse ideologies at work. We must recognize that abortion, similar to other reproductive strategies, is always a culturally based practice. Historical, religious, and ethnic differences must be borne in mind. Although ethical standards require a respect for diversity, cultural relativity has been used as an ideological tool to excuse acts of violence against women (Nagengast 2004). "Historically, no large group has suffered greater physical, psychological, and symbolic violence in the name of

culture and tradition than women have" (Nagengast 2004:109). There must be a balance between cultural respect and the universal truth that women must make the first decisions about their bodies.

The objective of abortion access is ultimately to improve the health of women and families. Unintended pregnancy can be reduced, and abortion services, which will always be needed no matter how accessible birth control is, can be a safe and legally acceptable option for a woman. The endeavor to secure abortion as a human right must not be a top-down enterprise, replicating colonialist hierarchies. Exporting choice ideology as it exists in the U.S. would simply reproduce western cultural domination. Efforts to ensure women's reproductive freedom on a global level will only be successful if the language in which it is delivered has cultural resonance.

Choice Ideology Subverting Feminism

As discussed in Chapter 2, choice ideology is very important to the staff of the Powell Clinic. As a common narrative for the abortion workers, it has served the staff well in many ways. For instance, the staff is able to support a pro-life woman during an abortion because being pro-choice means supporting all women's choice, even women who are morally opposed to abortion. Also, approaching a counseling session from the paradigm of choice gives the client the freedom to make her own decision, ensuring a better emotional outcome (Baker, A. 1995). Because they are committed to choice, the staff tries to reduce any coercive elements and ensure that a woman is there by her own will. Although choice ideology is a central paradigm for the clinic staff, clients do not often feel that they are practicing choice, and many do not think of abortion as political issue.

Although the staff of the clinic is deeply invested in choice ideology, reframing abortion rights as a reproductive justice issue is not a far ideological leap for these individuals who witness the inequalities that impact women's access on a day-to-day basis.

While choice ideology is an important part of the Powell Clinic's work culture, it can simultaneously perpetuate the hegemony of patriarchy. There is one experience, in particular, that complicated choice ideology for me and forced me to question my feminist ideals. In 1999, I was the counselor for a woman whom I will call Rhada. She came to the Powell Clinic to terminate her pregnancy because her fetus was female. It was my one and only experience with sex-selective abortion, or what feminists call female feoticide, and it is still difficult for me to consider. Rhada was 41-years-old and was originally from India. She terminated her pregnancy at 18 weeks LMP, a two-day process requiring a D&E procedure. Her three adult daughters sat in the waiting room during both of her office visits, and her husband dropped them off and picked them up. She wanted me to ask the doctor what she could do to increase her chances of conceiving a son. What happens with choice ideology when a woman's "choice" is to terminate a female fetus? What is Rhada's "right to choose" or was Rhada, along with her female fetus, a victim of a dominant ideology that devalues women and is preferential to men? The ideology of choice, which should be about promoting women's equality, became abruptly unjust. Patriarchy seeped into the clinic in the most brutal way. Suddenly, the U.S. abortion debates primary dialectic of woman vs. fetus became problematical, because the fetus *was* also the woman.

Across the world, there are 100 million "missing" girls due to sex-selective abortion (Jones, A 2000). In India, the number of female children per male children has

fallen from 972 girls per 1000 boys in 1901 to 929 girls per 1000 boys (Jones, A 2000). When radicalizing the pro-choice debate, Sekimoto warns that either pro-life or pro-choice ideologies from the U.S. could argue against the one-child policy in China (Sekimoto 2009). When it comes to U.S. intervention in developing nations, both political positions have the potential of sabotaging reproductive justice. Choice ideology could promote the right to abort a female fetus, whereas life ideology could promote the protection of all fetuses, regardless of its gender, or a woman's health or socio-economic realities. As the narrative of Rhada's abortion reveals, choice ideology does not properly address reproductive inequalities, nor recognize that those subjected are often complicit in perpetuating them.

Illegal Abortion Across the Globe

A comprehensive study conducted by WHO and the Guttmacher Institute concluded that abortion rates in countries where abortion is illegal are the same or higher than abortion rates in countries where it is legal (Guttmacher 2006). Essentially, the study demonstrated that making abortion illegal does little to deter women from seeking an abortion, even under dangerous circumstances. This WHO and Guttmacher Institute study indicates two important findings; namely that that abortion rates in countries where abortion is illegal are equal to or more than rates in legal countries, and that abortion is dangerous when it is illegal. For example, in Uganda where abortion is illegal, the abortion rate was 54 per 1,000 in 2003 (Guttmacher 2006). This is more than twice the rate in the United States at 21 per 1,000 women (Guttmacher 2009a). The lowest

abortion rates were in Western European countries (12 per 1,000) where abortion is legal and contraception is widely available (Guttmacher 2009a).

Besides being an ineffective deterrent, illegalization creates greater health risks for women than when abortions are legal. This has been demonstrated time and again. When abortion was legalized in South Africa in 1997, it led to a 90% reduction in abortion-related mortality for women (Guttmacher 2006). The same phenomenon occurred in African countries such as Chad and Burkina Faso, when abortion restrictions were lightened. However, in 2009, abortion remains illegal throughout most of the rest of Africa. Underprivileged women in Africa drink teas of boiled coins or neem leaves, or some ingest high doses of malaria drugs. WHO estimates that 30,000 women die annually from unsafe abortions in Africa (World Health Report 2005). In some countries, such as Kenya, maternal deaths from unsafe abortion are as high as 40% of all maternal deaths (Riungu 2008). Complications related to abortion are the second cause of death for women admitted to hospitals in Ethiopia (Guttmacher 2006).

It is estimated that one in four women in the world live under laws which severely restrict abortion, legal only to save a woman's life but not on other grounds (*i.e.*, rape, incest, or severe fetal abnormalities) (Guttmacher 2009b). For instance, in 1997, Poland's Parliament banned abortions for social or economic grounds. As a result, over 200,000 illegal abortions occur annually in Poland, with sometimes devastating effects on the lives of women and their families. In 2004, the Office of the United Nations High Commissioner for Human Rights condemned Poland's restrictive laws as putting "women's lives at risk by encouraging them to seek illegal abortions, sometimes from untrained practitioners" (Kaiser Daily Health Report 2004:1).

El Salvador's abortion laws are even stricter than Poland's. Women in El Salvador are actively prosecuted for seeking abortion services or performing abortions on themselves. An increasing number of Salvadorian women have been illegally using misoprostol since 1997, the year it was introduced (Hitt 2006). This is one of the medications used in the chemical abortion process. In many countries across the world, women use misoprostol as an abortifacient and the resulting miscarriage can be passed off as spontaneous. Misoprostol is sold at pharmacies for gastric ulcers or, if illegal, on the black market.[16]

Factory workers in Saipan have underground abortions because they would lose their job otherwise. Saipan factory workers owe money to their "recruiters" who transported them to the Northern Marian Islands to work in garment factories owned by U.S companies. Because they were made in U.S. territory, Saipan products had the label "Made in USA" for many years, but Saipan was not subject to U.S. labor laws, and women who were pregnant were regularly fired (Clarren 2006:35). Factory workers were forced to have dangerous abortions in order to not lose their jobs. This is the absence of choice.

