

The Politics of Abortion Care in Ohio

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Abstract

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“The Politics of Abortion Care in Ohio” is based on 16-months (November 2021-February 2023) of ethnographic fieldwork and 47 semi-structured interviews conducted before and after the *Dobbs* Supreme Court decision (2022) overturning the right to abortion in the United States (US). Currently, 14 states have banned abortion and three have bans prior to six weeks of pregnancy. I assert that the criminalization of abortion care is a form of structural violence that leads to direct harm experienced by pregnant people. My dissertation strives to make significant contributions to theories of state-based violence with particular attention to reproductive governance, the anthropology of policy, and the politics of care. First, I develop my concept of *reproductive gerrymandering*, which names a particular phenomenon wherein the political power of voters who support reproductive healthcare access is suppressed across political party lines. It gives the false impression that the majority of residents in states that predominately elect Republican representatives want government elimination of abortion and related services. I argue that reproductive gerrymandering is a form of bureaucratic violence used to promote anti-abortion agendas, which then causes everyday structural harm to pregnant people. Second, building upon theories of agnotology, or the study of ignorance, I argue that “heartbeat” bans—legislation that advances medical misinformation—manipulates biomedical terms to imbue a particular social meaning to embryos at a very early stage of pregnancy. I explore how biomedical practices, in this case the use of ultrasound technology to detect a

“heartbeat,” furthers the cultural production of ignorance around pregnancy and sends a strategic message about the beginnings of life. Third, I demonstrate how constant fluctuations in abortion policy shape temporalities of care in clinic settings. Finally, I reveal three overlooked dimensions of reproductive governance to better understand political control of reproductive bodies: administrative and regulatory, the spread of ignorance, and the political reconfiguring of reproductive time. Ultimately, I argue for the conceptual value of attending to temporalities of structural violence, and specifically the pace with which political violence unfolds.

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Introduction: The Politics of Abortion in Ohio

About 7 months before *Roe v. Wade* was overturned in June 2022, I drove for 3 hours past sprawling wheat and corn fields to an abortion rally in a small town in Ohio called Smithcord.¹ The day before, I had seen a post on Instagram about a rally to oppose a city ordinance to deem Smithcord a “Sanctuary City for the Unborn.” Even though there are no abortion providing facilities in Smithcord, the ordinance would ban abortions within the city limits and would penalize individuals who provide assistance to anyone seeking an abortion. Smithcord was the third city in Ohio to propose this type of local act.

When I arrived at the meeting point in the center of town, I found a group of 15 to 20 locals chatting and grabbing signs that said “abortion is healthcare.” Before I could walk any further into the group, a woman who was about five feet and five inches tall with curly blonde hair stopped me to ask for my name and whether I had signed-up to join the rally beforehand. I confirm with her that I did in fact register for the event online and provide her with my name. She excuses her curtness and explains that they have to be careful because they don’t know if there might be a spy from the anti-abortion group. Shortly after, a woman who appears to be in her late twenties speaks to the group about how there are many more people who share their progressive values in Smithcord, but that they are afraid to speak out.

About an hour later as the sun is starting to set, one of the organizers tells us to make sure that the children are in the middle of the group as we walk to City Hall to attend the hearing. One of the organizers turns to me and says that she is really nervous. I shudder and think about how to protect the children in the group if it were to be necessary. I walk next to a group of three girls

who must be pre-teens, maybe 12 or 13 years old. When we turn the corner to Smithcord City Hall I am appalled at the sheer number of anti-abortion demonstrators. There were close to 200 men and women holding signs that read “Protect the unborn” and “Sanctuary City.”

I watch as a couple of the organizers against the ordinance go to the front of the line and ask if they can enter City Hall. Two police officers outside of the building are dressed in bullet proof vests and carrying pistols. They inform the pro-choice² organizers that we are not allowed to enter unless we live within Smithcord city limits. One of the organizers presses them a bit more and they say that if there is enough space we will be allowed to listen to the testimony in the hallway. After hearing this, I decide to retreat closer to the back of the line while I wait for the Smithcord residents to enter. Then I feel a tap on my shoulder from a dark-haired woman who is maybe in her early twenties asking if we have more signs. One of our group members gives her their sign. A few moments later I hear her engaging with an anti-abortion demonstrator who is holding a sign with bloodied limbs on it. I hear the young woman yell out “it’s my choice!” I gently place my hand on her arm and say “Why don’t you come stand with us? It’s not worth it to engage with them.”

Shortly after, I realize that I have lost the other pro-abortion group members and it’s just us two. Suddenly we are being surrounded by the anti-abortion protestors. The signs with gruesome body parts surround us and the dark-haired woman begins arguing with a man. I try to distract her by asking her questions about where she grew up and whether she swims in the lake nearby. She continues to argue with one of the men. The signs and the large men behind them continue to close in on us. The bald man next to me lowers his sign so his head sits perfectly atop it. He barks continuously “Do you care about unborn babies’ lives?!” I am trembling and trying

to determine how we can get out of this situation. I think about how one of these men could have a knife or a gun and there would be nothing that I could do.

All I wanted was to drown out their voices, drown out their words. I tell the dark-haired woman that I am going to play music. I hope that this might diffuse the situation. I hold up my phone between our ears and we both start to focus on the words in the song instead of the vitriol surrounding us. Suddenly, a tall man in his twenties appeared. He had pushed the bald man aside to allow us to follow him out of the crowd. We were able to follow him to the front of the line where the remainder of our group was waiting to go inside.

I sat through the testimonies in Town Hall and then left immediately, driving home without stopping. As I wrote up my fieldnotes later that evening, I reflected on how hostile the anti-abortion protestors were and how the members in my group felt as though the police had sided with the anti-abortion group. I also pondered how common these extremist anti-abortion views were in Ohio. I would later learn that the crowd of nearly 200 anti-abortion protestors were mostly from outside of Smithcord, whereas only two of the pro-choice demonstrators (of which I was one) were not from the town. What at first appeared to be a local battle over abortion rights revealed itself to be a national move to ban abortion, one headed by Pastor Mark Lee Dickson, the founder of the Sanctuary Cities for the Unborn Initiative and the director of Right to Life East Texas (Ms. Magazine 2023). Ohio is one of six states where Mark Lee Dickson has assisted local council members propose City for the Unborn initiatives. In the midwestern and southern regions of the US, it may appear as though an entire town, city, or state is brimming with anti-abortion extremists, but this is not the case. Whereas this dissertation could be written as a clashing of two worlds—anti- and pro-abortion—what became clear in my

fieldwork is how important it is to trace the strategies behind mechanisms of reproductive control as well as the impacts of those strategies.

Approximately 7 months after the clash in Smithcord, on June 24th, 2022 the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision overturned *Roe v. Wade* (1973), the landmark case that had established the right to abortion until viability. Although *Roe v. Wade* provided some protections, it did not make abortion fully accessible to all Americans. In many states, including Ohio, abortion access pre-*Dobbs* was already burdened by targeted regulation of abortion provider (TRAP) laws. However, the *Dobbs* ruling allowed for the passage of the most restrictive abortion legislation in nearly fifty years. As of May 2024, 14 states have completely banned abortion and three have banned abortion prior to six weeks of pregnancy (Guttmacher Institute 2024a). Ohio, in particular, is illustrative of restrictive anti-abortion legislation—a form of reproductive governance (Morgan and Roberts 2012)—that has been passed across the midwestern and southern US, and this state has proved to be a particularly informative fieldsite over the course of 16 months as abortion policy continued to change.

From November 2021 to February 2023, with generous support from the National Science Foundation Doctoral Dissertation Research Improvement Grant in Cultural Anthropology, I conducted ethnographic fieldwork in Ohio to investigate how abortion doulas (non-medical support persons), healthcare workers (physicians, counselors, nurses, and administrative staff), policy experts, and abortion support organizers (individuals who provide practical and/or political support for abortion) interpret, navigate, and overcome an unsteady and, even, hostile legal terrain that affects abortion access and care. My dissertation project was initially driven by three core questions: 1) How do social and economic inequalities figure into the provision of abortion care and advocacy? 2) How do everyday acts of resistance to anti-

abortion legislation take shape? 3) Finally, what lessons can be learned from efforts to provide care when access to abortion is uncertain? However, after the *Dobbs* decision was released, it became increasingly important to trace reproductive governance tactics to learn from this critical moment.

In this introductory chapter, I summarize my main contributions to anthropological literature concerning structural violence, feminist anthropology, and the politics of reproduction. Next, I provide a brief background on the politics of abortion in the US and the ethnographic setting (Ohio). I also provide an overview of my research methodology, data analysis, and ethical considerations. Finally, I provide an outline of the monograph.

Contributions to Anthropological Literature: Structural Violence

Scholars of violence have investigated collective trauma brought about by extreme events, such as war or genocide (Das 1996; Kleinman, Das, and Lock 1997), and everyday or structural violence that exists in the quotidian, such as poverty or limited access to basic medical care (Galtung 1969; Scheper-Hughes 1993; Das 1995, 1996; Farmer 1996a; Scheper-Hughes 1996; Das 2007). Structural violence, in particular, refers to the way in which social structures or social institutions harm certain groups (Das and Kleinman 2000; Das et al. 2001; Das 2007) in an indirect yet systematic manner (Farmer 2004, 307). Attention has been paid to the historical circumstances that contribute to or lead to health inequities (Farmer 1996b; Scheper-Hughes 1993; Biehl 2005) and to the ordinary violence that occurs in the aftermath of a particular event (Das 1995). For Veena Das, a critical event is a moment of rupture and transformation in that it “attaches itself with its tentacles into everyday life and folds itself into the recesses of the ordinary” (2007b, 1). Extreme events do not exist in isolation; there is a build-up and an

aftermath that arises in the everyday that can reveal the structural harm experienced by certain groups. Smaller moments of build-up are unremarkable by themselves, but when considered as a whole make apparent issues of inequality in everyday violence (Povinelli 2011; Han 2012). The circumstances of my fieldwork, occurring both before and after the momentous *Dobbs* decision, provided a particularly useful vantage point to examine the historical factors leading to this moment as well as the ordinary violence that existed before and erupted after the *Dobbs* decision.

A careful analysis of violence—both extreme and quotidian—also reveals the importance of attending to the pace with which violence unfolds. With the exception of environmental studies scholar Rob Nixon (2013) who coined the term “slow violence,” little attention has been paid to the speed with which structural violence emerges.³ Slow violence is incremental, difficult to track, and, thus, relatively invisible (Nixon 2013, 2). It encompasses how years, decades, or even centuries of compounded trauma can lead to structural harm, such as the effect of toxic exposure on humans and their environment (e.g., Ahmann 2018). Further, drawing on Joseph Masco’s (2020) discussion of multiple temporal frames associated with nuclear fallout (the short-term threat of radiation and the long-term threat of cancer and shortened life expectancy), I contend that there are multiple temporal frames associated with political violence. In other words, studying structural violence in terms of its temporal dimensions draws attention to hidden harms. I advance these works by arguing for the importance of attending to the pace with which structural violence emerges with particular attention to how time is structured, navigated, and experienced.

Contributions to Anthropological Literature: Feminist Anthropology and the Politics of Reproduction

The politicization of healthcare access is never more pronounced than when gender, sexuality, and reproduction are entangled, as is the case in the US. Feminist scholars have contributed to theoretical debates concerning care, especially in relation to social and sexual reproduction. More specifically, feminist anthropologists began contending with questions concerning gender inequality in the 1970s (Ortner 1972; Rosaldo, Lamphere, and Bamberger 1974; Reiter 1975). At this time, they disrupted normative assumptions about women as domestic caretakers who suffer from universal subordination by studying gender dynamics across societies. They interpreted the meaning of gender beyond a particular place by exploring "broader patterns of meaning, interaction, and power" (Lewin 2006, 20). In particular, many raised questions about the social and economic conditions from which different forms of gender and sexuality arise. Rubin introduced the notion of a "sex/gender system" to describe how societies form their own customs based on biological and social characteristics (1975, 165). According to Rubin (1975), a political economy analysis of sex/gender systems is necessary to establish an understanding of the arrangement of sex and gender and how such systems are developed and perpetuated (177). By way of the ethnographic method, anthropological studies served to provide a cross-cultural comparative perspective to examine gender practices in different settings to interrogate the historical and cultural context from which gender arises.

In the late 1980s and increasingly in the 1990s, feminist anthropologists brought issues related to the politics of reproduction to the forefront of gender studies. Anthropologists wrote about sexual politics, such as demographic policies promoting fertility control in a Mexican indigenous community (Browner 1986), pronatalist policies banning birth control in Romania

(Kligman 1995), abortion debates and associated activism in the US (Ginsburg 1989), and the politics of lesbian motherhood in the US (Lewin 1995). In particular, the concept of stratified reproduction was created to refer to how "physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces" (Colen 1995, 78). Essentially, social forms of difference shape who is expected to shoulder social and sexual reproductive tasks. These scholars interrogated the mechanisms by which sexual reproduction is monitored, controlled, and resisted. Most importantly, they examined how multiple and overlapping identities inform social experiences of reproduction and the ability to access sexual and reproductive health resources.

Consequently, multiple and overlapping experiences of inequality are especially important to studies of reproduction (e.g., Colen 1995) and, in particular, the way in which race and reproduction are deeply entangled (Colen 1995; Roberts 1997; Collins 1999; Bridges 2011; Davis 2019; Mullings 2005; Rapp 2019; Andaya 2019a; Franklin and Ginsburg 2019; Sufrin 2019; Cromer 2019a). Prominent reproductive scholars have asserted the importance of investigating the interrelations of gender, race, and nation (Collins 1999; Franklin and Ginsburg 2019). In making this case, various scholars in recent years highlight the connections between race and abortion by examining white Christian nationalism and Trump administration anti-immigration policies (Franklin and Ginsburg 2019; Andaya 2019a; Cromer 2019a), the carceral restriction of abortion (Sufrin 2019), and the racial politics of frozen embryo personhood (Cromer 2019b). Reproductive politics are entangled with broader social and political movements (Briggs 2017) that produce gendered and racialized ideologies about the ability to reproduce and the circumstances under which reproduction should occur.

Similar to how early feminist anthropologists questioned the meaning of gender across cultures, feminist reproductive scholars ask under what conditions do seemingly innocuous medical processes, such as amniocentesis or the consumption of fetal sonograms, present themselves as having intense social and political meaning (e.g., Rapp 1999; Taylor 2008). Ultimately, scholars concerned with the politics of reproduction found that seemingly objective medical explanations for reproductive processes are undergirded by social and political motivations. The importance of analyzing social and cultural interpretations of reproductive processes is to uncover how they can be framed and used for political purposes, especially in relation to reproductive health care and access. I build upon this work to reveal the underlying political strategies used to frame seemingly objective medical processes in a highly politicized manner.

Demographers and sociologists have been exploring the effects of anti-abortion legislation across the US (Foster 2020; Cohen and Joffe 2020). Foster (2020), for instance, has studied the implications of having had or being denied an abortion, debunking many common American myths about the negative impacts of having an abortion. Further, Cohen and Joffe (2020) illustrate the obstacles one must overcome in order to have an abortion in the US; they also identify a breadth of individuals who assist pregnant persons in obtaining one.⁴ The importance of such investigations is that they address how policy shapes access, or lack thereof, to abortion, demonstrating the deleterious impacts of anti-abortion legislation. I build upon this work by focusing on both individual and organizational responses to anti-abortion legislation with special emphasis on localized interpretations of state policies and how they affect abortion care.

Until very recently, little social science qualitative research had been done on the everyday struggle to obtain or provide an abortion in areas of scarcity and precarity in the US (cf. [Arey 2021](#); [Alterman-Paradisi 2023](#)). Much of the research on access to abortion has been quantitative and tends to focus on distances to the nearest abortion provider (Jones and Jerman 2013; Gerdtts et al. 2016; Jones and Jerman 2017a; Bearak et al. 2020). Social scientists have begun to explore how provider scarcity and bureaucratic regulations—not just geographical distance—shape access to abortion in the US and elsewhere (Mishtal 2015; De Zordo, Mishtal, and Anton 2017; Ostrach 2017; Cohen and Joffe 2020). For example, Cohen and Joffe (2020) broadly outline the different barriers to abortion access in the US such as difficulty finding a clinic, cost, anti-abortion protestors, and waiting periods. A key goal of my own research is to contribute to such understandings by investigating the shifting tensions and moments of legal precarity as new legislation is passed and abortion clinics are no longer able to provide services.

The provision of abortion care and the context in which it is received has changed dramatically in the past few decades with new state legislation, declining access to care, the advent of medication abortion and telemedicine, new trends in national politics (including the rise of reproductive justice as both an analytical and activist framework), a global pandemic and, most recently, the overturning of *Roe*. To be clear, throughout this dissertation I refer to two types of abortion: medication and procedural. Medication abortion is when two types of pills (mifepristone and misoprostol) are given sequentially to stop the production of progesterone and to induce uterine cramps. In Ohio, mifepristone must be taken in front of the prescribing physician and misoprostol can be taken up to 48 hours later without supervision. The Food and Drug Administration allows mifepristone and misoprostol to be used through 10 weeks of pregnancy. Procedural or in-clinic abortion is when a suction device, also known as vacuum

aspiration, is used to remove the pregnancy tissue and can be used up until the gestational limit in Ohio: 21 weeks and 6 days of pregnancy (see Figure 1 below). Traditionally, this type of abortion has been referred to medically as a “surgical abortion,” but there has been a recent effort to change the phrase to procedural abortion to better reflect the actual procedure. For the purposes of this study, and to avoid confusion, I do not use the term surgical abortion because, in such instances, no incision has been made (ACOG: The American College of Obstetricians and Gynecologists 2023; Planned Parenthood 2024). Following the lead of many of my interlocutors, I use the expression “procedural abortion” to refer to in-clinic suction abortions. With this changing landscape, it is important to study how these shifts have affected abortion care and political resistance efforts. Thus, my research examines the everyday discursive formations that figure in abortion care with Ohio serving as an important case example of US trends.

Figure 1: Timeline of Normal Pregnancy

Day 1: First day of the last menstrual cycle before becoming pregnant.

Weeks 2-3 (approximately): Ovulation and fertilization of egg.

Week 4 (approximately): