

12-2019

The Georgia IUD Project: An Ethnography of Birth Control and Biopolitics

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THE GEORGIA IUD PROJECT: AN ETHNOGRAPHY OF BIRTH CONTROL AND
BIOPOLITICS

by

NICOLE ELLIOTT

Under the Direction of Cassandra White, PhD

ABSTRACT

Political events may constrain bodies, bodily autonomy, and agency. They also offer opportunities to embody resistance. Research suggests that the 2016 presidential election may have been a catalyst for people to select a long-acting birth control method that could “outlast a presidency.” The Intrauterine Device (IUD) is a form of highly-effective, reversible, and long-lasting birth control, and after November 2016 IUD insertions increased by 22%. This thesis explores the motivations of people in Georgia who chose to get an IUD after the election of anti-choice politicians in 2016 and 2018, through an ethnographic account of their birth control decision-making process. Study participants posited that the recent increase in IUD-use was due to fear of restricted reproductive rights. However, in describing their own decisions, IUD-users found their choices empowering, and follow biomedically-enforced narratives about responsible reproduction in a time of political and economic uncertainty.

INDEX WORDS: Birth control, Biopolitics, Intrauterine devices, Politics, Ethnography

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BIOPOLITICS

by

NICOLE ELLIOTT

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

Master of Arts

in the College of Arts and Sciences

Georgia State University

2019

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Nicole Elizabeth Elliott
2019

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BIOPOLITICS

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December 2019

DEDICATION

“The words we read and the words we write never say exactly what we mean.
The people we love are never just as we desire them. The two *symbola* never
perfectly match. Eros is in between.”

— Anne Carson, *Eros the Bittersweet*, p. 109

For all the people I love, here is something in between.

ACKNOWLEDGEMENTS

I came to GSU under something of a whim – I was working full time at a dream job, one that I had worked relentlessly towards for years. It wasn't what I thought it would be. I knew I had struggled as an undergraduate student, but I also knew that I would like to get my PhD someday -a dream I've had ever since I mentioned it once to my grandmother when I was young, and saw her eyes light up with pride. I wasn't sure I could make it in graduate school, but I wanted to try. I joined the MA program in the Department of Anthropology. I expected rejection and failure at every turn. I was half-hearted in my early attempts, always ready to call it quits and admit that graduate school wasn't for me.

I am immeasurably grateful to the Department of Anthropology for showing me that I was wrong. From the first moments of my classes with the incredible professors and students in this Department, I felt like I belonged. I want to extend my deepest, sincerest thanks to Dr. Kozaitis, for inspiring me to call myself an anthropologist for the first time. To Dr. Papavasiliou, who challenged me to write a thesis, even when I was sure I couldn't. To Dr. Sharratt, for encouraging me to share my opinions in class, even when I felt like I had nothing valuable to add. To Dr. Turner, for being an incredible role-model, and making me feel like teaching, one of the things I fear most in this world, was something I could do well. To Dr. Black, who helped me overcome my fear of writing imperfectly, and made me feel like I might be an academic after all. Finally, my deepest gratitude goes to Dr. White, who has become a friend as well as a mentor, counselor, and source of unending positivity and support.

There are many other people I need to thank for their support and encouragement, many of whom will have no idea the impact they had on my education. Thank you to Mark Terry, Faraz Vahid-Shahidi, Dr. Lisa Jones-Engel, and Dr. Donna Leonetti, whose classes turned my

world upside down. Thank you to my Canadian friends and colleagues in Health Studies; to the Northwest School and Watermargin, my first homes; and to the countless people who volunteered their time, stories, and commitment to be shared in this thesis. I am humbled at the incredible and terrifying honor I have in representing your stories in this work. Thank you for your honesty, enthusiasm, and support.

This thesis would not have been possible without the generosity of my supervisor and team of incredible colleagues at the CDC. Thank you for allowing me the time and space to make this work happen, and for your graciousness as I attempted to balance two very important, challenging jobs. I especially wish to thank Suzi Gates, Karen Voetsch, Chris Thomas, Anne Stanford, Tawanda Asamaowei, Ashley Verma, Brittany Curtis, and Sarah Kuester for their kind words and endless encouragement.

Finally, I thank my family, and especially Daniel. I should apologize for doing this while you were in law school, but you should know by now that this was all your fault. You've always made me feel like I could do the impossible.

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LIST OF ABBREVIATIONS

ACA – The Patient Protection and Affordable Care Act, often known as “Obamacare”. Federal statute enacted in March 2010 that made sweeping reforms to health insurance in the United States.

Dalkon Shield – An intrauterine device available used in the US from 1971 to 1984. Use of the Dalkon Shield caused 21 deaths; 13,000 women received injuries that caused infertility; and over 200,000 cases of pelvic inflammatory disease, miscarriage, and injury were reported.

IUD – Intrauterine Device, a form of long-acting birth control.

LARC – Long-acting, reversible contraception. IUDs and the Nexplanon implant are the only modern birth control methods that fall into the “LARC” category.

Medicaid – A state and federal program that provides medical coverage to low-income US citizens and lawful permanent residents. Medicaid currently provides 65.7 million people across the US with medical coverage.

OB/GYN – The medical field of Obstetrics and Gynecology, or an Obstetrician/Gynecologist

Roe v. Wade – The 1973 Supreme Court Case that found the 14th Amendment provides a fundamental right to privacy, and therefore protects the right of women to choose an abortion.

STD or STI – Sexually Transmitted Diseases or Sexually Transmitted Infections

Title X – The Title X Family Planning Program, a federal grant program that provides reproductive health and related preventive health services to low-income or uninsured individuals.

1 INTRODUCTION

The Intrauterine Device (IUD) is a form of highly-effective, reversible, and long-lasting birth control. It is typically a small plastic or metal device that is implanted by a medical professional in the uterus. Although it is the most popular reversible birth control method around the world (United Nations, Department of Economic and Social Affairs, Population Division 2015, 24) the US has lagged behind in acceptance of the IUD. In the past 20 years, the popularity of the IUD among birth control users in the US has soared. But getting an IUD in the US today can still be quite the ordeal.

There is a small, privileged group of people who are able to research their many birth control options, who have learned about IUDs, who come away from this education with a positive perception of the IUD, and are able to negotiate the consent of their provider to get one. If you are among them, you may feel a lot of anticipatory anxiety and excitement at the thought of getting one of the most effective, longest lasting birth control methods available today. You might spend hours reading stories online, whether those be from the IUD manufacturing page, a Facebook group dedicated to sharing “IUD Side Affect Support and Advice”, a Reddit thread with thousands of comments, or a magazine or blog article about the experience. In the course of that research, you will encounter many “horror stories” about the IUD experience –about fainting from the pain of insertion, about months of non-stop bleeding, about perforated uteruses and infertility, and about babies born with IUDs buried in their backs.

You will probably learn that the process of requesting and having an IUD inserted will differ greatly by provider –some will require a visit to conduct birth control counselling before insertion, some will put an IUD in within 10 minutes of meeting you. Some providers will require you to be at certain points in your menstrual cycle to insert the IUD. Some will numb the

cervix during insertion –others might prescribe pain medication beforehand. Some providers will deny an IUD to people who are too young, too old, too likely to have children soon, or to those who have never given birth. Some providers will deny people certain types of IUDs because too many will return, months later, asking for it to be removed. Some providers will caution their patients about the IUD, or scare them away from types of IUDs they don't recommend. Some providers will enthusiastically sing the praises of the IUD, and some will present the IUD to their patient as the only option. Some providers will over prepare you for the (minimal) pain of insertion –some will underprepare you, minimizing the potential pain involved.

You will learn that the insertion process will involve you laying on an exam table, nude below the waist, with your feet in stirrups. You will experience a number of confusing, quick, and uncomfortable sensations in your cervix –various measurements being taken. Your provider, when conducting these measurements, may make an offhand comment about your body, providing facts previously unknowable. You have a (tilted/textbook/perfect) uterus, or a (corkscrew/shallow/long) cervix. The insertion procedure could be 10 minutes, or an hour. The pain of insertion could be nothing – a quick pinch, or a short cramp –or it could be one of the most uncomfortable 15 minutes of your life. You might faint and need to be driven home, or lay down in the clinic for hours afterwards. You might get up and walk back to work 10 minutes later. After insertion, you will receive a trans-vaginal ultrasound to ensure that the IUD is in the correct position. Perhaps this will bring up thoughts of abortions, or debates about them, of the recent past. Maybe you are suddenly, bodily aware of the uncomfortable but privileged position you occupy as a person able to access your choice of birth control easily, affordably, and without shame.

The bill you receive after you get your IUD could be thousands of dollars –up to \$1300 without insurance just for the IUD, according to Planned Parenthood (Planned Parenthood 2018a, “How can I get an IUD?”). It could be \$0, or a \$20 co-pay, or the cost of the pregnancy test, STD screening, or appointment your insurance wouldn’t cover. Your doctor may wish to see you again in a month, or you may be done with your gynecologist for years now that your long term birth control is set. You may find yourself returning to your gynecologist, month after month, asking them to remove the IUD for you –only to be told to “hang on another month” for your symptoms – heavy bleeding, cramping, pain –to subside. Rarely, you may need to return to your doctor if the IUD has moved out of place, or even perforated the uterus. Most likely, you will experience few of these negative side effects, and go on to rarely think about the IUD for the years it may be inside you. You may talk to friends, family members, or partners about your IUD –about how the hassle and unpredictability described above was all worth it.

This is the process that some people in the US today go through to get an IUD – the lucky ones, those with health insurance, access to medical professionals, and knowledge of the relatively unpopular IUD. This is not a universal experience –the IUD has a long history in the United States of being forced upon people, especially women of color, or those who are poor, disabled, incarcerated, or on welfare. The types of coercion range along a spectrum, from court-mandated sterilization of women with disabilities, to inappropriately enthusiastic or unyielding recommendations by providers serving poor minority patients.

Recently, the IUD has received a surge of interest both among contraceptive users and in the news. The impetus for this thesis was to investigate the sharp increase in interest about IUDs by contraceptive users following the 2016 election. Of course, this increased interest happened within many contexts –certainly some of which were political. But this was also at a time when

health insurance coverage had lowered the cost of the IUD for many. Reproductive health experts had been recommending for years that long-acting, reversible contraceptives like the IUD be “first-line recommendations” for both adults and adolescents (Committee on Practice Bulletins-Gynecology et al. 2017).

The questions this thesis investigates are many: Who are the people who chose to get an IUD after the 2016 election? What narratives and stories do they tell about their decision? How do they frame their choice within broader political discussions about sexual harassment, reproductive justice, and neoliberal politics? Were their choices made from a place of empowerment, fear, coercion, practicality, or something entirely different? What role did political rhetoric play in this rush to get a relatively unpopular birth control method known for its longevity and effectiveness?

This thesis aims to provide some answers to these questions, through a focus on the stories of urban-living, Georgia residents who selected an IUD after November 2016. In the next sections of the Introduction, I will review the political backdrop of reproductive health and rights during the 2016 election season, as well as today. In Chapters 2 and 3, I briefly review the historic and contemporary political contexts surrounding reproductive choice in the United States, and turn to the rich vein of reproductive anthropology to summarize relevant theories and concepts, and outline a theoretical framework for this research. Chapter 4 reviews the methodology used in this thesis, detailing the ethnographic work I conducted as well as the analytical process used to generate results. In Chapter 5 I present the results of this ethnographic work, providing important quotes from study participants and outlining overarching themes I found within the data. Finally, Chapters 6 and 7 present my conclusions based on this research, and offers suggestions for future research in this field.

1.1 What is the Intrauterine Device?

The IUD is a form of highly-effective, long-lasting birth control. It is considered one of two “Long Acting, Reversible Contraceptive” (LARC) methods recommended by the American College of Obstetrics and Gynecologists (Committee on Practice Bulletins-Gynecology et al. 2017). There are 5 brands of IUDs available in the US. All are small (approximately 1.25 inches long), plastic, T-shaped devices that are either embedded with hormones or wrapped with copper wire to prevent fertilization.

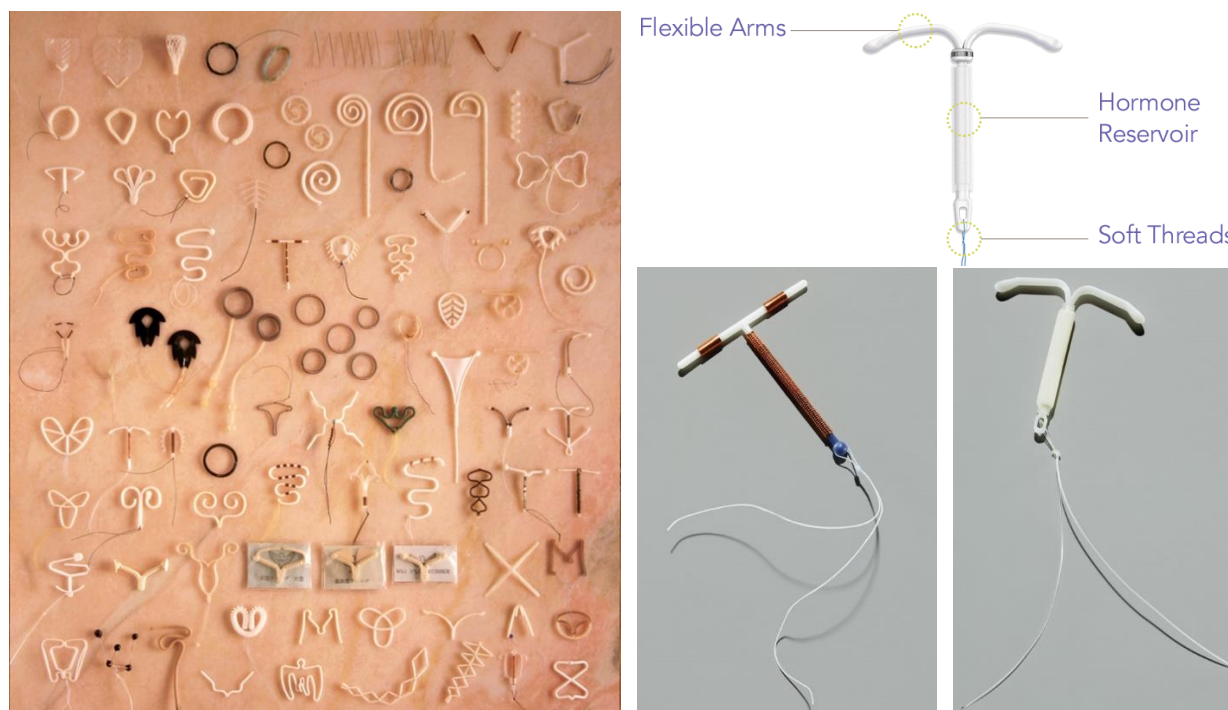


Figure 1.1 Bottom Right: The Mirena IUD, Photo Credit: Jamie Chung

Figure 1.2 Bottom Left: The Paragard IUD, Photo Credit: Jamie Chung

Figure 1.3 Left: The IUD Collection at the Percy Skuy History of Contraception Gallery, Dittrick Medical History Center, Case Western Reserve University

Figure 1.4 Top Right: Anatomy of the Kyleena IUD, © 2019 Bayer.

The IUD requires insertion by a medical provider. It is one of the most effective forms of birth control available today. Depending on the type of IUD, it is 99.2 -99.8% effective at preventing pregnancy (Trussell 2011). The IUD comes highly recommended by many of the

most popular reproductive health organizations in the US. According to Planned Parenthood's website:

IUDs are one of the best birth control methods out there — more than 99% effective. That means fewer than 1 out of 100 women who use an IUD will get pregnant each year. IUDs are so effective because there's no chance of making a mistake. You can't forget to take it (like the pill), or use it incorrectly (like condoms). And you're protected from pregnancy 24/7 for 3 to 12 years, depending on which kind you get. Once your IUD is in place, you can pretty much forget about it until it expires. (Planned Parenthood 2018b)

Planned Parenthood makes sure to highlight and frame the benefits of this method in ways that many women reiterate when they describe why they like the IUD –the relief from the responsibility of taking a daily pill; the excitement to not have to use condoms, often seen as an annoyance; the long-lasting nature of the IUD; and the ability to forget about the birth control method once it is inserted. These are also features which make the IUD quite popular around the globe –about 25% of women using contraception used an IUD in 2011 (Buhling et al. 2014).

1.2 IUD Use Today

Despite its global popularity, just 11.8% of American women who use birth control chose an IUD in 2014 (Kavanaugh and Jerman 2018). This number has risen steadily in the past 17 years –in 2002 just over 2% of women were choosing the IUD as their contraceptive method (Finer, Jerman, and Kavanaugh 2012). In 2014, the IUD became the 4th most frequently used contraceptive in America –beating out vasectomy for the first time (Kavanaugh and Jerman 2018, 16). Kavanaugh and Jerman, researchers at the Guttmacher Institute, note that the increase in the use of the LARC methods like the IUD and Implant are not coupled with a decrease in the number of people not using contraception –meaning that it's not new users turning to LARCs (2018, 17). Instead, it appears that users of other birth control methods are switching to LARCs, especially IUDs. There is also a simultaneous decrease in sterilization (both vasectomy and tubal

ligation) –indicating that some people are choosing to rely on other forms of birth control instead (Kavanaugh and Jerman 2018, 17).

There is a vast emic literature online about IUDs, and how difficult it can be to get one in the US. While many reproductive health efforts today are shifting to prioritize LARC access to prevent unintended pregnancy, a gap clearly remains. Sarah Kliff, a senior policy correspondent at Vox.com, conducted interviews with people who were refused IUDs by their providers:

The first time I asked my OB-GYN about whether an intrauterine device (IUD) was right for me was in 2010. The doctor flatly told me, ‘No.’ ...He immediately dismissed the idea. You've never had children, he explained, so it would hurt too much to get the IUD placed. He handed me a prescription for the Pill, and the visit was over (2016).

She goes on to note that myths about IUDs, long-dismissed by ACOG, are still preventing some women from receiving long-term, effective contraception:

There are numerous myths that still surround IUDs. Many of those that have been soundly rejected by science — that they're only appropriate for women who have already had children, that patients need to have the devices inserted while on their periods, or that they're inappropriate for teens — still circulate widely in doctors' offices (Kliff 2016).

These barriers exist on top of the lack of comprehensive sex education in schools across the US, the persistent stigma associated with IUDs since the disastrous and lethal Dalkon Shield, and the major expense of getting an IUD, even with insurance.

The expense can be significant. Prior to the ACA, an estimated 58% of women would have to pay some out-of-pocket cost for an IUD (Bearak et al. 2016). While most insurances (94%) offered some coverage for the IUD, cost sharing meant that patients were on the hook for “extras” like the insertion visit, ultrasounds, follow-up appointments, or even the IUD itself, which can range in cost from \$300-\$650 (Bearak et al. 2016). A completely out-of-pocket visit

for an IUD could cost as much as \$1300 (Planned Parenthood 2018a). Once the ACA, with its mandate that contraceptive care be covered with no cost-sharing by the patient, went into effect in late 2012, women incurring out-of-pocket expenses for the IUD dropped to just 13% (Bearak et al. 2016). All of these factors make it difficult for women, even those highly motivated by politics, personal factors, or health issues, to get an IUD.

1.3 Birth Control to Outlast a Presidency

Around the beginning of 2017, I became increasingly aware that one of my niche interests was a national, trending news interest. As a self-described birth control nerd, this was very exciting –but the reasons for it were decidedly not. Donald Trump was elected president of the United States on November 8th, 2016, and people were flocking to get long-term birth control because of it. Between November 2016 and January 2017, major media outlets in the US began covering the story that IUDs (intra-uterine devices, a form of highly effective and long-lasting birth control) were ‘trending.’ On November 10th, 2016, US searches for the term “IUD” hit the highest recorded level since Google Trends began tracking in 2004. Since the election, web searches for “IUD” have continued to grow, with noticeable peaks around key political dates like the US House vote in May 2017 to repeal and replace the Affordable Care Act.

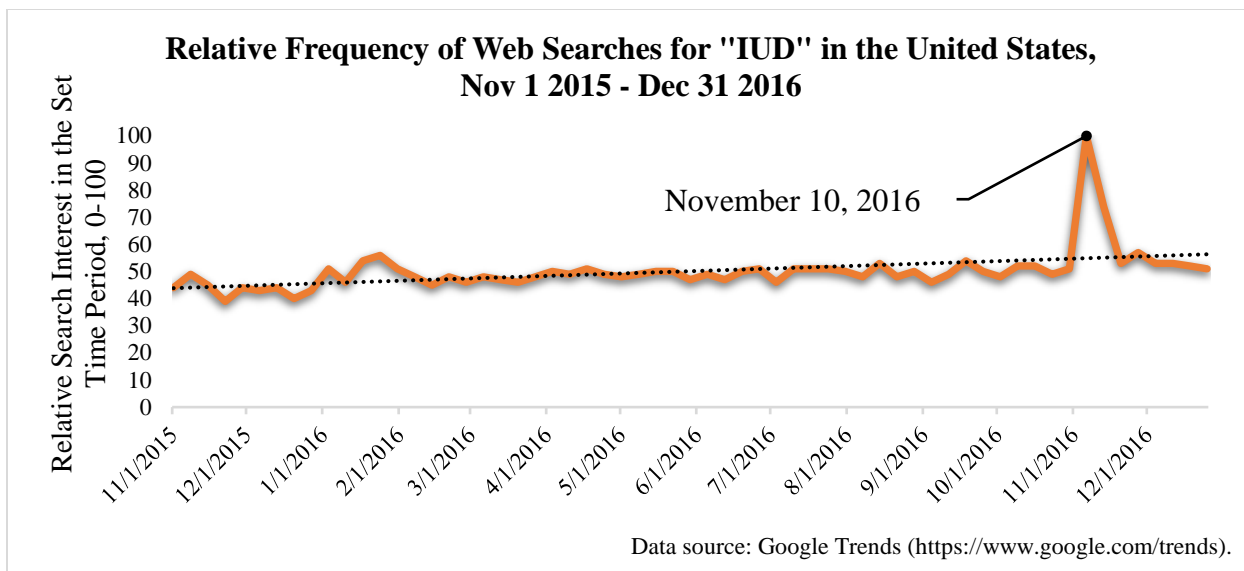


Figure 1.5 Relative Frequency of Web Searches for "IUD" in the United States, Nov 1 2015 - Dec 31 2016

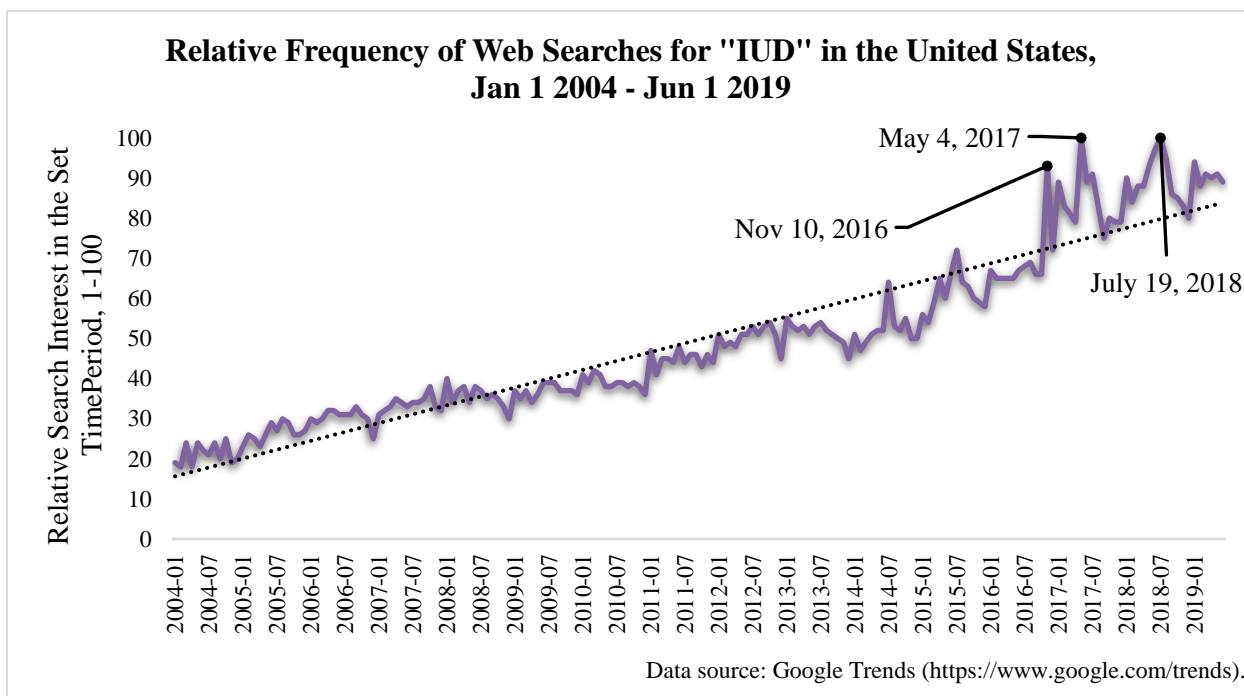


Figure 1.6 Relative Frequency of Web Searches for "IUD" in the United States, Jan 1 2004 - Jun 1 2019

The increased interest was not limited to mere Google searches. Cecile Richards, director of Planned Parenthood, told CNN that the organization had seen a 900% increase in appointments for IUDs since the election (Richards 2017). Data sets from athenahealth, a major national insurance provider, showed a more modest, but significant, uptick in IUD insertions of 19% between October and December 2016 (Rice 2017).

A recent analysis indicated that in the 30 days after the November 2016 election, IUD insertions went up 21.6% compared to the same time period in 2015 –the authors estimated that the election of Donald Trump contributed to an additional 2.1 IUD insertions per 100,000 women per day (Pace et al. 2019). Pace et al note:

If our findings were projected to the approximately 33 million women in the United States aged 18 to 45 years in 2016 with employer-sponsored health insurance, this rate would correspond to approximately 700 additional insertions per day in association with the 2016 election (2019).

An increase of 700 IUD insertions per day in the 30 days following the election (or 21,000 additional IUD insertions) is a truly staggering, especially when you consider how just a few years ago this was a vastly unpopular birth control method.

Headlines from November 2016 explicitly connect the public concern over the repeal of the Patient Protection and Affordable Care Act (shortened to ACA, and also known as Obamacare), the potential threat to Planned Parenthood’s federal funding, and the increased interest in long-acting birth control like the IUD:

Table 1.1 Headlines from Major Media Outlets about Birth Control after the Presidential Election, November 2016

Headline	Source	Date
<i>Get an IUD Before It's Too Late</i>	The Daily Beast	Nov 2, 2016
<i>Why women are making gynecologist appointments post-election</i>	USA Today	Nov 9, 2016
<i>Trump can end Obamacare's free birth control — and he doesn't need Congress's help</i>	Vox	Nov 10, 2016
<i>Searches for IUD Birth Control Spike After Trump Presidential Victory</i>	ABC News	Nov 10, 2016
<i>For Planned Parenthood, Trump Era Starts With Worried Calls and Defiant Donations</i>	Bloomberg	Nov 10, 2016

<i>Threat Of Obamacare Repeal Might Steer Women Toward Contraceptive That's Not Their Top Choice</i>	Forbes	Nov 11, 2016
<i>Will You Lose Your Health Insurance Under President Trump?</i>	Gizmodo	Nov 11, 2016
<i>Women Rush To Get Long-Acting Birth Control After Trump Wins</i>	NPR	Nov 11, 2016
<i>Trump Win Fuels Donations, IUD Demand at Planned Parenthood</i>	Fortune	Nov 12, 2016
<i>Mass. Planned Parenthood Sees 16-Fold Spike In IUD Demand In Days After Election</i>	WBUR	Nov 14, 2016
<i>'Birth control is a political act': the pre-Trump contraception rush starts now</i>	The Guardian	Nov 14, 2016
<i>Doctors Report More Women Asking About IUDs After Election</i>	ABC News	Nov 15, 2016
<i>Women rush to the doctor for birth control, fearing Trump will limit access to contraception. But will he?</i>	LA Times	Nov 15, 2016
<i>The Rush to Get an IUD Is Very Real</i>	Vice	Nov 17, 2016
<i>Contraception Concerns with Uncertain Future of ACA</i>	WMFE	Nov 25, 2016

The rhetoric evident in these headlines shows a serious, political concern over the security of health insurance, birth control access, and affordability under the Trump administration. The concern, even before the unexpected 2016 election results, was justified. In 2007, Mike Pence introduced the first federal measure to deny Title X funding to organizations that provide abortions, like Planned Parenthood. Pence has a long record of being anti-choice, and as Governor of Indiana worked to make it exceedingly difficult to obtain reproductive health services like abortion.

1.3.1 The Affordable Care Act

Trump and Pence campaigned on a promise to repeal the ACA, the legislation passed in 2010 that significantly impacted public health, reproductive health, and overall insurance coverage.

Among many other provisions, the ACA

- 1) required insurance companies to provide preventive health care (including most birth control methods) at no cost to the patient,
- 2) eliminated discrimination and denial of coverage based on “pre-existing conditions”, and
- 3) helped millions of Americans who were uninsured or underinsured find coverage through the expansion of Medicaid coverage, the creation of state-based insurance marketplaces,

and the individual mandate that incentivized everyone to get coverage or face penalty fees.

Numerous studies have shown that the ACA had a significant impact on public health in the US. After implementation, 16.9 million Americans became insured (Carman, Eibner, and Paddock 2015). The ACA improved health insurance coverage for young adults, low-income families, the unemployed, and adults without a college degree (Griffith, Evans, and Bor 2017). The ACA helped reduce some of the racial and ethnic inequities in health insurance coverage (Alcalá et al. 2017; Artiga et al. 2019). More women of reproductive age became insured, and many saw reductions in the cost of their birth control owing to the ACA (Bearak and Jones 2017; Law et al. 2016; Snyder et al. 2018; Bearak et al. 2016). Naturally, threats to repeal the ACA frightened the 50% of Americans who viewed the law favorably, and the 72-75% of Americans who found it important to keep the provision that insurers do not discriminate or deny coverage to people with “pre-existing conditions” (Wu et al. 2018).

1.4 Restricting Access to Abortion

The constellation of policies, attitudes, and political rhetoric that make up today’s Republican platform on birth control and abortion began to form in the late 1970s, largely in response to the supreme court ruling in *Roe v. Wade* (Ginsburg 1998, 46). Called the New Right, Ginsburg describes this movement as “a coalition of right-wing politicians, religious leaders, and “pro-family” groups” that uneasily combined “a libertarian celebration of individualism, economic freedom, and capitalism, and a traditionalist emphasis on community, moral order” and “the proper role of government, family, and sexuality in American society” (1998, 46–48). Prominent figures in the New Right era would include Phyllis Schlafly, a constitutional lawyer,

political activist, and noted anti-feminist; Congressman New Gingrich; and President Ronald Reagan.

Evangelical Christians are among the most important stakeholders in the development of the New Right. In the United States, about 41% of adults identify as evangelical Christians, but that number jumps to 53% among those who identify as Republicans (Newport 2018b).

Evangelicals are more likely to be highly conservative, and have maintained consistently high levels of support for President Trump, especially the “highly religious White Protestants” (Newport 2018a). Still, President Trump is an atypical conservative, one with socially liberal credentials who has previously voiced support for Democrats, abortion access, and same-sex marriage equality. He risks alienating these Evangelical supporters if he waives his current, conservative stance on key issues of importance to them, like rolling back abortion rights (Andaya 2019:12; Fieler 2017).

Following the 2010 midterm elections that brought a mass number of conservative legislators to office, abortion restricting legislature has surged (Guttmacher Institute 2016). Between 2011-2016, the US passed more than one fourth of all abortion restricting legislation enacted since the 1973 Roe v. Wade ruling (Guttmacher Institute 2016). In May 2019, Georgia passed one of the most restrictive abortion bans in the US. House Bill 481 was signed into law by Governor Kemp, and will prohibit abortions from occurring after a fetal ‘heartbeat’ (more accurately a flutter or electrical pulse of the cells that will eventually become the heart) is detected. This can occur as early as 6 weeks into pregnancy, but pregnancy development is calculated from the first day of the pregnant person’s last period (Mervosh 2019; Gordon and Hurt 2019).

Functionally these bills prohibit abortion at 4 weeks post-conception –a time when most people don't yet know they're pregnant. Furthermore, few medical providers provide very early abortion – ultrasound can only reliably pick up pregnancies starting at 4.5 weeks (Heaton 2016), so many providers prefer to wait until 5-6 weeks into pregnancy, when an ultrasound can reliably confirm that a person is pregnant (Planned Parenthood n.d.).

A sweep of abortion restricting legislation has occurred since spring 2019. 6 states, including Georgia, have passed these so-called heartbeat bills (Gordon and Hurt 2019). 2 states have restricted access to abortion after 18-22 weeks (Gordon and Hurt 2019). Alabama has banned abortion outright, unless the health of the mother is at risk (Gordon and Hurt 2019). Often this is done explicitly with a Supreme Court challenge in mind: with two new conservative Supreme Court Justices appointed by Trump, *Roe v. Wade* is seen as vulnerable.

Georgia's HB 481 goes beyond banning abortion access after 6 weeks. It contains language that describes a "natural person" as "any human being including an unborn child", mandates that unborn children be counted as part of the state's population, and will establish a fetus as a dependent in the tax code (Prabhu 2019). The bill defines appropriate defenses in case a person is criminally charged for seeking an abortion or attempting to self-abort –this has some lawyers concerned that pregnant people will be held criminally liable for seeking abortion, miscarrying, and even seeking abortion services in another state (Stern 2019).

1.5 Disparities in Access to Reproductive Health Care

Another concern clearly seen in the headlines and political rhetoric following the election was the status of Planned Parenthood. Planned Parenthood describes itself as "the country's leading provider of sexual and reproductive health care" and provided over 9 million patients

with reproductive health services in Fiscal Year 2018 (Planned Parenthood 2019). Planned Parenthood receives federal funding from Medicaid reimbursements and Title X –a program that provides birth control and reproductive health care to low-income women. Republicans, including the Trump-Pence administration, would like to exclude Planned Parenthood from all federal funding sources, based on their ideological opposition to abortion –a service Planned Parenthood has a notorious reputation for providing. Just this month, Planned Parenthood announced that it would no longer use Title X funds to pay for family planning services. This followed several months of failed legal challenges to the February 2019 rule that “prohibits the use of Title X funds to perform, promote, refer for, or support abortion as a method of family planning” (Department of Health and Human Services 2019).

In Georgia, health insurance coverage, access to reproductive health services, and pregnancy outcomes are bleak. According to Dr. Adrienne Zertuch of the Georgia Obstetrical and Gynecological Society, half (79) of Georgia counties have no obstetrician/gynecologist, 58 of these have no hospital with obstetric services, and 9 counties have no doctor at all (2015). This means that appropriate medical care is out of reach for many rural Georgia residents, or only available to those who can afford the cost of travelling to the nearest urban center. Georgia has highest the maternal mortality rate in the country, at 46.2 deaths per 100,000 live births (America’s Health Rankings analysis of CDC WONDER Online Database 2018). The national average in 2018 was 20.7 (America’s Health Rankings analysis of CDC WONDER Online Database 2018)

Stark disparities in maternal mortality have persisted for many decades: black women consistently have maternal mortality rates 3-4 times higher than their white peers, and Native American women have a maternal mortality rate that is almost double that of white women

(Centers for Disease Control and Prevention 2019). Higher maternal mortality rates especially impact women who are uninsured –they are 3-4 times more likely than insured women to die during or up to 1 year after pregnancy. (America’s Health Rankings analysis of CDC WONDER Online Database 2018). 13.2% of Georgians are uninsured as of 2018 (America’s Health Rankings analysis of U.S. Census Bureau, American Community Survey 2019), and Georgia was among the 23 states that did not accept Federal funds to expand Medicaid eligibility under the Affordable Care Act. According one analysis, Medicaid expansion could have covered an additional 726,000 Georgians, 240,000 of whom are uninsured and have no realistic way to acquire health insurance (Norris 2018). Given these bleak statistics, did Georgians with access to affordable birth control rushed to get effective and long-lasting methods like the IUD? If so, why, if they are not those most affected by these structural inequalities?

1.6 Politics, elections, and birth control

In a study of political party and birth control decisions since the 2016 election, Judge and Borrero found that 42% of survey participants had concerns about future contraceptive access after the 2016 presidential election (2017). 91% of concerned participants cited a fear that “*birth control will cost more or cost too much*”, 69% feared “*Planned Parenthood or other family planning clinics will close*” and 68% worried that “*abortion will be less accessible or not an option*” (Judge and Borrero 2017). Nearly 10% of study participants had switched to a new birth control method since the 2016 presidential election, over half of whom selected a LARC method.

Study participants could select all of the applicable reasons why they had switched to LARC method, and the most frequently selected options were: “*I wanted a method that would last longer*” at 86% and “*I worry I won’t be able to get this method in the future*” at 68%. 65% of those who switched to LARC methods following the election said that the election had

“influenced the decision a great deal” and an additional 25% noted that the election somewhat influenced their birth control choice (Judge and Borrero 2017).

This research will add to this important work in exploring how birth control methods can reveal political concerns, and illuminate how birth control users may adhere to or resist cultural scripts about reproductive norms. Through an ethnographic account of the birth control decision-making process of 35 IUD-users, this research examines the narratives about responsible reproduction, and how these narratives get incorporated into the stories IUD-users tell about their birth control decisions in the wake of political threats to reproductive freedom.

Using theoretical frameworks from biopolitics, biomedicalization, critical medical anthropology, to reproductive responsabilization, I describe how IUD-users, facing uncertain healthcare access, enshrine reproductive autonomy into their very bodies. Describing their choice of birth control method as one that is empowering, protective, or both, IUD users deny that their choice of birth control method is ‘political’ and instead assert that they have made a ‘personal’ choice that supersedes the influence of political events. In describing their method of selecting the IUD, participants adhered to biopolitical and biomedicalized scripts, re-enforcing the idea that the best birth control method was the one that was doctor recommended, most effective at preventing pregnancy, and the most cost-effective given the uncertainty of health insurance coverage for birth control in the future. Despite this, study participants consistently noted that the general increase in IUD-use in the United States following the 2016 election was due to fear of political repercussions, such as loss of healthcare coverage or access to affordable birth control. This research contributes to the body of work on how political events impact bodies, bodily autonomy, and agency, and uses novel methods, such as online/Facebook-moderated focus group

sessions, to produce this ethnographic account of birth control choices and politics in the US today.

2 BACKGROUND

2.1 Why study birth control?

Birth control methods can make clear what otherwise might be hidden in plain sight. Russell, Sobo, and Thompson note that contraceptives can serve “as symbols and metaphors of other culturally salient issues” (2000, 19). Birth control methods sit at the center of cultural and individual feelings about sex, marriage, reproduction, women’s health and autonomy, and scientific advancement – because of this birth control “is part of who people are, their identities, and relationships” (Russell, Sobo, and Thompson 2000, 20).

Reproductive activities can be a fruitful space to analyze power dynamics (Martin 2001). Human beings do not reproduce in a purely biological fashion—they reproduce into cultural, economic, and political conditions that may support or deter their reproduction (Browner 2000; Martin 2001). According to Petchesky, “fertility control is not, then, simply a private strategy of individuals...it occurs within definite social contexts and sexual power relations” (1990, 25). Women’s reproductive choices are culturally mediated and gender ideologies, cultural norms and values, and expectations of how women ought to behave are strong influencers/mediators of the reproductive choices available to them (Browner 2000).

The practice of regulating fertility is not a neutral one in the modern American culture. Political rhetoric about women’s reproduction, and therefore about abortion and birth control, is shaped by cultural scripts and ideologies that infuse our understandings of biology, culture,

gender roles, and normative behavior. Ortner argues that across multiple cultures, men are generally associated with culture, and women are generally associated with nature (Ortner 1972). This nature/culture dichotomy (Ortner 1972) informs our understandings of human reproduction, and especially fertility-control methods like abortion (Martin 1991, 2001; Ginsburg 1987; Ginsburg 1998).

Many Americans today see our access to reproductive technologies as dangerous – this can be seen in recent cultural clashes over emergency contraception (Wynn and Trussell 2006), abortion (Ginsburg 1998), and assisted reproductive technologies (Inhorn 2006). Some believe America needs to ‘return’ to a more virtuous past where these options were not available freely. The Catholic Church is well-known to support limited contraceptive practices in the form of “natural family planning” (also known as fertility awareness or the rhythm method), but restricts and condemns as “unnatural” contraceptive methods like condoms, oral contraceptives, and even coitus interruptus (colloquially known as the ‘pull-out’ method) (Kalbian 2014). This perspective, espoused in the *Humane Vitae*, has enormous rhetorical and political consequences across the globe – many people in the United States, even those who are not Catholic or Evangelical, consider birth control methods to be unnatural and against the will of God.

Researchers conducted an ethnographic study of African-American and White southeastern women who used contraceptives, and found that many expressed a desire for “natural” reproduction:

‘Natural’ is a catch-all concept with mixed meanings in contemporary US culture, but for participants this concept was evoked in reference to reproductive and other biological systems that ideally should operate without interference from contraceptive methods (Woodsong, Shedlin, and Koo 2004, 70).

For many in the US, reproduction should be ‘natural’ –that is, free from the influence of biomedicine and modernity. Natural generally excludes the use of contraception, because it may alter the menstrual cycle (conceived as a natural way to cleanse the body, and something that is God’s plan for women), and because it prevents pregnancy –going against nature and God’s plan for women to be mothers (Woodsong, Shedlin, and Koo 2004, 68). This helps illuminate many of the other assumptions and expectations Americans have about reproduction –that it lies solely in realm of the feminine and domestic, that it be free from technological interference, that it should remain unaltered by changing cultural norms or values (Martin 2001; Ortner 1972).

Public health campaigns, legal frameworks about individual rights, and biomedicine all have large stakes in this discussion, and offer their support for individually regulated fertility that includes technological and cultural intervention. This too has enormous impacts in the framing of conversations and practices surrounding reproduction. In modern abortion debates we see a rejection of the involvement of politics in reproductive decisions, but a simultaneous refrain that abortion decisions should be between a woman and her doctor. In my own experience working in adolescent health clinics, I’ve seen Nurse Practitioners refuse to prescribe birth control or emergency contraception without first conducting a 30 minute counselling session with the patient. The most popular form of contraception in the US has, for decades, been the birth control pill –a method that requires users to renew their prescription monthly in concert with their pharmacist and primary care provider. It is important to counter assumptions that biomedicine is a neutral, apolitical institution –medical providers make subjective decisions every day. In a recent study of providers, the politics of the county they work in, and their willingness to prescribe emergency contraception, researchers found that the more counties

leaned Republican, the less willing providers were to prescribe emergency contraception (Cleland et al. 2018)

In public health, we see a significant emphasis in the United States on preventing teen pregnancy. This has brought important funding and needed attention to the current state of sexual health education in schools, and has helped many more adolescents across the country get access to affordable, confidential, and developmentally appropriate reproductive care. Still, this work creates enormous shame and stigma for teens who become pregnant. Scripting teen pregnancy as a public health problem marks these teens as abnormal, emblematic of a societal ill, or a failure. This failure could be seen as coming from public health, the education system, the healthcare system, or from the parents or moral failings of the pregnant teen themselves. This narrative, in assigning a “wrong age” at which to become pregnant, also creates the opposite: a mythical ideal age at which one is supposed to reproduce.

The granting of legal rights to a specific act, especially a biomedically-controlled one like abortion, also commands that this right is exercised responsibly. Fordyce notes that the American concept of women’s freedom (granted through access to birth control, and the legal individual right to access it) has always been coupled with notions of moral and societal responsibility. (Fordyce 2012, 118) Singer applies the sociological term “responsibilization” to reproductive governance and abortion in Mexico. Her analysis shows that along with Mexico’s legalization of abortion, medical and public health providers have expectations about the motivations and actions of a person seeking an abortion:

many staff members saw abortion as a juncture from which to begin a project of moral change and improvement. Noted Sara, “I’ve never been one to criticize people who undergo abortions . . . but one has to learn her lesson.” For staff, “learning one’s lesson” meant subsequent and responsible use of birth control to prevent a repeat abortion. As I discuss in the next section, for staff,

subsequent responsibility was a quid pro quo for the right to abortion (Singer 2017).

Responsibility in reproduction is prescribed - one must act in a specific, biomedically approved way. As Fordyce notes, “Liberal citizens have been granted the freedom to make choices because they can be trusted to make the right choices” (Fordyce 2012, 118). This leaves us with the implication that legal rights concerning reproductive activities must be earned through good behavior.

As the state takes decisions about women’s health and access to services out of the hands of physicians, providers, and the women themselves, it is also important to explore how women themselves perceive their role in “planning” their reproductive lives, and the sorts of issues that govern these “choices.”
(Fordyce 2012, 119)

As conservative political movements endeavor to limit access to health care services related to reproductive health, it is important to, as Fordyce recommends, consider the elements of choice and planning in IUD-users’ stories.

2.2 A Brief History of Modern Birth Control in the US

Birth control has a fraught history in the United States. The patron-saint of the modern American birth control movement, Margaret Sanger, founder of Planned Parenthood, was herself a eugenicist who championed birth control and opposed abortion (Petchesky 1990, 89–94).

Petchesky notes:

In its quest for legitimacy, the birth control movement, under Sanger’s leadership, turned increasingly to the medical profession and the elite professionals who espoused eugenics...Sanger’s strategy, which became that of Planned Parenthood, was to give birth control an aura of scientific and medical respectability by assimilating it within the framework of social engineering (“planning”) and public policy...Historically this meant a shift away from a focus on individual women’s right to and need for sexual and reproductive autonomy and toward a focus on “medical necessity” in a

narrow sense, populationism, and the fiscal problems of the state. (Petchesky 1990, 92)

The birth control pill was originally tested on nurses and patients of the inventors, but human trials quickly moved on to psychiatric patients in Boston and women in low-income housing projects in Puerto Rico and Haiti (Wittenstein 2016, 71). This research was conducted on poor women of color, in a time before informed consent in research, and in “dosages and combinations now known to be extremely hazardous” (Petchesky 1990, 171). Quickly after the pill was brought to the United States, reports of the ill effects of the high amount of estrogen surfaced, but the complaints of women were often ignored until the Nelson Pill Hearings of 1970, largely organized by women’s health advocates and feminists (Wittenstein 2016; Petchesky 1990; Bailey 1997)

The IUD was not initially designed with American women in mind – it was produced shortly after the birth control pill in the 1960s, and designed to be a method that was provider-controlled, cost-effective, and didn’t need a daily action by the user to ensure its efficacy (Takeshita 2012, 33–34). The IUD was initially developed out of concern for “uncontrolled” population growth in lower-income countries (Takeshita 2012). It was seen by IUD manufacturers and reproductive scientists as an ideal method for use in lower-income countries, where birth control needed to be prioritized “for the masses” as opposed to the individual:

IUD enthusiasts during the 1960s shared the vision that population management was a matter of figuring out how best to manipulate the biological function of reproduction. It fell on some initial researchers to build what amounted to a machine part that efficiently controls the uterus....women in the IUD discourse were stripped of agency as they were represented as “the population”...As scientists and physicians, IUD advocates knew that the device was not yet perfect. They nonetheless pursued the idea that the global population problem had a technological solution. They reasoned that since men and women of the global South were incapable of regulating their own fertility,

a technology that takes control over their bodies for them would best address the ostensible need to regulate population growth in the global South. (Takeshita 2012, 34)

Problematic fertility, defined by birth control developers in the United States, had a technological and biomedical solution. By transferring control of the birth control method from patient to doctor, Americans could enforce their vision of appropriate “reproductive futures” (Ginsburg and Rapp 1995, 3) on the unwilling, irresponsible, incapable masses (Takeshita 2012, 41).

This history has had a lasting impact on the IUD’s role in global family planning movements today. The IUD is second most popular family planning method worldwide, and was used in China as an essential way to enforce the one-child policy ((Shi 2017; Takeshita 2012)) The IUD has been used in many lower-income countries as a way to “modernize” the population through scientifically mediated fertility decline (Takeshita 2012; Marchesi 2012; Mishtal 2012).

In the US, the IUD and most modern birth control methods in the United States have been used to control the reproductivity of women –predominantly women of color, women with disabilities, incarcerated women, and women of low-income. Even today, certain women are seen as too “irresponsible” to be trusted with methods that they can start/stop at will, such as condoms or the hormonal pill, patch, or ring (Takeshita 2004; 2012). Instead, these women (primarily incarcerated women, women of color, teenage mothers, women who have chosen to abort, women who have had ‘too many’ children, and the poor) have the IUD imposed upon them.

IUDs may be imposed upon American women either through reproductive coercion, most commonly found in legal settings like prison, or through “implicit pressure” in contraceptive counselling and provider/patient interactions (Gomez and Wapman 2017). Gomez and Wapman

found that a majority of young Black and Latina women in the United States have felt pressured by their healthcare providers to use contraceptives, and are sensitive to the implicit biases providers may have in which method would be “best” for young, poor, African-American and Latina women (Gomez and Wapman 2017; Gomez, Mann, and Torres 2018). As Powderly notes, this can often be the result of supposedly apolitical public health efforts to increase access to effective birth control methods:

Advocates for birth control generally intended it to be an option for all women, regardless of race or class. The reality, however, was often that poor, otherwise unempowered women, often from minority groups, were most in need of such advocacy. Upper-class women had access to information and methods of birth control through their private physicians. They could pay for whatever was available. They voluntarily reduced the numbers of children they had. The well-intentioned efforts on the part of advocates for birth control to improve access for poor minority women often had the effect of targeting these women for efforts to reduce the numbers of children they had... com[ing] dangerously close, on a population level, to achieving the desires of eugenicists to reduce the numbers of poor minority people in the population.” (Powderly 1996, 23)

It is essential to keep these histories of reproductive coercion in mind when studying birth control advocacy today.

While family planning projects have come under scholarly critique for reproducing inequities, much of this literature celebrates reproductive rights such as abortion, as a fundamental component of women’s citizenship in liberal societies. This perspective misses the ways in which reproductive rights can be embedded in processes of governance designed to fashion subjects who align with state goals. (Singer 2017, 250)

These concepts are critical to understand how IUD-users have incorporated hegemonic ideologies into their decision making process – and to remember that narratives about reproductive rights and empowerment can be found in concert with biopolitical scripts that serve to define which reproductive activities are valued.

3 THEORETICAL FRAMEWORK

How can we begin to link the ways politics have influenced birth control choices throughout history to this thesis research? What commonalities exist between the examples shared above, and my own ethnographic exploration of the people who got IUDs in droves after the 2016 election? An important way to do this is through the use of a theoretical framework that helps us read these events in light of anthropological and social science theories. This chapter will present the theoretical framework I used in this research, drawing on key theories and concepts from anthropology, sociology, and other social science fields.

Political events may constrain bodies, bodily autonomy, and agency. They also offer opportunities to embody resistance (Foucault 1995). Bodies and bodily processes are also culturally mediated—societies depend upon regulation of both “the social body” and the “individual body” to “control their populations and institutionalize means for producing docile bodies and pliant minds in the service of some definition of collective stability, health, and social well being” (Scheper-Hughes and Lock 1987, 8; Foucault 1995; Martin 2001; Rapp 1990). This regulation can come in the form of direct, top-down power, or through more culturally mediated, norm-generating, regulatory power that is upheld both by institutions and individuals—this is Foucault’s biopower (Foucault 1995).

The body social is a lens through which we can understand illness and health are mediated through society and read onto the body. The body social theorizes the body as symbolic of societal ills. “the body in health offers a model of organic wholeness, the body in sickness offers a model of social disharmony, and disintegration.

To best understand how political events impact bodies, bodily autonomy, and agency, as well as how resistance to this can be enacted through the body and individual choices in birth

control, I will use Foucault’s theory of biopolitics as a frame. The biopolitical framework will allow me to explore and situate the ways people may choose to “resist and comply” (Mamo and Fosket 2009, 941) with cultural and institutional scripts that discipline bodies. I will look explicitly at theories of biopolitics in reproduction, paying attention to “reproductive governance” (Morgan and Roberts 2012; Morgan 2019); the biomedicalization of reproduction; and the political, economic, structural, and cultural factors that constrain reproductive choice today. Because reproduction falls at the intersections of these macro and microlevel forces, critical medical anthropology will also be an important paradigm in my research.

3.1 Biopolitics and Biopower

Biopolitics and biopower are useful frames to understand how politics affect the body. Foucault’s (1995) theory of biopolitics indicates that power is relational—everyone has power relative to the people and structures they interact with, but institutions are the main way that power dynamics in our modern society form. Disciplinary structures in institutions like schools, workplaces, prisons, and even in media and policy, instill in the individual a sense of self-regulation. This is primarily through the creation of a sense of inescapable visibility—the panopticon is a central, disciplinary device that divides and subjugates the disciplined. This creates self-discipline: the subjugated people are correcting their behavior in line with the principles of the institution. Crucially, this also indicates that every individual has the power for self-reflection, and the capacity to resist acting in ways that reproduce their own subjugation (Foucault 1995).

Biopower operates at the broad population level. It is a “set of mechanisms through which the basic biological features of the human species became the object of a political strategy” (Schirato, Danaher, and Webb 2012, 90). Biopolitics and biopower inform how

institutions and cultures create narratives and set expectations for women about appropriate behavior in reproduction. Scheper-Hughes and Lock describe the concept of the body politic as a lens similar to biopower—the body politic defines and creates politically correct bodies that serve the needs of the state (Scheper-Hughes and Lock 1987, 26–27).

Krause and De Zordo describe biopolitics as operating on a sliding axis between two poles—one being individually focused on control of the body and the other being population focused on control of society (2012, 139). They emphasize that power is not one directional—individuals can and do exercise power, or re-produce it when they internalize the norms and expected behaviors that State institutions use to regulate society (Krause and De Zordo 2012, 139–40). In post-industrial societies like the United States, the political governance of reproduction is an important aspect of controlling society—this is an expression of Foucault’s biopower. Morgan and Roberts, in defining reproductive governance, describe institutions as “different historical configurations of actors—such as state institutions, churches” or “international financial institutions, NGOs, and social movements” (Morgan 2019, 113) and note that these all utilize mechanisms to influence reproduction (2012, 243).

3.2 Politics of Reproduction

While political and socio-structural factors present significant and pressing barriers to reproductive health and justice, Browner notes that women’s reproductive choices are culturally mediated and that gender ideologies, cultural norms and values, and expectations of how women ought to behave are strong influencers/mediators of the reproductive choices available to women (2000). Morgan and Roberts (2012) conceptualized “reproductive governance” as a method of analyzing how states and institutions regulate and/or exert control over reproduction. As “shifts in reproductive governance are facilitated by the now international political legitimacy ascribed

to the concept of universal human rights,” Morgan and Roberts (2012) leave room for anthropology to explore the ways globalization has moved beyond strict definitions of state-enacted governance, to use international politics and discourses to reproduce ideologies of gender and responsible “reproductive citizenship” (Singer 2017).

Colen created the term “stratified reproduction”—meaning the different ways “reproductive labor” is “experienced, valued and rewarded” (Colen 1995, 78). Reproductive labor is defined in this context as the “physical, mental, and emotional [labor] of bearing, raising, and socializing children and of creating and maintain households and people” (Colen 1995, 78). This understanding of reproductive labor emerged with feminist scholarship on Marxism in the 1970s, explicitly defining the dimensions of reproductive labor beyond the reproduction of the labor force. Stratified reproduction results from and perpetuates inequalities that are determined by cultural, political, and economic markers of status like race, ethnicity, class, and citizenship (Colen 1995, 78). Ginsburg and Rapp broadened this definition to include “the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (1995, 3). Andaya and Mishtal observe that “politicians and others bemoan the low birthrate among desired reproducers while critiquing the ‘overfertility’ of national, religious, and ethnic Others” in recent American efforts to restrict access to legal abortion (Andaya and Mishtal 2016, 43).

Smith-Oka (2015) in her ethnography of physician-patient relations in a Mexican hospital, brings up powerful indications of class in who gets to be a reproductive citizen. She also alludes to important notions of authority and knowledge in reproductive activities. Who is an authority when it comes to reproductive choice? Whose knowledge is prioritized in reproductive decision making? How do we assign value and importance to authoritative

knowledge, and which kinds of knowledge triumph in circumstances when they conflict or contradict each other?

3.3 Biomedicalization

Biomedicine is certainly seen as an authoritative voice in reproductive concerns in the US today. Adele Clarke and co-authors argue that biomedicine relies on an “extension of medical jurisdiction of health itself (in addition to illness, disease, and injury)” (Clarke et al. 2009, 48)

Biomedicalization can take many forms. The medicalization of reproduction and the ‘female’ body (Petchesky 1990); the separation of self from body (especially during reproductive events) that cisgender women experience (Martin 2001); the role of agency and authoritative knowledge in reproductive decision-making (O’Dougherty 2013); and the way racism, classism, and other systemic prejudices compound to make reproductive justice even more inaccessible for women of color (Oakley et al. 2018; Takeshita 2012; many others). Martin (2001) and many other feminist scholars would argue that this is not coincidental, but an intentional effort to police reproduction and control women’s bodies (Petchesky 1990). Many scientific institutions, and critically biology and biomedicine, are “socially mediated by male-dominant institutions” which has a profound impact on women’s bodies (Petchesky 1990). Martin states that biomedicine is a powerful a source of authoritative knowledge that limits and shapes women’s choice and degree of control in reproductive situations, particularly during birth (2001).

Mamo and Fosket note that “as a discourse, biomedicalization travels culturally and increasingly shapes people's conceptions of health and illness, social identities, and ways of being in the body” (2009, 927). Biomedicalization works in tandem with the gender ideologies and power dynamics elucidated above to assert an authoritative control over women and the reproductive body. As Martin notes: “When science treats the person as a machine and assumes

the body can be fixed by mechanical manipulations, it ignores, and it encourages us to ignore, other aspects of our selves, such as our emotions or our relations with other people” (2001, 19–20). This can be seen in part in the medicalization of birth and reproduction—as Sargent and Gulbas contend in their review, this “shift in birth practices. . . has been accompanied by a concomitant loss of women’s control over the birth experience” (2011, 292). Biomedicalization has a resounding impact on women’s choice and autonomy in all aspects of reproduction, including the selection of nonreproductive technologies like the IUD (Denbow 2015).

Scheper-Hughes and Lock describe the biomedical gaze as controlling (1987, 26), and this disciplinary gaze filters into provider-patient discussions of birth control, even when the providers are ‘well-intentioned’ or unaware of it:

There is an important historical context within which to view the current ethical and policy issues with long-acting contraceptives. Well-intentioned efforts to empower all women, including poor women of color, must be balanced with a keen sense of the abuses evident in the history of the birth control movement. (Powderly 1996, 31–32)

When providers make unilateral decisions for their patients, they are denying their patients reproductive autonomy. This is a well-documented issue in family planning, as Dehlendorf et al note : “by framing effectiveness at preventing an unintended pregnancy as the deciding factor for whether a method choice is a positive outcome, contraceptive interventions neglect the multitude of intersecting factors affecting women’s reproductive decisions” (Dehlendorf et al. 2018).

Higgins, in her discussion of LARCs and reproductive justice, says “the field has witnessed a distinct shift from options-based counseling, in which a wide array of contraceptive methods are presented to potential contraceptives users, to directive and/or first-line counseling, in which one or two LARC methods are recommended over all others” (2014). This focus is generally on

which methods are the most effective at preventing unintended pregnancy, and can limit patients' ability to choose methods that work best for them and their partners (Higgins 2014). Clearly, this can have a significant impact on reproductive autonomy and women's overall health and well-being.

3.4 Biosociality and Identity

Through biomedicalization, identities and communities may be built around the knowledge that technological advances in biomedicine produce (Clarke et al. 2009, 48). Biosociality is the formation of new types of "individual and collective identities" (Clarke et al. 2009, 78) that are centered on medical traits, illnesses, and conditions –particularly ones identified through genetic testing, or rare conditions that are intimately linked to biomedicine both in their diagnosis and in their search for treatments and cures (Rabinow 1996; Brekke and Sirnes 2011, 348; Clarke et al. 2009, 78). Termed "biocollectives" by Brekke and Sirnes (2011, 349), these groups find empowerment in active participation in biomedicine, in advocating for research into their conditions, in negotiating the ethics of new research frontiers (Brekke and Sirnes 2011).

Does a community of IUD users exist? If it does –why? Biosociality may be one way to understand how individuals form new identities through the use of technologically, biomedically developed birth control methods like the IUD. Modern birth control users are linked by genetic traits, albeit ones that are not rare –their ability to become pregnant. Pregnancy itself is now a biomedical condition – one which can lead to an array of poor health outcomes, all of which are biomedically mediated (Martin 2001). Birth control users have readily adopted modern technological advances in biomedicine since the creation of the birth control pill, while also demanding active participation and engagement in the research for safer, more effective birth

control methods. If IUD users do feel that there is a community, or shared identity around their use of the IUD/birth control, biosociality could be one way to interpret this.

3.5 Critical Medical Anthropology

Critical medical anthropology connects “the biological and the social, the personal and the political, and the local and the global” (Almeling 2015, 425) and has been used in numerous anthropological works on reproduction (F. D. Ginsburg and Rapp 1995; Colen 1995; Scheper-Hughes and Lock 1987; Inhorn 2006; Dudgeon and Inhorn 2004; Martin 2001; Yates-Doerr 2011; Shi 2017; O’Dougherty 2013; Lazarus 1994; Fordyce 2012; Alianmoghaddam, Phibbs, and Benn 2017). Critical medical anthropology (Baer, Singer, and Johnsen 1986) is a mediating discipline—it explores the relationship between the social body and individual body (Scheper-Hughes and Lock 1987). Critical medical anthropology is both theoretical and practical—it investigates the political, economic, and socio-demographic categories that shape power dynamics, while remaining committed to challenging these hegemonies when they lead to illness and dysfunction (M. Singer and Castro 2004, xiv). Critical medical anthropology’s “work should be at the margins, questioning premises, subjecting epistemologies that represent powerful, political interests to oppositional thinking” (Scheper-Hughes 1990, 73). Furthermore, critical medical anthropology must recognize the discipline’s complicit role in creating these dangerous power dynamics—from anthropology’s historic participation in colonial projects, to medical anthropology’s continued participation in biomedical reductionism (M. Singer and Castro 2004, xiv; Scheper-Hughes 1990; Scheper-Hughes and Lock 1987).

Medical anthropologists have produced abundant descriptions and accounts of the unique ways in which reproductive governance is enacted through public health campaigns centered on “responsibility” and reproductive health (Fordyce 2012; E. O. Singer 2017; Yates-Doerr 2011;

Zalk 1986; Smith-Oka 2015; De Zordo 2012; Morgan and Roberts 2012). In the United States today, liberal discourses advocating for expanded reproductive access use the language of choice, rights, and responsibility (Singer 2017; Lazarus 1994; Wynn and Trussell 2006; Fordyce 2012; Morgan 2015). This framing links rights with responsibility, and centers both at the individual level.

Singer demonstrates this phenomenon, by exploring how the presumably rights-affirming legalization of abortion in Mexico is, in reality, just the latest iteration of government-determined reproduction (2017). The public health scripts that claim to offer autonomy and individual bodily control of reproduction also define the nationally acceptable reproductive citizen and encourage Foucauldian self-discipline of reproductive activities (Singer 2017).

3.6 Bodies under threat

Biomedical researchers and contraceptive developers “construct ideal IUD users” (Takeshita 2004); obstetricians, medical schools, health insurers, and hospital administrations define “normal birth”; government agencies and scientific experts, political activists create “responsible contraceptive users” (Wynn and Trussell 2006); public health marks teenage sexuality as problematic risk-taking – but how do women incorporate these oppressive biopolitical narratives into their stories (Martin 2001)?

Scheper-Hughes and Lock note that threats to the stability of the current social order may lead to cultural or symbolic expressions of protection and self-regulation (Scheper-Hughes and Lock 1987). Xenophobia and purging of social deviants is common, as are individual concern about bodily boundaries and points of entry or exit (Scheper-Hughes and Lock 1987, 24). We can see aspects of these concerns clearly in the political rhetoric used by Donald Trump.

Scheper-Hughes and Lock describe potential impacts of the body politic under threat, which resonate with the reasons why people increasingly sought out birth control, and especially certain IUDs, in the wake of the 2016 election:

Individual hygiene may focus on the maintenance of ritual purity or on fears of losing blood...symbols of self-control become intensified along with those of social control. Boundaries between the individual and political bodies become blurred, and there is a strong concern with matters of ritual and sexual purity...Individuals may express high anxiety over what goes in and what comes out of the two bodies (Scheper-Hughes and Lock 1987, 24).

Is the selection of a long-acting birth control method like the IUD, one that ‘protects’ from pregnancy, one that could stop periods, or one that could eliminate the need for systemic hormones, related to the political fears of invasion and cultural change?

Many scholars have noted the dual nature of power relationships in the study of women’s reproduction, where women can be both subjects before institutions like biomedicine and empowered resisters of hegemonic values (Alianmoghaddam, Phibbs, and Benn 2017; Colen 1995; Ginsburg 1998; Ginsburg and Rapp 1991; Martin 2001; Takeshita 2012). Medical anthropology is full of accounts of this site of contention, and of descriptions of resistance to biomedical attempts to subjugate women and their reproductive activities (O’Dougherty 2013; Smith-Oka 2015; Martin 2001; Krause and De Zordo 2012; Fordyce 2012; Lazarus 1994; Welch 2010; Wynn and Trussell 2006; Sargent and Gulbas 2011; Takeshita 2010). This research will add to this important work in exploring how birth control methods can potentially be used to resist political and social movements, even while submitting to biomedical, biopolitical scripts about reproductive norms.

3.7 Is this a feminist ethnography?

My research intersects with the feminist ethnographic tradition, but is subject to the many questions and challenges inherent in conducting, or attempting to conduct, equal, equitable, non-exploitative feminist ethnography. As Abu-Lughod defines the term:

imagine the woman fieldworker who does not deny that she is a woman and is attentive to gender in her own treatment, her own actions, and in the interactions of people in the community she is writing about. In coming to understand their situation, she is also coming to understand her own through a process of specifying the similarities and the differences. Most important, she has a political interest in grasping the other's situation since she, and often they, recognize a limited kinship and responsibility. (1990, 26)

Certainly my research fits into this definition of feminist ethnography. However, in a paper on the same topic, Stacey challenges the possibility a feminist ethnography, noting that an inherent power differential is present in ethnographic research between the researcher and informants (Stacey 1988). While the “ethnographic method can (and often does) place the researcher and her informants in a collaborative, reciprocal quest for understanding” the research product, the ethnography, is written by the researcher, through her own interpretations of the conversations, no matter how collaborative (Stacey 1988, 24).

Researchers Craven and Davis distinguish feminist ethnography as one that “pay[s] attention to power differentials” inherent in the researchers’ choice of research methods, and “use[s]...a feminist ideology to interpret findings” (Craven and Davis 2013, 1). Feminist activist ethnography combines feminism with activist ethnography – what others like Mullins (2011) or Rylko-Bauer, Singer, and van Willigan (2006) might call an “engaged anthropology”.

I would argue that this is an inherent part of a praxis-oriented anthropology that aims to identify and address power imbalances in human society, and carefully considers positionality of the researcher while doing so (Kozaitis 2000). As much as I would like to situate my research

within an activist ethnography or praxis-oriented anthropology, I can't claim that my efforts will solve social problems, or even be particularly collaborative with my study participants. As a graduate student working in a short time frame in which to conduct this research, I did not feel as if I had the time or power necessary to work with study participants towards a common research goal.

Still, I tried to incorporate their suggestions, questions, and calls to action into my research and ethnographic writing, and I am grateful for the opportunity to represent their stories here.

4 METHODOLOGY

To achieve the aims of this research, ethnographic methods proved ideal. According to Whitehead (2005), ethnography is a research approach that “is a holistic approach to the study of cultural systems” involving “an interpretive, reflexive, and constructivist process” that “presents the world of its host population in...thickly described case studies” (4-5). My methods for this research included collecting ethnographic data from people who chose to use an IUD as birth control at some point after the November 2016 Presidential election. This data came from semi-structured interviews, anonymous surveys, and a moderated Facebook discussion. I also analyzed media content from Twitter, Facebook, and Tumblr to better understand the current political climate and rhetoric of American politics in 2019. Participant observation, another hallmark of the ethnographic method, was comprised primarily of social media interactions and analysis. However, as I will discuss later (in my positionality statement), I bring my experience as a recent IUD-user to this work, and some of my experience navigating the health care system in choosing an IUD certainly informed this research.

4.1 Research Approach

In February –April of 2018, I conducted a pilot of this research for a graduate Qualitative Methods class. During the pilot I interviewed 8 individuals, all of whom were using the IUD as their birth control method. Some of them had acquired their IUD prior to 2016, and some after the 2016 presidential election. I also documented my experience getting my own IUD at a local Atlanta clinic. Based on what I learned in this process, and the marginal differences I found in motivation between participants who acquired an IUD pre or post 2016, I narrowed the scope of my thesis research to include only those who had used an IUD after the 2016 election.

I designed flyers and business cards that directed interested study participants to a website I created for recruitment. The website was built with Wix, a free website builder. I also created a Facebook page for the study, as well as a Twitter profile. Icon images used in the flyers, cards, and website/social media platforms were purchased from the Noun Project, a website that houses designer-submitted drawings for free use or purchase.

4.2 Recruitment Strategy and Bias

After receiving IRB approval in April, I began recruiting potential study participants. Flyers and business cards were distributed in both the Savannah and Atlanta-Decatur metro areas. I received permission to distribute flyers and cards around the Georgia State University-Atlanta campus, Emory University, Spelman College, Georgia Tech, Agnes Scott College, The Phillip Rush Center, Charis Books and More, public libraries, numerous coffee shops, bars, office buildings, clinics and hospitals. I also distributed flyers in public areas near MARTA stations and parks. On May 10, I participated in the inaugural Decatur Lantern Parade, and made an IUD lantern with the website to advertise the project. The feedback I received during the

parade was overwhelmingly positive. Many local activists and reproductive health workers came up to me to inquire about the project, and were supportive of this research.

I created social media posts requesting study volunteers, and shared them via Facebook, Twitter, and LinkedIn. I received permission from local Georgia groups to share the request for participants on their Facebook pages. These groups and organizations included political, reproductive health, and professional networking groups I was already a member of, including Metro Atlanta Feminists, the Atlanta Science Tavern, Spark Reproductive Justice Now, Access Reproductive Care Southeast, Southerners On New Ground, Charis Books and More/Charis Circle, the PHAP Alumni Association (a public health networking group), do better ga, and Activists Recruiting, Organizing, and Mentoring in Atlanta.

Undoubtedly, this incorporated a certain political bias into the results- by relying on my social network, the political beliefs and interests of recruited participants are likely closely mirror my own. I can't pretend that my study intended to reach a representative sample of all Georgians who got an IUD after the 2016 election. Notably, there are key voices missing from this project, voices that often are missing from discussions of reproductive health – those of men, trans people, and non-binary people. To my knowledge, all study participants received their IUD within the American or Canadian healthcare system. I did not collect racial or ethnic data, but some interview and focus group participants did share this identity with me during our conversation. Based on this, I know that the voices of white women are likely over-represented in this research. Based on research from the Guttmacher Institute, IUD use is highest among contraceptive users who: are Hispanic, aged 20-39, have given birth to 1-2 children, expect to give birth to 0-2 more children, had fewer than 2 sexual partners in the past year, rely on income that is less than 200% of the Federal poverty level, had some college or graduated from college,

and are cohabitating or married to a partner (Kavanaugh and Jerman 2018, 17). Many of these characteristics are representative of most of those who chose to participate in this research, but not all.

I sent recruitment emails to the individuals who had participated in the pilot research, and reached out to the people who had expressed interest in participating via the website after the pilot had finished, but before I had received IRB approval for this thesis.

4.3 Participation

Potential study participants were asked to participate in 1 of 3 ways:

1. An interview, either by phone, video, or in-person. Potential participants were required to fill out a brief contact form on the website to schedule an interview.
2. An anonymous survey, taken on the website, in which users could provide as much detail as they desired to 10 key questions.
3. A private, invitation-only, moderated Facebook discussion. Potential participants were required to fill out a brief contact form to receive the Facebook event invitation.

Between May and June 2019, I interviewed 10 people who had used IUDs as birth control at some point since November 2016. Most interviews were conducted in-person, primarily at local coffee shops and restaurants in the Atlanta and Decatur metro-area, and in Savannah, GA. 1 interview was conducted via telephone with someone in the North Georgia area.

11 people completed an anonymous survey online, which included a pared-down version of the same interview questions. 16 people (including 2 who had previously completed in-depth

interviews) participated in the moderated Facebook group discussion, which occurred on June 9th, but accepted comments through June 12th from invited participants.

Study participants self-selected into this research. All potential study participants who expressed interest were contacted to schedule an interview. The interviews were semi-structured, covering topics from likes/dislikes about the IUD, sex education, political ideology, previous birth control use, and experiences with the reproductive health system. All of these topics were intended to elicit various aspects of how a person may come to decide to use an IUD, whether it be due to the political climate or other factors.

Informed consent was sought for all study participants, as required through the Georgia State University Institutional Review Board. Signed consent forms were not collected. All interview participants have been assigned pseudonyms, and no personally identifiable information was collected from the survey-taking participants or Facebook discussion participants.

Permission to record the conversation was requested from all in-person interview participants. In-person interviews were recorded using Otter, an audio-recording and transcribing app, and with a pen-based tape recorder. Using the preliminary transcripts generated by Otter, I edited and re-transcribed the interviews.

Interview questions, survey questions, and Facebook discussion questions all covered similar topics. Topics included history of birth control method use, experience with formal or informal sex education, identification with a community of IUD users, political beliefs and concerns, current socio-political events in the United States and Georgia, health insurance coverage and navigation of the health care system, emic definitions of reproductive choice and reproductive justice, and experiences discussing birth control methods with health care

providers, family members, romantic/sexual partners, and friends. Most of these were explored in more depth in the semi-structured interviews than in the participant-administered surveys.

4.4 Analysis

I created a data set of the transcribed interviews, anonymous survey submissions, and the Facebook group discussion in the qualitative data analysis software program NVivo 10. I used the NVivo autogenerated themes to explore initial relationships in the dataset, but ultimately identified themes and explanatory quotes without the use of the NVivo software.

My analysis utilizes another hallmark of anthropological research – grounded theory. According to Bernard, grounded theory is an iterative approach that involves reading transcripts from ethnographic interviews, identifying themes and building theoretical models that might explain these themes, and revisiting the accuracy of these theoretical models throughout the analysis process (2006, 492). As I interviewed and immersed myself more in my research, I developed theories about why certain people got the IUD following the 2016 election. As my research progressed, I edited and revised these theories based on what I was hearing from interview and survey participants. Finally, I present these theories with illustrative quotes from study participants –what Bernard calls “exemplars” (2006, 492).

4.5 Positionality

My perspective as an insider, a user-of birth control methods and someone experienced with IUDs, reproductive concerns, and the American healthcare system, helped build a bridge to connect with interview participants who I had never met before. This helped enormously in building rapport quickly with participants, especially when I only had an hour or two in which to conduct interviews. My emic experience helped me feel more comfortable during interviews. It often assuaged my discomfort with being an academic observer studying people by asking about

some of their most intimate experiences and deepest fears –about sex, family, relationships – about genitals, periods, money, health, and their very ability to make decisions about their bodies that worked best for them. This helped especially when, as Abu-Lughod describes, our experiences diverged, allowing me to explore the “tell-tale imprint of a specific cultural context and meaning” (1990, 22). When our experiences as women, as IUD users, as Georgians concerns about the state of reproductive rights diverged along lines of privilege, I attempted to “contextualize” as Abu-Lughod calls on feminist anthropologists to do, by constantly considering “which woman? What kind of feminine?” (1990, 21-22), instead of writing a monolithic story about ‘women’ or ‘IUD users’. The opportunity to do so regularly occurred in the research process, as many women shared their concerns about racial violence, deportation raids, potential verbal abuse by Trump supporters, precarious health insurance coverage, and inability to discuss their birth control method with family members.

Another critical point of convergence and divergence was my in position as an ‘embodied user’ of an IUD. In the course of my pilot study, I sought to acquire an IUD. As the results of that study showed, many of the participants were demographically similar to me in gender identity, sexuality, political beliefs, religious affiliations, age, economic class, and career path. While this is partly due to the convenience sampling of IUD users, and my recruiting through social media platforms where I would only be able to reach people who were direct contacts or friends-of-friends, my privilege and positionality are still important factors to consider. My recruitment messages and strategy may be biased, reaching only those who sought IUDs for similar reasons as I did. My positionality as a privileged, so-called ideal user of the IUD was critically important to consider throughout the data collecting process as well as during analysis. Scholars like Takeshita have covered this important topic in depth:

Following the insertion, I too became an embodied knower. Keeping to a feminist research methodology that anchors objectivity in accounting for the researcher's own values, social positions, and relationship with the research subject, I had to be reflective about who I was—a satisfied IUD user generating an academic analysis and a feminist critique of the device...my situatedness—the historical, geographical, and social position that I occupy as an educated woman living in the United States 40 years after the contraceptive method was revived—shaped my own experience, which was not easily comparable to that of other women due to our grossly different positionalities. Knowing that classic feminist critique of the IUD regarded the device as inherently oppressive, potentially dangerous, and prone to abuse I felt slightly uneasy with my own positive relationship with the device. Would I be regarded as betraying women if I cast this technology in a positive light as it related to my own experience? (2010, 40)

Takeshita struggles with her position as an embodied IUD user, concerned that her satisfaction with her selected birth control method may bias her efforts to problematize and critique the IUD. I found myself relating most strongly to her struggle to accept her position as a safe, acceptable, intended, appropriate user of the IUD. As a privileged, American, employed, cisgender woman with health insurance, I too represent a vastly different 'intended user' of the IUD than manufacturers originally intended.

Unlike so many women around the globe, the IUD was not, and could not be imposed upon my body –it was my choice among many, reasonably good birth control options that I could afford through my health insurance. I am not presently incarcerated, nor am I currently participating in a government welfare program – two conditions that have recently been used to justify the imposition of long-acting birth control methods such as the IUD, the implant, or even sterilization on women in the US. My health insurance, a benefit of a secure, full-time job that pays me a living wage, covers most birth control methods. In the event that my health insurance did not cover the birth control method of my choice, I am in a position to change health

insurances, to take time to research the many options provided by my employer to select one that better fits my needs. Prior to the ACA, many people in the United States did not have this privilege.

When seeking my IUD, doctors did not put up (much) resistance to my interest in using the device. I have been in a monogamous relationship with a cisgender man for 7 years – this privileges me enormously in constructing me as a safe IUD user (Takeshita 2010; Takeshita 2004). Additionally, as a white, cisgender, straight-passing woman, my position is one of extreme privilege in conducting this type of research. My fertility is largely prioritized by the medical system and by American culture at large. Some aspects of my identity undercut this privilege –being a person of size who is labelled Obese by the medical community, my chronic health conditions, and my ‘single’ marital status may have impacted my choice in ways that I can’t see. Still, my position as someone who stands to benefit enormously from the IUD, and who would experience minimal resistance to enacting my reproductive wishes by the medical community is very different than some of the participants in this study, and many women in the United States besides.

Takeshita notes that her experience getting an IUD required careful attention to the biosocial and political-economic systems that inform modern women’s ‘choice’ of birth control methods (Takeshita 2010). In my analysis I attempt to contextualize my own, and my participants, experiences in a similar way.

5 ETHNOGRAPHIC FINDINGS

A total of 35 people participated in this study. 10 participants completed an in-depth interview, either in person (n=9) or by phone (n=1). 11 participants completed an anonymous

survey online, and 16 participants (including 2 who had already completed an in-depth interview) joined a moderated Facebook discussion. Most of the participants were currently using an IUD for birth control. Most of the participants were women –some did not explicitly state their gender identity. The most common type of IUD used by participants of this study was the Mirena (51.4%, n=18). The next most common IUDs were the Kyleena (22.8%, n=8) and Paragard (17.1%, n=6). Paragard has been available on the US market the longest, since 1989. Kyleena is a relatively new IUD –it was approved by the FDA in September 2016, and was available for use beginning in October 2016. That this method was this popular among participants certainly indicates that something is changing among IUD users today. Two participants used the Liletta, and 1 used the Skyla IUD.

Mirena is the most popular IUD in the United States, so it was proportionately represented in this study. Paragard has been available on the US market the longest, since 1989, and is the only long-acting birth control method that does not use hormones, making it another popular choice. Kyleena is the newest IUD in the US market–it was approved by the FDA in September 2016, and was available for use beginning in October 2016. That this method was this popular among participants certainly indicates that something is changing among IUD users today –perhaps that the preferences and demographics of IUD users are shifting.

5.1 Planning Reproductive Futures

How do birth control users conceptualize themselves as planners of their reproductive futures (Fordyce 2012, 119)? Reproducing in America requires careful planning, saving, and social support. Krause uses the term “suspended rationality” to describe how Italians come to have one of the lowest fertility rates in the world, but also a high rate of unplanned pregnancies (Krause 2012). Her research found that for some Italians, having a baby often makes no rational

sense –it is expensive, often thankless, and impeded by societal structures that devalue reproduction (Krause 2012). In this case, the only way to have a baby is to let go of planning and rationality. Many women in this study noted the difficulty and irrationality of childrearing, expressing frustration with the knowledge that they may never get there:

I also think American women delay childbirth for when they are more financially stable, which might never happen because our current government only cares about making the rich richer. (Anonymous 27-year old woman)

Before 2016 was the last time I really seriously considered like, what my life would be like in the future if [my husband] and I had kids. Since then it just hasn't been like, a viable option. Or it hasn't felt like a viable option. (Chelsea, 29, freelance writer)

Many people want children but don't have them due to financial concerns, but I believe parenting is a human right that should be accessible to everyone, and our social systems should provide better support...I don't want to live in a world where only the rich can afford to have kids. (Hilary, 41 year old woman)

This type of financial planning/rationalization extends to calculations about birth control methods as well. Numerous participants noted that the IUD was a fiscally responsible method – that it was less expensive than buying condoms or other birth control methods. For those who had to pay a significant amount for their IUD, they noted that the cost wasn't much compared to the number of years the IUD would protect them from pregnancy.

Others, like Delia, a 34 year old law student, refused to let social and economic barriers stand in the way of their plans for reproduction:

My estranged husband decided that growing up was too hard. We were supposed to have a child this year...that was all too hard, and he left, and he's with a 19 year old. ...I don't get to wait 10 more years to decide if I want to have a kid or not, like he does. And if he stays with this 19 year old, he gets to wait until he's 40, and she's 30, and he feels more "mature"... Women, or people with the ability to carry a baby don't have that option biologically. Science has made it easier to get pregnant later, but I don't want to deal with all the extra issues that come with getting pregnant later, if I can avoid that stigma...Everyone's like, well maybe this is not your time to have a kid, and I

looked at them –well, if not now, when? When is it my time? Men don't have to worry about that.

This story came up in our conversation after a question prompting her opinion on reproductive justice, and she connected justice strongly with individuals being able to choose the reproductive plans that they want –ideally without the social stigma and political and economic obstacles that so many people face today. Delia went on to describe to me the frustrating amount of education and advocacy she's had to do in her social circle, to explain why she's choosing to have a child in the near future, without a partner. She also noted that part of the timing has to do with the financial consequences of having a child while being employed. She is choosing to get pregnant while she is still a law student, because she knows that becoming pregnant early in her legal career will have a devastating and long-lasting impact on her opportunities and earnings. While she is determined and excited about her plan to become pregnant within the next year, she highly values her copper, non-hormonal IUD as a part of this plan. The non-hormonal IUD allows her to pursue pregnancy immediately once she removes it, without concern for lingering side effects of the hormonal IUDs in her system.

5.2 Birth control without reproduction

This type careful reproductive planning bled into discussions of pain and menstrual cycles as well –many described side effects of the IUD in terms of a calculated cost/benefit ratio. Study participants often remarked that they loved not having a period –this being a common effect of the most popular IUD, the Mirena. In describing their experience with the notoriously painful IUD insertion, many described the pain of insertion, and the irregular spotting after insertion, as being worth it for the reward of no periods for 3-5 years.

Multiple participants independently mentioned the period-tracking app Clue, an app used to track everything from weight, mood, acne, arousal, and the start/end dates of periods, fertile

days, and pre-menstrual syndrome. For many women, birth control and careful planning are not reserved solely for contraception –the use of these methods extend beyond sexual activity that could lead to pregnancy:

I identify as bisexual...and people always ask me like, if you ever got into a relationship with a woman would you keep your IUD? And I would say absolutely, yes. And when they asked me why, I would just say because it is the birth control I feel best about using. To me, it's not necessarily about who I'm having sex with. More so that I'm protected in the way that I want to be protected. (Olivia)

For so many people it's not about pregnancy...it's called birth control, but any sort of hormone regulation is so important for so many people for such a variety of reasons. (Chelsea)

I loved that I was still able to donate eggs without removing [the IUD] or messing with it in any way. (Hannah)

I don't have an IUD just for birth control, I have it for health reasons –to help with the symptoms of PCOS that can sometimes be debilitating. (Anonymous 23-year old woman, current graduate student)

Though this connection remained unsaid, there seemed to be a strong connection between birth control and adulthood. More than one participant indicated they turned to the IUD once they reached a particular hallmark of maturity in American culture – settling in to a long term, monogamous relationship. Others did so after they had finished having their children. Many used the term “protected” throughout our conversations – implying both protection from pregnancy, but perhaps also protection from the chaos of the social and political climate of the US today. For the women who participated in this study, contraception has become unanimous with adulthood and planning for their futures, reproductive and otherwise.

5.3 Partners

It's striking how individualized the responsibility of planning their reproductive future is in these accounts. When describing their birth control selection process, virtually no participant mentioned partners, family members, healthcare providers, or religion without prompting. After

prompting, most said that their partner was supportive of whatever they decided, or that they had only told family members as an afterthought, or that they felt they couldn't tell family members at all. Most participants noted that their male partners were supportive, but not particularly involved in the decision-making process. Nora, a 26 year old public health advisor, jested in the Facebook discussion "He's just happy to be along for the ride ;)". Gabriela, a 21 year old college student studying education, put it this way:

My boyfriend at the time, I didn't really talk to him about it. Because I mean ultimately, the decision was on me and I felt like this decision transcended him. You know, he might not be here five years from now.

Gabriela is referring to the 5 years that the Mirena IUD would be effective –implying that the birth control could last longer than the relationship, and in fact transcends the relationship between her and her boyfriend.

For Erin, a 36 year old working in communications, her husband's support was important, but a point of disunity between them:

It's not that he's not supportive, but I think that he would love to have another kid and he's not like, totally... you know (hesitating) happy about me not wanting more kids. But he's very respectful of it being my choice, which is great. That's why I would never ask him to have a vasectomy or anything like that, I think he'd flip out about that. But when it's my body I think he's ok with it.

Again we see how there is a specific individuality involved in choosing birth control – although it implies a specific reproductive future for Erin and her husband, her husband is ok with the IUD because it is seen as Erin's. At the beginning of the interview, Erin noted that she wanted to participate in this research because she thought she brought a unique perspective as someone who was done with her family. However, she also emphasized that she chose the IUD because she wanted something less permanent than surgical sterilization, because "it is still reversible. Like if I somehow changed my mind, because you never know." Planning a reproductive future

today also involves planning for change – no matter how set you think your path may be. To me, Erin sounded reasonably certain that she was done having children, but knew that she needed to plan for more than one possible reproductive future.

5.4 Reproductive Autonomy

The reversibility of the IUD is often seen as one of the primary benefits of the birth control method, and previous research has indicated that the increase in IUD use may be coupled with a decrease in more permanent methods of sterilization (Kavanaugh and Jerman 2018). Numerous participants noted that one of the best things about the IUD was its long-lasting effectiveness, coupled with its reversibility:

I can choose to take it out early if I decide I want kids. (Anonymous woman who is 24 years old and works as an account liaison)

For me it was the longevity of it, and also having reversibility....eventually I want kids, just not now. (Sam, 28, works for a financial tech startup)

I didn't feel like I was old enough to have –to make the decision to get my tubes tied or anything like that. It was so permanent. Even though I am plenty old enough now, I like this, so I don't see any point. (Liz, 41, zoo educator)

For some, this reversibility is not a benefit. Several women noted that they had been denied sterilization, or heard about friends who had been denied sterilization, and were directed towards the IUD instead:

The doctor that was going to tie my tubes had just retired and the replacement refused to do it because I was only 30. So I convinced her to let me get an IUD instead. (Nadyah, 40 year old woman)

I know some friends of mine who are probably only in their 20's who know they don't want to have kids, and are now having issues finding a doctor that's willing to tie their tubes. (Sam)

I think doctors should not tell women that they can't have their tubes tied without having a partner, or at least having a child first...I was reading through Reddit, and apparently it's very common with women that have told their clinicians that they want their tubes tied, they've been rejected and said

*that they need to have a child first. And they need to consult their husbands.
(Vish, a 19-year old college student).*

This denial of reproductive agency is something that was very affecting for Olivia, a 34 year old non-profit/advocacy worker in Savannah:

I had gone in somewhere, and I had inquired about getting my tubes tied. And they were like, we can't do that. You're not married, you don't have kids, you're under 25....I have known for a long time that I would probably not have children. I have always kind of left myself open in case that changed, but for the most part I've remained steadfast. So I really wanted to know what it meant to get my tubes tied, if that was something –could I access it, could I even afford it? I had questions. And I felt like, I went to someone to ask questions, and it was cut off even before I was able to get that information. Which I think –if you're anybody in this world, and you're trying to make decisions about your body, that can be very disarming.

Olivia went on to connect this reproductive injustice to the ongoing maternal mortality crisis in Georgia. She identified the similarities in providers denying access to birth control, and doctors not listening to women, particularly black women, when they feel something is wrong during birth or pregnancy.

Paternalism from health care providers, especially reproductive providers, was mentioned by several participants:

When I got my first IUD in 2011 my doctor didn't want to give it to me because I hadn't had a child. (Anonymous 27 year old woman)

I started to get recurring BV [bacterial vaginosis, a common bacterial infection in the vagina] after about a year of having the IUD I was treated and retreated for BV with my gynecologist telling me that it had nothing to do with my IUD, however after about 6 months of dealing with almost constant BV I ended up getting it removed and haven't had BV since. I now have the Paragard and haven't experienced this at all! (Kelsey, 28, health educator)

So I went to my second gynecologist and I was like I really want this [the copper IUD], and she was very ashamed to know that I wasn't on any formal birth control at the time. I was like oof, I feel like a kid. And I'm not, I was 24. Anyway, she was like, 'I'm not putting the copper one in you, I pull those out of women after three months all the time...you are not going to be able to handle

this, I'm not doing this for you. You're going to need the hormonal one.'
(Kayla)

Kayla did not feel that this was coercive, and took her doctor at her word that the Paragard would be a bad choice for her. In concluding this story, she noted that “I felt like my gynecologists were supportive of my choice, though a little ashamed of me for not having made it sooner.” She also noted how although many people, including many doctors, often doubt women when they say they don't want children, her gynecologist was supportive and understanding of Kayla's desire not to have children.

Many participants noted that reproductive paternalism can come from other sources as well –Chelsea remarked “I have so many female friends who are like, I'm never gonna have kids, and their families or their healthcare providers are like –but you might!”

5.5 Contraceptive Anxiety

Across all of the interviews, surveys, and comments in the Facebook discussion, anxiety, worry, risk, and fear were pervasive –not just in describing concerns about access to birth control, but also in describing the benefits of/hesitations about birth control and the IUD:

“I wanted something I wouldn't have to worry about for a few years.”

“The feeling of not having to worry about pregnancy.”

“I wouldn't have to worry about taking birth control and remembering it.”

“I was worried about not getting my period at all with the IUD.”

“I was researching IUDs because my constant anxiety of the “pull out” method was too much for me and my long-term partner”

“It's worry free and I don't have to do anything!”

“It's very low risk and moderately painless, so I think I like it.”

“I like not having to worry about anything except it falling out.”

“I decided to get an IUD because of the blood clot risk with oral bc (birth control) in women over 30 and 35.”

“My friends and I talk about birth control...I constantly tell them to switch to an IUD, I know they are using the pill, but they said that they are scared.”

“I’m concerned about hormonal IUDs and blood pressure.”

“I was afraid of how I would react to it.”

Few women identified an explicit political motivation behind their decision to get an IUD, and when asked if their decision was a political one, almost everyone said no. In the next breath, virtually all participants identified numerous political factors that influenced their decision: insurance coverage, employment changes, the cost of birth control, the availability of their preferred birth control method, their desire to prevent pregnancy, wanting to delay childrearing until they were financially stable, not wanting to raise children at all, their concern for overpopulation and the environment, and their worry about the side effects of other forms of birth control. While these factors are not strictly associated with a Political party, they are structural and political-economic concerns that deeply affected the participants of this study.

There was a striking, near-universal contrast drawn between ‘political’ choices and ‘personal’ ones:

#9 Was getting your IUD a political choice?

7 Comments



Figure 5.1 A screenshot, with names removed, of the Facebook focus group discussion responses to the question "was getting your IUD a political choice?"

Here the Facebook group discussion outlines the difference in perceptions of personal versus political. Despite one participant noting early in the discussion that to her (and Gloria Steinem), the personal was political.

5.6 Navigating the American Healthcare System

Striking in these stories was the comfort and ability to navigate the complexities of the American health care system. Numerous women described detailed plans that they would enact in the event of a major medical event – some were implementing these plans in the present. Liz, a 41-year-old zoo educator and mother of two, has been traveling to Montreal in order to treat her son’s Osteogenesis imperfecta, a brittle bone disease. She has been making this week-long trip every 6 months for 10 years. The impetus for these trips started when her son was very young, and her insurance refused to cover the DNA testing necessary for diagnosis. Doing her own research, Liz determined the best place for her son was a specialty hospital in Canada, and after over two years on the waiting list, her son was finally accepted into the hospital program.

Kayla, a 26 year old woman working for a travel agency, was explicit in outlining her privilege in being able to access an abortion if needed. She noted that because she was a wealthy, white, woman, she could access abortion with ease, and she wanted to provide monetary support for states that protected abortion access:

I don’t know if I would have actually done it, but I always said this was my plan: I would not get an abortion in Georgia. If I need an abortion, I’m going to fly to Portland and do it, and reward the state that has such open access and go spend my tourism dollars there, and make it a trip (laughing).

Another woman has remained in Canada due the volatility of reproductive healthcare access in the US:

Because of my health I cannot carry a child, and if I were to get pregnant it would likely kill me and the child. It is very important to me not to be in that position, and part of the reason I stay in Canada where abortion is accessible, legal and safe. (Alice, 29 year-old woman)

When asked why she chose an IUD, Gabriela immediately linked it to her impending loss of health insurance:

I was on Peach State at the time, and my insurance was going to expire when I turned 19. After that I wasn't going to have anything going for me. At the time, I wasn't sexually active for anything, but I knew that maybe in the future I would want to be, and if I didn't have anything in the moment, I wasn't going to have anything later. So I was like, let me get ahead of the game and be prepared for later....I was really thinking ahead, like 'oh my god, my insurance is about to expire.' ...I was thinking of how I was going to afford paying for the pill every month –like, \$54 a month, I won't be able to make that.

Gabriela also noted that none of the adults in her family have insurance, because of the cost, and because their undocumented status made them ineligible for many public insurance options. At 18, she planned intensely for her impending loss of insurance, calling her insurance, double checking coverage, and scheduling preventive health care visits –because, as she put it, “you never know when the next time is going to be that you're able to afford it”.

Some women faced significant financial barriers to getting the IUD:

My first IUD was around 2012 and at that time IUDs were covered by insurance as “devices”, meaning I would have to pay full cost and apply it to my deductible –this would be about \$1400. My gynecologist agreed to implant the IUD as part of a regular (covered) yearly checkup and pap smear, if I could obtain one otherwise more cheaply. I ordered from a Canadian pharmacy for \$8-900, which saved a little money...I got a Bayer Mirena in box, just as my gynecologist would have received is she ordered through her US pharmacy (Anonymous 41 year old woman who is a medical writer)

Again, the intensive planning and effort that is sometimes required to get healthcare services in the United States is striking. That so many participants had similar stories, and demonstrated such experienced ease and comfort with negotiating these obstacles, speaks volumes about the American healthcare system today.

5.7 Elections and Reproductive Fears

When asked if people had concerns about birth control prior to the 2016 presidential election, many women replied that they had not thought about it. Many indicated that they were shocked by the election of Donald Trump, and that reproductive health concerns quickly

materialized and grew throughout his Presidency. Others noted that both the 2016 Presidential election, and the 2018 Gubernatorial election of Brian Kemp, played roles in either selecting the IUD, or feeling relieved that they had already done so:

Abortion might be more legal now than it was 40 years ago, but if you are a wealthy white woman in a city, you have not had problems getting an abortion. And still, if you're poor or in a rural area, you still have problems getting an abortion. So I personally was not concerned [about my reproductive health/birth control]. (Kayla)

I really just wasn't sure at first if I really wanted to do it, because I was afraid of how I would react to it...But part of the reason I did decide to get it was because I was worried that I might not be able to in the future. Like if something happened with healthcare and my insurance stopped covering it through work, or like, God forbid birth control became illegal or something. (Erin)

It's something that so many more of my friends have been talking about both in the past 3 or 4 years, and more specifically since HB 481. Since that passed I—I had thought about getting an IUD since he [Trump] got elected, and then I don't know what happened, I guess I just forgot about it. But after the heartbeat bill I was very much like, 'oh shit, I need to get this, I need to get this done.' (Chelsea)

2016 happened and then it was like, we're just gonna re-up the sucker [IUD] now, we really are. Just install a new one in there, I don't know how this is going to go. (Olivia)

Since the election, I've heard a lot more about [birth control]. Mainly because a lot of people were urging women to go on birth control had anyone gotten sexually assaulted or raped or anything like it was just more of like a precaution like, 'oh go on birth control because like, you don't want to get accidentally pregnant from rape or anything'. (Vish)

I think it's terrifying, with the attempts to restrict reproductive rights like abortion. If they succeed, if they knock one off their list, what's next? Will they say birth control is murder? Where's the line that they draw? (Amy, 32, an environmental scientist)

Fear notably extended beyond birth control access. Some participants, like Vish, described the increase in violent rhetoric and threats they experienced in association with the 2016 election:

He targets people of color. And a large majority of my friends and family are Muslims, and they're also Mexicans –my boyfriend is Mexican. And so we

have been out in public and received threats before. I've been called a terrorist....people think just because [Trump] is the president, it's okay, because he said it, but it's not... I played a sport in high school, and we played against one team that was primarily white. And our team was primarily black. We're rolling up to this school and we see, probably like six trucks lined up in the parking lot with these big Trump stickers on the back, and they have their Confederate flags, and they're waving them at us. That was probably one of the scariest moments of my high school life. They knew about [the demographic makeup of] our school, they were trying to intimidate us...it was probably October, about a month before [Trump was elected President]. (Vish)

Gabriela noted that the threat of violence or fear of persecution didn't feel as bad as in 2008. She described the terror her mother felt during immigration raids then, and how she spent two nights in jail after being caught in an interior immigration check-point, a road-block supposedly checking for drunk drivers. Prior to this, her mother had been pulled over by a police officer, and was instructed to go directly home and stay there (Gabriela indicated that frequent immigration raids were occurring at the time):

That time was really bad. I remember my mom didn't even want to take us to the pool. We locked ourselves at home. Right now it doesn't feel as bad as it felt then. But I guess I'm kind of scared that we're going to get back to that, back to how bad it was then.

This was clearly a significant and frightening event for Gabriela and her family. In our conversation, she spoke at times about the amount of work she's had to do in getting her IUD in a country and under policies where it feels, at times, like people like her are unwanted. I could sense her frustration in describing the hours she spent researching the IUD, in making secret calls hidden from her mother to the insurance company to confirm coverage, in coordinating numerous healthcare visits for herself while graduating from high school, in planning ahead for years of being uninsured, the amount of education and advocacy she has done for her friends - encouraging them to get an IUD if they were sexually active or uninsured. This frustration crept in when she discussed immigration policies under Kemp and Trump, and when she discussed access to health care, preventive services and affordable birth control, and abortion.

5.8 Women's Anger

Anger, particularly about the legality of abortion in Georgia, was pervasive in many of the conversations I had with participants. Often, this was shared with humor or sarcasm, or with a hint of detachment in the voice. Each participant seemed truly passionate about the subject of reproductive choice. While not all were familiar with the term, most people described many aspects of reproductive justice being important to them, and especially concerning given the current political situation in Georgia. I could feel that most of the participants were indignant and righteously angry on behalf of others –especially those that would be most impacted by restrictions on abortion. Moments of anger came through in discussions of birth control and sexual harassment as well:

I never understood why –well, I do know why, but I never understood why birth control or the ability to control what happens in reproductive health is always the woman's burden. And it doesn't seem fair that we inject these hormones into our bodies that affect us so negatively, for no reason. (Delia)

How crazy isn't that there are people who cannot get health insurance? It's awful. Just -constant rage, constant, low level simmering fury, and literally 24 hours a day, even when I'm sleeping, constantly angry. And my parents are like, 'why are you always so angry, why is everything political?' Because everything's political! (Chelsea)

Not [having a period every month] is a little scary, especially with the new laws in place. Because I'm doing everything in my power. I'm taking the precautions. If something does happen out of that, it's not fair that I would be punished for it, because I'm doing everything that I can not to get [pregnant].(Gabriela)

My mom has no problem with sexual harassment to a point that scares me. It doesn't bother her when people do it to me. I'd come home so upset, like, 'this guy grabbed me, grabbed my butt' and she'd just say, 'Oh Kayla, come on' [dismissively] –are you fucking kidding me right now? I'm your daughter! I'm not even just a general woman, I'm your literal daughter who's crying about sexual harassment and you're like 'aren't you overreacting?'" (Kayla)

There's very few people in the world who are having abortions [as their main method of] birth control. That is ridiculous. That is a ridiculous concept. And I just think it's completely stupid that some of these idiots think that that's what

people are doing –and then the whole idea that your ectopic pregnancy, you can just take it out of the frickin fallopian tube and implant it in the right spot –No! Read Something! These uneducated people who are in office don't even know what science is. And they're just taking so much away. I don't know what in the world we're going to do without science. (Liz)

Anger was frequently mentioned, along with fear, as a reaction to the 2016 election, and in conjunction with the wave of abortion restrictions sweeping the country in summer 2019. Anger, especially righteous anger and indignation, also appeared in conversations about the side effects of birth control, and lack of birth control options available for men/those who don't have the capacity to get pregnant. Jody, a microbiologist, described her frustration with these side effects along with the lack of tolerance for these side effects by men:

I think one of the things not really touched upon was the history of birth control, and how long it took for us to get to inventing IUDs and getting them implemented mainstream. I think this leads, to me, to the frustration of the super shitty side effects of other birth control methods we've put with for decades, and that awful study about the male birth control trial being cancelled after complaints of super minor side effects. There's something to be said with how many women are on board with IUDs even though long term effects aren't clear. To me, that shows how terrible the alternative is, that many of us consider the risk of the unknown worth it.

Most participants noted their frustration at the long list of side effects and significant health consequences they had to endure through years of hormonal birth control –from lowered sex drives, weight gain, migraines, nausea, acne, painful periods, ovarian and uterine cysts, hair loss, to depression and increased risks of stroke and blood clots. Many had chosen the IUD because it either offered a non-hormonal, highly effective method of birth control (the copper Paragard), or because the hormones were non-systemic and localized to the uterus, hopefully limiting the number of side effects they'd encounter.

6 DISCUSSION

In describing the impetus for selecting their IUD, participants described a clear delineation between the realms of “personal” decisions and “political” ones. When asked if their decision to get an IUD was “a political choice”, most participants described the many reasons that they had selected an IUD as the best choice for them, describing health concerns, financial situations, desired side effects or lack thereof, and their research into other birth control methods. Many participants also described distinctly political factors driving their decision to select the IUD, despite classifying these as a part of their personal decision-making process. These factors included concerns over limited health insurance access, the effectiveness of the IUD in case abortions became difficult to access in the future, the alternative cost of a monthly prescription should the Affordable Care Act be repealed, their desire to use a method that contained non-systemic hormones or no hormones at all, their inability to secure a more-permanent birth control method like sterilization, their fear of having an unplanned pregnancy or raising a child not according to their specific timeline, or their concern over having children (or more children) in a precarious economic and political climate.

As an outsider, it was clear that these concerns were indeed political. Most participants sensed this in some way –when asked to posit why IUD use had increased in the US after the 2016 election, many gave a variation of a single, succinct thought: people were afraid. This of course could be what many people thought that I, the researcher posing this question, wanted to hear. They may have assumed that it was my hypothesis, and fear was certainly a factor I considered keenly in my original interest in this topic, and likely bled into the framing of my research process, questions, and interview style. Still, there is an interesting distinction between the motivations that participants ascribed to the general increase in IUDs, and their own reasons

for attaining one. While fear permeated many aspects of our conversations about politics and birth control, it was rarely top-of-mind in participant discussions on selecting the IUD.

As someone who elected to get an IUD in Georgia in 2018, I feel that resistance to summarizing the complex, difficult, wide-ranging choices I have made to something as simplistic as fear. It feels disingenuous, a little disrespectful even, to look at the requirements to attaining an IUD –the complicated maneuvers, extended research, and navigation of the intricate bureaucracies –and ascribe these to a mass of people. No one wants to hear that the unique motivations and choices they made are commonplace. Acknowledging that fear had a place in my decision to get an IUD is very difficult –it feels like a denial of my agency, like I am admitting to being a victim. Admitting that something is a political choice, in the emic parlance, feels reactionary –perhaps even thoughtless.

Instead, as many participants did in their interviews, it feels easier to ascribe this choice to one of empowerment. But empowerment was a difficult concept to describe – few participants could pinpoint what precisely was so empowering about their choice of birth control method.

Protection was one such concept that many turned to when discussing empowerment. Protection was defined in these discussions in many ways, not solely in the common parlance of public health and “protection” from pregnancy. Often, protection was described in a sense of self-fortification, and the IUD described as a way of enshrining reproductive choice and autonomy into participants very bodies.

The participants in this study were well-informed about their birth control options, concerned about their freedom to choose the methods that worked for them should they lose their health insurance, and compassionate towards those who might already be in that situation. Given the fear of a potential ACA repeal, or the defunding of Planned Parenthood, I had anticipated that

some of these women would feel that they were ‘cornered’ into using an IUD, but none expressed this sentiment. All seemed satisfied (often using terms like “love”) with their IUD, and the main driver of their decisions were their own research and preferences; stories and recommendations from friends, family, and providers; and whether their insurance would cover the method they chose.

All participants shared a concern about the attacks on reproductive rights, whether it be changing coverage of birth control by Republican policy-makers, or the defunding of major healthcare providers like Planned Parenthood. For some, this fear motivated them to choose an IUD as their birth control method, aligning with the predominant narrative in the media about women ‘choosing birth control to outlast a presidency.’ For others, IUDs were the next natural step in their reproductive life, and they felt relief that their birth control, at least for now, was set. Still, fears about cost and birth control access in the future were evident. Some were left with little or no choice about which birth control method they could use, and would prefer more options be available to them –but with insurance and healthcare providers denying them access to more permanent types of birth control, they chose an IUD instead, and seem satisfied with that method for now.

However, political and structural factors played into women’s pre-existing contraceptive anxiety. This research was conducted at a very specific moment in Georgia’s history, especially for those who will be affected by House Bill 481, the bill that will ban abortion in the state at 6 weeks of pregnancy. This was clearly on the minds of virtually every participant, as it had just been passed at the time of most of these interviews. Participants described striking concerns about access to birth control –whether via the cost, insurance coverage, the legality of certain

birth control methods, and the consequences and options available to them if their birth control method would fail.

In arguing for better birth control options, some IUD users echoed sentiments indicating that use of modern birth control methods may be a point of biosocially defined identity. By adopting a techno-scientific, biomedical device, IUD users are engaging in a kind of biocitizenship. Knowing that their vision of their reproductive future may not be politically supported, they have embraced a biomedical intervention/technological device that ‘protects’ them from pregnancy, and engenders their engagement with discourses shaping future research into birth control.

7 CONCLUSION

Multiple women emphasized that choosing the IUD had been an empowering choice for them –that it had liberated them from fears of pregnancy, or the financial burden of birth control, or that it made them feel protected. Often, protected was not expanded upon, nor directly connected with protection from pregnancy. Perhaps the protection the IUD offers is more than contraceptive. The IUD may be an assurance, as many participants insisted, that participants were blameless in the case that they became pregnant when they did not want to be. Participants wanted the right to choose how they reproduced, and in accepting this right they also wanted to demonstrate that they were responsible reproducers, who took planning their reproductive futures very seriously.

Perhaps in a time when many participants noted that they were terrified and ashamed of the election results, they turned to a birth control method that was reliable, responsible, and preferred as a first-line recommendation by many biomedical experts. No participant explicitly stated that their choice of birth control after the election was a show of resistance –an act against

the conservative ideology that tends to prioritize certain women's reproduction. Still, resistance in reproductive choices was clear –in how participants chose when and how they would have children, how they were raising their children, whether to have children at all, or to have children outside of the nuclear-family model expected in the United States.

Protection may come from adherence to biomedicalized, bipolitically-mediated scripts about responsible reproduction. This adherence engenders protection from blame for being irresponsible in reproductive decisions, at a time when reproductive and healthcare access are uncertain for many American birth-control users. As an IUD-user myself, and in the face of potential threats to my health insurance coverage and access to birth control, I wanted to be seen as blameless. I did not want to subject myself to the social ridicule that could result from any number of the birth control choices available to me. In weighing my options, between an unplanned pregnancy, abortion, expensive birth control methods or reliance on birth control methods that could be difficult to access in a post-Affordable Care Act world, I chose a method that best adhered to biomedical scripts about responsibility. I chose a method that would last a long time, was cost-effective, was among the most effective at preventing pregnancy, and would be very unlikely to leave me dealing with an unplanned pregnancy.

The inability or unwillingness to describe these choices as political merits further investigation. Clearly, political fears do impact birth control decisions, as evidenced in the ethnographic accounts presented here. The difficulty in naming these fears as political when narrating our own decision-making processes deserves the attention of future anthropological research. Future studies may also consider an exploration of the different ways individuals and scholars conceptualize what is political versus personal, and why these concepts are so often presented as two opposing ends of a spectrum. Finally, it would be worthwhile to continue to

explore the decision-making narratives used by birth control users, and especially recent users of the IUD. These narratives can help us better understand how political resistance can be enacted through the body and individual choices in birth control, and how political events impact bodies, bodily autonomy, and agency.

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