Many women across the world have very few safe options to ending unintended pregnancies. Globally, thirteen percent of maternal deaths are caused by complications from unsafe abortions.

> Of the estimated 46 million abortions worldwide each year, about 26 million take place under unsafe conditions, often in countries where abortion is illegal, resulting in the death of 78,000 women. Millions of more women experience medical complications. Almost all of these

[16] Several women from Mexico have come to the Powell clinic after having taken a large dose of misoprostol earlier in the pregnancy. Misoprostol sometimes fails to cause a miscarriage and this is especially problematic because it is a teratogen, meaning it causes birth defects.

> deaths occur in developing countries where of 154 million pregnancies each year, 65 million are unplanned. Thirteen percent of all pregnancies in Africa, 40% in Latin America, and 29% in Asia end in abortion--a total of 36 million (Henshaw *et al*., 1999:35-36).

The harm caused by unsafe abortions is especially disturbing when one considers the unproblematic nature of the procedure when performed by a skilled practitioner under medically acceptable conditions. It has been proven time and again that when abortion is legal, maternal health improves. The World Health Organization called unsafe abortions a "preventable pandemic"(Grimes *et al.* 2006). Every day across the globe, women suffer from unsafe abortions and the indignity that they entail: sterility, ostracism, and death. Every day, children become orphans or, alternately, women have children they cannot support or feed. In most countries in which abortion is illegal, there is no exception for cases or rape, incest, or severe fetal anomaly. Less rarely, there is an exception based on preserving the life of the mother.

Beyond the physical harm caused by illegal abortions, many women across the globe are incarcerated for infanticide when they successfully abort a fetus and are found out by authorities. Incarceration from infanticide can last anywhere from months to ten years, leaving thousands of children motherless during this time (Karafin 2008).

Linking Abortion to Human Rights: A Reproductive Justice Model

In 2007, Amnesty International, shifting its earlier position, adopted a policy that held abortions should be available to women in instances of rape, incest, and compromised health. Amnesty International does not recognize abortion as a right for women when it comes to elective terminations, but does support access to what the organization calls

"women at risk" (AI 2008). In 2007, the Deputy Secretary General of AI, Kate Gilmore, wrote in a press release:

> Amnesty International stands alongside the victims and survivors of human rights violations. Our policy reflects our obligation of solidarity as a human rights movement with, for example, the rape survivor in Darfur, who, because she is left pregnant as a result of the enemy, is further ostracized by her community (AI 2007).

For some in the human rights movement, being forced to carry to term an unwanted pregnancy is also damaging, mentally and physically, even if it is not in the context of grave human rights violations, such as occurred in Darfur. As demonstrated by the Institute of Medicine (1995), unintended pregnancies compromise a woman's well being. This harms her physical integrity, a right established in the Universal Declaration of Human Rights (UDHR). I argue that all women are "at risk" of becoming unintendedly pregnant and not having the necessary resources to have a child. I propose that restrictive abortion laws promote violence against women. Unsafe abortions are a gender-based discrimination, as men experience no equivalent risks during their lifetime. Abortion should be recognized as a fundamental right embedded in the right to physical wellbeing as established by the Universal Declaration of Human Rights.

The reproductive justice model is based on the understanding that women in the U.S. and across the world all experience unintended pregnancy, but that these pregnancies occur within the context of unequal situations. A reproductive justice model goes beyond choice ideology, which demands that all persons are treated equally, because it also addresses the economic imbalances that impact women's reproductive decisions.

The reproductive justice model, unlike choice ideology, is compelling because it addresses the economic and social disparities women face when seeking abortion

services. Through the shifting relationship of power and powerlessness, women make abortion decisions. The reproductive justice model allows for alternative ways of understanding an abortion decision. Reproductive justice includes a right to access to abortion, but also, the right not to have an abortion. As demonstrated by China's one-child policy, abortion can be promoted by the state, and in some instances, violently enforced. Furthermore, the reproductive justice model can incorporate important feminist issues such as sex-selective abortions without undermining women's right to abortion. The reproductive justice model places abortion and other reproductive decisions within the context of the hegemonic and the subaltern.

Turning Abortion from a Negative to a Positive Right

Choice ideology is founded on a right to privacy, and with the *Roe v. Wade* decision, the government was effectively told not to interfere with women's reproductive decisions. As a result, abortion was legally constructed as a negative right based on privacy from state interference, not a positive right, which requires that the U.S. government acts to ensure women's access. When abortion was conceptualized as a private issue for women to the exclusion of the government, restrictions on federal funding were ideologically supported. In *Harris v. McRae* (1980) Supreme Court Justice Potter Stewart wrote in the majority opinion:

> [R]egardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in *Wade*, it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for

> certain medically necessary abortions. Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life (*Harris v. McRae*, 448 U.S. 297 [1980]).

When the Supreme Court considered the right to state-covered abortion, the establishment of the right to abortion on negative, due process grounds proved to the undoing of public funded abortions. According to supporters of the Hyde Amendment and *Harris v. McRae*, taxpayers' money should not be used to pay for women's abortions. This is clearly a morally driven and not a financial based policy, as first trimester abortions cost around $400 dollars while full-term deliveries cost the state over ten times as much.

In a study on unintended pregnancy, the Institute of Medicine found that,

> A woman with an unintended pregnancy is less likely to seek prenatal care and is more likely to expose the fetus to harmful substances. The child of an unwanted conception especially is at greater risk of being born at low birthweight, of dying in the first year of life, of being abused, and of not receiving sufficient resources for healthy development. The mother may be at greater risk of depression and of physical abuse herself, and her relationship with her partner is at greater risk of dissolution (Brown and Eisenberg eds. 1995:251).

The reproductive justice model demands that governments make pregnancy termination services legal and accessible to women. Abortion is articulated as a positive right. Doctor Roberta views restrictive abortion laws, which do not hold up to the "undue-burden" standard as conceptualized by the courts, as creating barriers for disadvantaged women. She said:

> I have never met a restrictive abortion law that I truly believe that the intentions behind it were in the interest of women. I have met people who supported those laws believing that they were doing something good for women. But, I have yet to meet one that has truly helped women. They always and disproportionately impact the poor, young women, and women

> of color. They are effective if your agenda is to see that those women have children they don't want. They create significant barriers (Roberta Powell, staff interview:11/15/2006).

When abortion is theorized as a human right, then it becomes a government's obligation to ensure that this right is not only protected, but that it is accessible without barriers. Construing abortion as a positive right, an entitlement to abortion, is the center of the reproductive justice model.

The reproductive justice model must be linked to economic justice in which women have the resources to continue a pregnancy. It must provide that women also have the option to parent. Reproductive justice is the freedom of individuals to make decisions regarding their reproduction free of coercive elements.

The reproductive justice model not only includes the right to abortion, it also includes the right to contraception in order to reduce unintended pregnancies. Politicians on both sides of the abortion debate agree that the U.S. abortion rate should be reduced. However, it is the manner in which abortion rates are reduced that will impact the well being of women and families. If abortion rates are reduced by decreasing women's access to abortion services, as seems to be the current trend, low-income women, rural women, and women of color will be disproportionately impacted by these restrictions. The efforts to reduce the U.S. abortion rate must begin with providing more contraceptive options and effective healthcare delivery. On many occasions, women have come to the Powell Clinic with an unintended pregnancy because their birth control prescription had run out and their doctor could not see them for months. Reducing the U.S. abortion rate must also address the abstinence only sex education programs that have proven to be an

abysmal failure. Many of the Powell Clinic's clients have not been educated about birth control. Beatrice told me how she never learned what her options were:

> I guess, before getting to the decision part, a lot of people don't know where to go for birth control. Now I know, but for a long time I didn't know that there were places you could go to get on it. They should make young people more aware. Maybe, go to the high schools and tell them all the places that they can go that will help you, so that they don't have to get to this decision of having a baby or not. My Mom told me, never have sex, and that was it. She never said, well, if you do, then…There weren't options. And the schools didn't help. In sex education, they told you about condoms, but they didn't tell you where you could get birth control or anything. It was just use a condom. They showed stuff about all the diseases, but we really didn't discuss pregnancy that much as getting sexually transmitted diseases, trying to prevent that. It might be better now (Beatrice, client interview:12/14/2006).

New Reproductive Technologies

Promoting a reproductive justice model is prudent because it creates a framework for new reproductive technologies that are emerging from scientific innovation. Since the 1980's, new reproductive technologies (NRTs) have provided innovative ways of reducing unintended pregnancy while simultaneously creating new methods for state control over women's bodies. New forms of pregnancy termination (mifepristone in 2000) as well as new contraceptive methods which solve the "problem" of fertility for women (Implanon 2008) have profoundly altered women's reproduction and its relationship with the state. New reproductive technologies have the potential of providing all women with greater control over their procreativity. The rhetoric of "advancement" promotes the perspective that more sophisticated technologies create more choices for women. However, feminist theorists have deconstructed this modernist agenda and argued that new reproductive technologies have the potential of promoting social and political agendas over the

wellbeing of women. NRTs have been used as tools that enable the state to more effectively control and survey women's reproduction (Hartman 1995, Holms 1992, Roberts 1987).

Depo Provera is an example of an NRT that can be used clandestinely. Depo Provera is an injection that protects a woman from pregnancy for three months. Clinic nurses regularly administer the Depo Shot immediately after their abortion procedure with the client's consent.[17] However, I can easily imagine a context in which the Depo Shot could be given as a "vaccine" to a population that a state has deemed undesirable reproducers.

Raymond (1993) looks at new reproductive technologies with a critical eye, questioning the consequences NRTs have on women's bodies and attacks the discourse of choice that can be used to legitimize reproductive oppression. Raymond argues that much of technological reproduction is "brutality with a therapeutic face" (1993:14). Hartman (1995) also critiques NRTs for the rhetoric of "advancement" which promotes the perspective that technology is always objectively applied. Hartman argues that women's choices are constrained by the economic and social need for children, the level of reproductive control in a sexual relationship, the availability of birth control methods and infertility treatments, the control of information, and biomedicine's research priorities. According to Hartman, NRTs are being developed to control certain populations rather than to promote women's reproductive freedom. In a reproductive justice model, the right to reproductive self-determination includes both access to safe abortion and autonomy in deciding how and when to contracept. While new

[17] During the counseling session, the staff is trained to address birth control issues and help a client decide on an appropriate method if she so chooses.

contraceptive technologies can expand certain women's choices, they simultaneously create new possibilities for abuse. Historically, women's bodies have been subject to the control of men, from partners to policy makers. The developments of new methods of contraception have opened new terrains of colonization (Raymond 1993:ix). From a human rights perspective, it is important to critique the narrative of NRT's as advancements that promote reproductive choice, and explore NRT's affect on economic-inequalities, familial structures and parenthood, and women's health outcomes. As Spivak argues, a woman's womb is a tangible place of production. As such, it situates women as agents in a theory of production (Spivak 1996).

Although the state's power is profound, it is not total. "In a multitude of ways women assert their alternative view of their bodies, react against their accustomed social roles, reject denigrating scientific models, and in general struggle to achieve dignity and autonomy" (Strathern 1992:67). Women have both cultural and moral agency to decide about their reproductive futures, but they do not have equity in their range of decisions, especially those involving the use of new reproductive technologies. Biomedical discourse has historically reinforced dominant ideological constructs about the appropriate roles of women. These hegemonic ideologies have limited women's social roles to that of the private sphere of reproduction and childrearing.

In the changing landscape of reproductive technology, the reproductive justice model establishes a wider platform that can link abortion rights to reproductive autonomy, and other women centered issues, such as Human Immunodeficiency Virus (HIV), human trafficking, genital cutting, honor killing, and prostitution. Reproductive and sexual rights are:

> Constellations of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make and implement decisions about her reproduction and sexuality (Freedman 1999:149).

Historically, abortion has been a contentious issue for reproductive health policy makers. However, evidence across the globe indicates that restricting abortion services puts women's health at risk and undermines women reproductive and sexual rights. I recognize that my position is controversial at best, heretical in some circles, but I propose that the wellbeing of women can only be achieved when abortion services are legal (*i.e.*, safe) and accessible.

A Multicultural Approach to Abortion as a Human Right

There are many "women at risk" such as refugees, imprisoned women, women in war, women at war, immigrant women. However, even women in the southwestern United States are "at risk" as the health care system fails to help them prevent unintended pregnancies and then marginalizes them when they experience one. Some women in smaller towns in New Mexico cannot find a pharmacist that carries Plan B, also known as the morning after pill. Even if a pharmacy does carry Plan B, pharmacists have, in the past, refused to fill a prescription on moral grounds. In Albuquerque, when a pharmacist at Walgreen refuses to fill a prescription for Plan B, a woman can call the next closest pharmacy. In a town that has only one pharmacy and, sometimes, only one pharmacist on staff, this can be much more prohibitive for women. These same pharmacists may also refuse to fill prescriptions for birth control. Women in smaller communities in New

Mexico, in the U.S. and throughout the world are at greater risk. Rural women are vulnerable populations across the globe.

The issue of abortion raises difficult questions for the anthropologist. Some may be morally opposed to abortion. Beyond personal beliefs, abortion is a cultural fact and it is universally practiced. Abortion is a common reproductive strategy employed by women throughout the world. However, where it is illegal, abortion is relegated to the private sphere of women. Most patriarchal cultures throughout the world would not condone abortion as a reproductive right as it would be perceived as promoting women's promiscuity and unrestrained sexuality.

Abortion and Sexuality

During the 2006 movement to outlaw abortion in South Dakota, Senator William Napoli, the sponsor of the bill, argued that most abortions are simply a matter of convenience. Napoli said that the ban could make exceptions in special cases. When Napoli was asked what the type of scenario would warrant an exception, he said:

> A real-life description to me would be a rape victim, brutally raped, savaged. The girl was a virgin. She was religious. She planned on saving her virginity until she was married. She was brutalized and raped, sodomized as bad as you can possibly make it, and impregnated. I mean, that girl could be so messed up, physically and psychologically, that carrying that child could very well threaten her life (A News Hour with Jim Lehrer Transcript, March 3, 2006)

For Senator Napoli, abortion could only be justifiable if a virgin was viciously raped. In his world, only a woman with the most immaculate sexuality would deserve to end a pregnancy that had resulted from the most sadistic of acts. The Senator's comment

exposes what I believe is the essential issue of abortion in the U.S.: abortion is not so much about protecting fetuses as it is about controlling women's sexuality. When approached from this perspective, it makes sense that many of the same Americans that are against abortion are simultaneously opposed to birth control, the dispensing of emergency contraception, and Gardasil, the Human Papilloma Virus (HPV) vaccine. The problematization of women's sexuality is exposed in the conundrum of the pro-life script that women use abortion as birth control (are hyper-sexual and have abortion after abortion) while abortion simultaneously reduces fertility. Abortion is just the tip of the ideological iceberg that has to do with sexuality and woman's role in society. Pro-life women having abortions is no more of an incongruity than the anti-sexuality position which vilifies those who have abortions while simultaneously opposes practices that reduce unintended pregnancies.

Conclusion: Hope in the Future

On January 23, 2009 President Obama overturned the "global gag rule," also known as the Mexico City Policy. This policy mandated that U.S. family planning assistance would be withheld from foreign NGO's that provided elective abortion services or counseled women about abortion options. This repeal means that health clinics in developing countries will again be able to offer the world's poorest women access to reproductive-health services, from birth control to prenatal care *and* be able to discuss abortion options while receiving U.S. funds. This is an important step toward achieving reproductive justice for women around the world.

Abortion, which I would argue is a universal phenomenon, can be approached as a religious doctrine, a public health issue, a criminal law debate, or a human rights issue. In the last decade, abortion has edged into the realm of the human rights debate in the context of a right to reproductive and sexual health. The Center for Reproductive Rights promotes linking abortion to reproductive justice. This provides a model that can include maternal health and rights to contraceptive technologies without coercion. The reproductive justice argument does not marginalize women on the bases of economic status, ethnicity, disability, nationality, age, or first language. Unlike the pro-choice argument that depends on the status quo, the reproductive justice argument is founded on principles established by the human rights movement, such as women's right to physical wellbeing. A campaign for abortion reform should be firmly rooted in women's basic right to security of person, including the right to physical integrity.

If we include abortion as a part of the universal human rights system, we must address issues of cultural relativism that will invariably arise, such as with the matter of female circumcision. With female circumcision, there is conflict between those who want to suppress the practice completely and those who feel that it is a cultural right of passage and should be preserved. It is the ongoing conflict within human rights theory between cultural relativity *vs*. universalism, individual rights *vs*. collective rights, and civil and political *vs*. social and cultural rights (Nagengast 2004). A reproductive justice position may not be able to resolve these issues immediately, but it provides a model to open dialogue. As with any social change, people within a culture must create a campaign for abortion rights, or colonialist hierarchies are simply replicated. The reproductive justice model provides a different language to discuss situations fraught

with national sovereignty issues, such as China's one child policy and the tactical use of rape as a weapon in war. Most international conventions on human rights skirt the abortion issue, primarily because abortion is a particularly difficult issue for many human rights advocates, anthropologists, and policy makers. Instead of using choice ideology, reproductive rights advocates and social theorists must move to frame abortion in terms of a social justice issue - thereby acknowledging the social inequities which come to bear when women seek abortion services and linking abortion rights to the right to contraception. When we do, we work for the dignity of all women.

APPENDICES

Appendix A:
Research Study Participants' Biographical Sketches

1. 1/24/06
Marsha was a 28-year-old Native American woman from a Pueblo. She had three children and worked as a cashier at the casino. She was 15 weeks from her last menstrual period. She was single, and had never been married, but was engaged to the father of her two-year-old before he left her when she was ten weeks pregnant with her terminated pregnancy. She graduated high school and had been working at the casino for one year.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic survival
Secondary Narrative: Unpartnered

2. 1/24/06
Amanda was 19-years-old and was a student at the University of New Mexico. She identified as Spanish and her family has been in New Mexico for many generations. She grew up in a small town thirty minutes south of Albuquerque. She was studying business administration and this was her first pregnancy. She was ten weeks from her last menstrual period.

Identification Before: Pro-life Identification After: Both
Primary Narrative: Career/School
Secondary Narrative: Failed contraception

3. 1/24/06
Kristina was a 22-year-old woman from northwestern New Mexico. She is ¼ Navajo and ¾ "Spanish" and was raised by her Grandmother in a traditional Navajo belief system. She was feeling physically well at the time of her post-operative exam. She had three children, all of whom are being raised by her mother and grandmother as she attends a two-year vocational school in Albuquerque. Kristina dropped out of school at age 15 and received her General Equivalency Diploma (GED) a little over a year ago in 2005. She was 19 weeks from her last menstrual period.

Identification Before: Pro-life Identification After: Undecided
Primary Narrative: Health indication
Secondary Narrative: Career/School
Tertiary Narrative: Failed contraception

4. 2/3/06
Janet was a 26-year-old woman with 4 young children ranging in age from 7 to 3. She lived in Albuquerque, but was raised in a small town in northwestern New Mexico. She

is Navajo and has never been married. She worked at a call center in Albuquerque and made eight dollars an hour on which to support her kids. She was 10 weeks from her last menstrual period when she had her abortion.

Identification Before: Pro-life Identification After: Undecided
Primary Narrative: Rape
Secondary Narrative: N.A.

5. 2/7/06
Tanya was a 19-year-old Hispanic woman a town south of Albuquerque. She had one young daughter and was married. Her highest level of education was the eighth grade. She was 5 weeks from her last menstrual period when she had her abortion.

Identification Before: Pro-life Identification After: Undecided
Primary Narrative: Infidelity (her)
Secondary Narrative: Child spacing

6. 2/7/2006
Mattie was a 26-year-old woman who identified as Hispanic and Native American. She grew up in Albuquerque and was attending graduate school at UNM. This was her first pregnancy and she was 6 weeks from her last menstrual period at the time of her abortion.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Health indication
Secondary Narrative: Economic fitness

7. 2/7/2006
Candice was a 37-year-old Native American woman who lived in Albuquerque. She had three children. Her youngest child was eight years old and her oldest was 20. Her highest level of education was the tenth grade. She was 16 weeks LMP.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Age (old)

8. 2/7/06
Dori was a 25-year-old, Hispanic woman born and raised in the South Valley of Albuquerque. She was 8 weeks from her last menstrual period when she terminated her pregnancy. She was twenty-five years old, single, and has three children, her oldest was

seven and her youngest was eight months old. She had full Medicaid and it covered the cost of her abortion.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic survival
Secondary Narrative: Child spacing

9. 2/14/06
Carrie was a 20-year-old woman from one of the Pueblos. She was 8 weeks LMP and underwent the surgical procedure, which Medicaid covered. She had two children and a previous miscarriage. She was not married.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic survival
Secondary Narrative: Child spacing

10. 2/14/07
Nicky was a 25-year-old white woman. She was not married, had a year old child, and had some undergraduate education. She was seven weeks pregnant, had the surgical procedure and Medicaid covered the process. She had a previous abortion at a clinic in Texas when she was 19.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Career/School
Secondary Narrative: Child spacing

11. 2/14/06
Beatrice was a 24-years-old Hispanic woman and was not married. She was in her last year at UNM and had a previous abortion when she was 18. She was born and raised in Albuquerque. She was 7 weeks from her last menstrual period and paid $395 dollars for her abortion.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: N.A.

12. 2/21/06
Shane was a 22-year-old Native American woman from a small town about an hour north of Albuquerque. She was unmarried and had a young child. She was 6 weeks from her last menstrual period and underwent the chemical or medical abortion. New Mexico Medicaid covered her procedure.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Child spacing
Secondary Narrative: Economic survival

13. 2/21/06
Elizabeth was a 27-years-old single mother of one daughter. She identified as "White" and was in her third year at UNM. Elizabeth had one previous termination and was 7 weeks from her last menstrual period.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: N.A.

14. 3/7/06
Melanie was a 20-year-old single woman from Albuquerque. She was Hispanic and had one child and had one miscarriage. She dropped out of high school during the tenth grade to have her child. She was 6 weeks from her last menstrual period and had the surgical procedure.

Identification Before: Pro-life Identification After: No opinion
Primary Narrative: Economic survival
Secondary Narrative: Unpartnered

15. 3/7/06
Lauren was a 20-year-old Native American woman. She was 17 weeks from her last menstrual period, a procedure, which involves two steps for dilation. She had one previous vaginal delivery and lived with her mother and grandmother in a small town in Northern New Mexico. She paid $650 cash for her abortion.

Identification Before: No opinion Identification After: No opinion
Primary Narrative: Child spacing
Secondary Narrative: Unpartnered

16. 3/7/06
Dorothy was an 18-year-old white woman and this was her first pregnancy, terminated at eight weeks LMP. She was from Albuquerque, was single and was about to graduate from high school.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Age (young)

17. 3/7/06
Reanna was a 23-year-old woman who lives in Albuquerque. She identified as "mixed" (half Black and half White). She was an athlete and Senior at UNM. This was her first pregnancy and she was 5 weeks LMP at the time of her termination.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Economic fitness

18. 4/4/06
Lena was a 25-year-old woman from a small town approximately 3 hours south of Albuquerque. She was single and had two children, ages 6 and 4 with her long-term boyfriend. She identifies as "Spanish" and her family has lived in New Mexico for many generations. She completed high school and worked as a secretary. She paid cash ($395) for her abortion.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Health indications
Secondary Narrative: N.A.

19. 4/4/06
Audrey was an 18-year-old, single mother with a one year-old son. She was 5 weeks LMP at the time of her abortion and dropped out of school in the 11th grade when she became pregnant with her son. She identified as Spanish and no one in her life knew about her abortion. Medicaid covered her procedure.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic survival
Secondary Narrative: Child spacing

20. 4/4/06
Maricella was a 18-year-old, single woman from Albuquerque. She was in her first year at UNM and she identified as Hispanic. This was her first pregnancy and she was 7 weeks from her LMP. She used New Mexico Medicaid for her abortion fee.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Age (young)
Secondary Narrative: N.A.

21. 4/11/06
Ariela was an 18-year-old Hispanic woman from Albuquerque. She was not married and lived with her parents in the South Valley. She was not currently working. She graduated from high school last year and plans to marry her boyfriend in "a few" years. Ariela paid cash ($395) for her abortion at 10 weeks LMP. This was her first pregnancy.

Identification Before: Pro-life Identification After: Undecided
Primary Narrative: Age (young)
Secondary Narrative: Economic fitness

22. 4/11/06
Sylvia was a 22-year-old single woman who lives in a small town just south of Albuquerque. She had a young daughter. She lived with her parents and she attended UNM for two years before she had her daughter. She was staying at home with her daughter and was looking for a job. She was 15 weeks LMP at the time of her abortion. She did not wish to reveal her ethnicity.

Identification Before: No opinion Identification After: Pro-choice
Primary Narrative: Child spacing
Secondary Narrative: Economic survival

23. 4/11/06
Cindy was a 19-year-old Hispanic woman who lived twenty minutes north of Albuquerque. She was not married and Graduated High School the year before our interview took place. She had a previous abortion when she was 18 at our clinic and also had an early miscarriage. She was 14 weeks LMP at her termination. She had New Mexico Medicaid, which covered the cost of her abortion.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Age (young)
Secondary Narrative: Career/School

24. 4/11/06
Nellie was a 24-year-old single, white woman who lived in Albuquerque. She was tall, with light hair and blue eyes. She wore jeans and a white top. She was in graduate school at UNM. This was her first pregnancy with which she originally had a twin pregnancy and miscarried one. She terminated her pregnancy when she was 7 weeks LMP. She used Presumptive Eligibility Medicaid for her insurance.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Health indications
Secondary Narrative: Economic fitness

25. 4\11\06
Alma was a 19-year-old, single, Hispanic woman from Albuquerque's South Valley. She dropped out of high school in the 11th grade. Medicaid covered her abortion at which time she was 12 weeks from her last menstrual period. This was her first pregnancy.

Identification Before: Undecided Identification After: Pro-choice
Primary Narrative: Economic fitness
Secondary Narrative: Age (young)

26. 4/11/06
Madeline was a 26-year-old woman and was single. She lived in the Albuquerque area and identifies as mixed race, half African American and half White. This was her first pregnancy and she was 6 weeks from her last menstrual period. Her boyfriend paid for the $395 procedure on his credit card because she didn't have any insurance. She was about to graduate from a six-month trade school.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: N.A.

27. 4/25/06
Lorena was a 21-year-old Hispanic woman from Albuquerque. She was single and was in her second year of her undergraduate education. This was her first pregnancy and she was 8 weeks. She used private insurance to pay for her abortion.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Economic fitness
Secondary Narrative: Age (young)

28. 4/25/06
Tammy was a 34-year-old Hispanic woman. She was single and the mother of two children. She lived in a small town about twenty miles South of Albuquerque. She used her private insurance to pay for her 7 week termination.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Age (old)
Secondary Narrative: Unpartnered

29. 4/25/06
Camille was a 26-year-old Hispanic woman from Albuquerque. She was 11 weeks from her last period, and this was her second abortion. She had a previous termination three years earlier. She was married and in her third year of college. Her private health insurance covered elective abortion with a twenty-five dollar co-pay.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Failed contraception

30. 5/16/06
Shaundra was a 30-year-old Hispanic woman from Albuquerque. She had a Bachelors degree from UNM and worked as a paralegal. She was not married and had one child. She was thirteen weeks from her last menstrual period when she had her abortion.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Unpartnered
Secondary Narrative: N.A.

31. 5/16/06
Nuria was a 21-year-old woman from Las Cruces. She was unmarried and this was her first pregnancy. Her mother is from Cuba and her father's family is from the southwest ("Spanish") and has lived in New Mexico for many generations. She identified racially as Black. She was a junior at NMSU and She paid $395 for her abortion at seven weeks from her last menstrual period.

Identification Before: Pro-life Identification After: No opinion
Primary Narrative: Career/School
Secondary Narrative: Economic fitness

32. 5/16/06
Kim was a 19-year-old Hispanic woman who lived in Albuquerque. She worked as an assistant manager at a dollar store and got her GED four years earlier when she dropped out of high school to have a twins when she was 15. She had another child a year later. She was not married and had one previous abortion. She was 13 weeks from her last menstrual period and Medicaid covered her procedure.

Identification Before: Both Identification After: Pro-choice
Primary Narrative: Economic survival
Secondary Narrative: Child spacing

33. 5/16/06
Chantelle was a 23-year-old single, Hispanic woman from Espanola. She had a previous abortion and had no children. She had private insurance through her mother and was twenty weeks from her last menstrual period when she had her abortion.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Addiction
Secondary Narrative: N.A.

34. 6/13/06
Pauline was a 33-year-old, single, Hispanic woman from Albuquerque. She had three children, three miscarriages, and a previous abortion. She was eight weeks at the time of her abortion and she used Presumptive Medicaid.

Identification Before: Both Identification After: Pro-choice
Primary Narrative: Economic survival
Secondary Narrative: Age (old)

35. 7/18/06
Janine was an 18-year-old Hispanic woman from Espanola. This was her first pregnancy, and at six weeks from her last menstrual period, she opted for a chemical or medical (mifeprex) abortion. She paid cash for her procedure. She had just graduated high school.

Identification Before: Pro-life Identification After: No opinion
Primary Narrative: Age (young)
Secondary Narrative: N.A.

36. 7/18/06
Ruth was a 31-year-old, Hispanic woman who lived in Albuquerque. She had a bachelor's degree, and was a teacher. Ruth had two children, has had one miscarriage, and one previous abortion. She was married, her husband was disabled, and she used private insurance to cover her procedure at six weeks from her last menstrual period.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic Survival
Secondary Narrative: N.A.

37. 7/18/06
Lenora was a 24-year-old Native American woman that lived in Albuquerque. She was single and had one child. She was ten weeks from her last menstrual period. Medicaid covered her abortion.

Identification Before: Pro-choice Identification After: Pro-life
Primary Narrative: Career/School
Secondary Narrative: Economic survival

38. 7/18/06
Patricia was an 18-year-old, white woman from Albuquerque. This was her first pregnancy. She was twenty-one weeks from her last menstrual period when she had her abortion. She dropped out of High School in the ninth grade and had was in jail when she found out that she was pregnant. Lovelace Community Health Plan or Lovelace Salud! covered her abortion costs.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Coercion
Secondary Narrative: Economic fitness

39. 8/22/06
Tiffany was a 25-year-old, white woman from Albuquerque. She worked in real estate and was nine weeks from her last menstrual period. She had one previous abortion and she was not married. She paid cash ($395) for her abortion.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Unpartnered

40. 8/29/06
Rita was a 42-year-old Native American woman from a Pueblo North of Albuquerque. She was single, had three children and had a High School diploma. This was her first abortion and she was seven weeks from her last menstrual period. She received a clinic loan to pay for her abortion. She identified her religion as traditional and she worked as a waitress.

Identification Before: No opinion Identification After: No opinion
Primary Narrative: Age (old)
Secondary Narrative: Health indications

41. 8/22/06
Jacki was a 34-year-old Navajo woman who lived in Albuquerque. She was divorced, had one child, and worked as an Administrative Assistant. Jacki was five weeks from her last menstrual period and used private insurance to pay for her abortion. She was married to a Navajo man and they lived on the reservation together until he left her. She moved to Albuquerque to make a better life for herself.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Unpartnered
Secondary Narrative: Career/School
Tertiary: Failed Contraception

42. 8/29/06
Rochelle was a 20-year-old Hispanic woman. She was single and lived in Albuquerque. She identified as a Christian and was a High School graduate. This was her first pregnancy and she was 6 weeks from her last normal period.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Health indications
Secondary Narrative: Economic fitness

43.10/10/06
Heather was a 31-year-old Albuquerque resident. She was a white woman who was single with three children. She identified as a Christian and she worked as a Nursing Assistant. This was her fist abortion and she was 7 weeks LMP. She used Medicaid to cover her procedure.

Identification Before: No opinion Identification After: No opinion
Primary Narrative: Economic survival
Secondary Narrative: Unpartnered

44. 10/10/06
Cody was a 27-year-old Native American woman from the Farmington area. She was a sophomore at UNM and lived in Albuquerque. She had one child and had one previous miscarriage. She identified as Catholic and Medicaid covered her abortion. She was nine weeks from her LMP.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Economic survival
Secondary Narrative: Infidelity (him)

45. 10/10/06
Florence was a 21-year-old Native American woman. She was 10 weeks from her LMP and it was her first pregnancy. She was from Gallup but was a student at UNM and Medicaid covered her abortion.

Identification Before: Pro-choice
Identification After: Pro-choice
Primary Narrative: Unpartnered
Secondary Narrative: Career/School
Tertiary Narrative: Economic fitness

46.11/14/06
Luz was a 23-year-old Hispanic woman from a small town twenty miles South of Albuquerque. She was married with one child and she had one previous abortion. She had her child when she was 15 and dropped out of High School after tenth grade. She had a general anesthesiologist put her to sleep for her procedure. She was 10 weeks from her last normal period.

Identification Before: Pro-life
Identification After: Pro-choice
Primary Narrative: Infidelity (her)
Secondary Narrative: N.A.

47. 11/14/06
Erlinda was an eighteen year-old Navajo woman who lived in Albuquerque. She completed her tenth grade in High School and was in Job Corps. She grew up in Northwestern New Mexico and had five sisters. She was not married and this was her first pregnancy. She was nine weeks from her last menstrual period and Medicaid covered her procedure.

Identification Before: Pro-life
Identification After: Pro-life
Primary Narrative: Career/School
Secondary Narrative: Unpartnered

48. 11/14/06
Sarah was a 34-year-old white woman from Taos. She was raised in New England and had lived in New Mexico for almost six year. She was a massage therapist and was not married. This was her first pregnancy and she paid $395 for her procedure at 7 weeks from her last menstrual period. After our interview, she gave me her massage therapy card to give to other clients for free massages.

Identification Before: No opinion Identification After: No opinion
Primary Narrative: Unpartnered
Secondary Narrative: N.A.

49. 12/20/2006
Marisol was a 29-year-old Spanish-speaking woman who lived in Albuquerque and was originally from Chihuahua, Mexico. She was undocumented, had three children, was not married and paid $395 for her procedure at 9 weeks from her last menstrual period. She was undocumented and worked cleaning offices and houses.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Unpartnered
Secondary Narrative: Economic survival

50. 12/20/2006
Veronica was an 18-year-old woman, single and had a young child. She lived in a small town just north of Albuquerque. Medicaid covered her procedure at five weeks from her last menstrual period. She had dropped out in the 11th grade to have a child. She was attending Job Corps to get her high school diploma and be trained in a career.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Child spacing
Secondary Narrative: Career/School

51. 12/20/2006
Annie was a 20-year-old Hispanic woman from Santa Fe. This was her first pregnancy and she was eleven weeks from her last menstrual period. Her private insurance covered the procedure.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Health indications
Secondary Narrative: N.A.

52. 12/20/2006
Hillary was a 19-year-old Native American woman who lived in Albuquerque and identified as Christian. She received a partial clinic loan ($150 for $395 fee) and this was her first pregnancy.

Identification Before: Pro-life Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Unpartnered

53. 12/20/2006
Anna was a 32-year-old woman from Amsterdam studying holistic health in Albuquerque. She had no children and was single. This was her first pregnancy and she was 6 weeks LMP.

Identification Before: Pro-choice Identification After: Pro-choice
Primary Narrative: Career/School
Secondary Narrative: Economic fitness

54. 12/20/06
Polly was a single, 25-year-old, Hispanic woman who had two children. She was from northern New Mexico and she was 7 weeks from her last menstrual period at the time of her abortion. Medicaid covered her procedure. She worked two jobs as a clerk in a convenience store and as an assistant for an elderly woman in her town. She lived with her Mother and Grandmother.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Economic survival
Secondary Narrative: Career/School

55. 12/20/06
Lucinda was a 23 year-old Hispanic woman. She was separated from her boyfriend and was 10 weeks from her last menstrual period when she terminated her pregnancy. She lived in a small city about eighty miles southwest of Albuquerque. She had a 12th grade education and had one small daughter.

Identification Before: Pro-life Identification After: Pro-life
Primary Narrative: Infidelity (both partners)
Secondary Narrative: Economic survival

Appendix B:
Protocol for Screening Client Participation

These are the guidelines for soliciting participation from clients for the project "Choice Ideology and the Parameters of its Practice: Abortion Narratives in New Mexico."

Do not solicit participation from clients who you assess to be under profound emotional duress.

Do not solicit participation if you feel it may negatively influence a client's emotional wellbeing.

Do not ask clients who are under the age of 18 to participate

Do not ask clients who are mentally ill or mentally disabled.

Do not ask clients who cannot read or write.

Do not ask clients if participation would greatly lengthen their office visit (*i.e.*, more than 15 minutes).

Do not ask women who have a fetal demise.

Do not ask clients whom I, Abigail Adams, counseled during their abortion (Please refer to the upper left corner of the clients chart to determine who counseled her at the time of her procedure).

Solicit participation *only* at the time of the client's post -operative exam.

Appendix C:
Client Consent Form

Participant Consent form for Collaborating Participants in the Project Entitled:
Choice Ideology and the Parameters of its Practice:
Abortion Narratives in New Mexico.
(Client/Patient)

Introduction:
You are invited to participate in a dissertation research study conducted by Abigail Adams of the Anthropology Department at the University of New Mexico. You were selected as a possible participant in the study because you came to the clinic for an elective pregnancy termination and you are at least 18 years of age.

Purpose of the Study:
The purpose of the study is to collect women's stories about pregnancy termination and the way that they feel about their decision to have an abortion. The study will also investigate the clinic staff's ideas about choice, and clinic protesters' beliefs about personhood.

Procedures:
You will be asked to fill out some general information about yourself such as your age, race, education, and pregnancy history. Then you will be asked questions regarding your abortion experience. You will not receive payment for participation. If you agree or decline to participate, it will not affect your access to health care at this clinic. Participating in this study will take 10 to 15 minutes. Participating is completely voluntary and may add 5 minutes to your wait.

Potential Risks and Discomforts:
You will be asked personal questions regarding your abortion experience, such as why you decided to have an abortion, how you feel about your decision, and how you identify politically. It is possible that some questions may cause you emotional distress. If you feel uncomfortable or distressed at any time, please stop the interview for your own wellbeing. If participating in this interview would cause you any emotional difficulty, it is recommend that you do not participate. If you want a counseling referral, it will be provide to you. You can request to view a list of the questions before agreeing to participate in this study.

Potential Benefits to Participants and/or Society:
Your participation in this interview gives you an opportunity to share your story anonymously, so that others may know how and what women feel when making a decision to have an abortion.

Confidentiality:

Any information obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Your private information will be recorded with pen a paper in a notebook and your name will never be associated with this information. Your name will be kept confidential and will *never* appear in any publication.

Participation and Withdrawal:
You can choose whether to participate in this study or not. If you volunteer to participate, you may withdraw at any time without penalty or loss of benefits to which you might otherwise be entitled. You may also refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. For example, if the researcher feels that a question is causing you a negative emotional impact, the interview will end. By signing this consent form, you are not waiving any legal claims, rights or remedies because of your participation in this research study.

Identification of Investigators and Review Board:
The project, its aims and any adverse affects it may have upon me have been explained to me fully by Abigail Adams, MY PHONE NUMBER. I understand that if I have any questions regarding the project, I am free to contact the following persons at the University of New Mexico: Responsible Faculty Member's Phone Number, Chair of the Main Campus IRB'S PHONE NUMBER and/or direct my questions to the Clifford Powell Clinic manager: Julie Rue, CLINIC PHONE NUMBER. Any contact of these persons will remain confidential.

I understand that Abigail Adams may use materials from my interview for future publications. I understand that she will be the chief author of any material produced. I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have received a copy of this form for my records.

Signature of Research Participant

_____

Name of Participant (please print)

_____ _____

Signature of Participant Date

Signature of Investigator

In my judgment the participant is voluntary and knowingly providing informed consent and possesses the legal capacity to provide informed consent to participate in this research study.

_____ _____

Signature of Investigator Date

Appendix D:
Participant Questionnaire

Interview Guide for Patients

Age _____ Marital Status: Single Married Divorced

Ethnicity: White Black Hispanic Native American Other _____
(please specify)

Highest Educational: Grade School High School Under Graduate Graduate School
Level Completed

Pregnancy: _____ Birth(s) _____ Miscarriage(s) _____ Abortion(s) _____ NA
History

Method of Payment: Cash Medicaid Private Insurance Loan

Appendix E:
Interview Guide

1. A lot of people say that it is important for women to have a choice regarding reproduction. Tell me what you think about choice?

2. Do you feel like choice applies to you? Do you feel like you have a choice?

3. What are the things that went into your consideration to end this pregnancy?

4. Some women feel that they don't have a choice. How would you describe your own experience?

5. What are the things that are going on in your life that influenced your decision?

6. In what parts of your life were you supported in making this decision and what parts weren't you supported?

7. What did you think about abortion before you found out that you were pregnant?

8. Did you identify as pro-life or pro-choice before your abortion? How do you identify now?

Appendix F:
National Vital Statistics Data Form for Reporting of Pregnancy Terminations in New Mexico

Facility

Type of Facility where termination occurred
Hospital Clinic Physician's Office Other

City, Town of Location of pregnancy Termination

County of pregnancy Termination

PATIENT

Age of Patient _____

Married? Yes No

Education (circle only highest grade competed) 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17+ UNK

Date of Pregnancy Termination ___/____/____ Mo. Day Yr.

Residence: State County City, Town, or Location Inside City Limits? Yes No

Race
Black White Native American specify tribe _____ Other specify _____

Patient of Hispanic Origin? Yes No If YES, specify whether: US Southwest Cuban Mexican Puerto Rican Other – Specify: _____

Date last normal menses began _____/_____/_____ Mo. Day Yr.

PREVIOUS PREGNANCIES

Live Births

Number now living _____ None Unknown
Number now dead _____ None Unknown

Other Terminations

Number of spontaneous ____ None Unknown
Number induced _____ None Unknown

TERMINATION PROCEDURE

Procedure that Terminated Pregnancy (check only one)

Suction Curettage
Sharp Curettage (D&C)
Dilation and Evacuation (D&E)
Intra-Uterine Instillation (Saline or Prostaglandin)
Hysterectomy/Hysterotomy
Medical (Nonsurgical), Specify Medication(s) _____
Other (specify) _____

Physician's estimate of gestation _____ Weeks

Procedure performed by M.D. D.O.

Name and address of individual preparing this report

Appendix G:
Statistical Significance of CBS News/The New York Times Polls
Chi-Square Test

WITH "UNSURE"	Year	# of Cases	Generally Available	Strict Limitations	Not Permitted	Unsure	
	1993	1,113	49%	30%	19%	2%	**100%**
	2005	1,155	28%	40%	30%	2%	**100%**
	1993	1,113			211	22	
			545	334			**1,113**
	2005	1,155			347	23	
			323	462			**1,155**

WITHOUT "UNSURE"	Year	# of Cases	Generally Available	Strict Limitations	Not Permitted	
	1993	1,091	50%	31%	19%	**100%**
	2005	1,132	29%	41%	31%	**100%**

Contingency Table					
	1993			211	**1,091**
		545	334		
	2005			347	**1,132**
		323	462		
				558	**2,223**
		869	**796**		

CONTIGENCY TABLE 2 X 3
CHI-SQARE TEST
df = (r-1) x (c-1) = 2
Alpha = 0.05
H_0 = There is no relationship
H_a = There is a relationship
X_{CRIT} = 5.991
Since 5.991 is less than the calculated chi-square value of 109.68,
we reject the null hypothesis & state that there is a relationship between the year and the participant's opinion on abortion.

			Observed	Expected	$(O-E)^2/E$
Chi-Square Table	1993	Generally Available	545	426	32.93
	1993	Strict Limitations	334	391	8.22
	1993	Not Permitted	211	274	14.43
	2005	Generally Available	323	443	32.28
	2005	Strict Limitations	462	405	7.92
	2005	Not Permitted	347	284	13.90
					109.68

List of Acronyms, Initialisms and Abbreviations

ACLU	American Civil Liberties Union
AI	Amnesty International
AMA	American Medical Association
ATF	Bureau of Alcohol, Tobacco and Firearms
CAF	Chicago Abortion Fund
CBS	Central Broadcasting System
cc	cubic centimeter
CDC	Center for Disease Control
CEDAW	Convention on the Elimination of Discrimination Against Women
CPCs	Crisis Pregnancy Clinics
D&C	Dilation and Curettage
D&E	Dilation and Evacuation
D&X	Dilation and Extraction
EDC	Estimated Date of Confinement
EMA	Eastern Massachusetts Abortion Fund
ERA	Equal Rights Amendment
FACE	Freedom of Access to Clinic Entrances Act
FDA	Food and Drug Administration
GHB	Gamma Hydroxy Butyrate
HCG	Human Chorionic Gonadotropin
HHS	Health and Human Services

HIPPA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IUD	Intra Uterine Device
IV	Intra Venous
LAM	Lactational Amenorrhea Method
LFL	Lutherans For Life
LMP	Last Menstrual Period
mg	milligram
MMC	Medicaid Managed Care
MSC	Medical Students for Choice
MVA	Manual Vacuum Aspirator
NAF	National Abortion Federation
NARAL	National Abortion Rights Action League, National Abortion and Reproductive Rights Action League or NARAL Pro-choice America
NGOs	Non-Government Organizations
NMSC	New Mexico Supreme Court
NMSHSAR	New Mexico Selected Health Statistics Annual Report
NOW	National Organization of Women
NRT	New Reproductive Technology
PASS	Post Abortion Stress Syndrome
POC	Product of Conception
PPFA	Planned Parenthood Federation of America

PPH	Planned Parenthood
Ob/Gyn	Obstetrics and Gynecology
RCRC	Religious Coalition for Reproductive Choice
RHEDI	Center for Reproductive Health Education In Family Medicine
SCHIP	State Children Health Insurance Program
SOUP	Study of Unintended Pregnancy
TEA	Texas Equal Access Fund
TRAP	Targeted Regulation of Abortion Providers
UCSF	University of California in San Francisco
UDHR	Universal Declaration of Human Rights
UNM	University of New Mexico

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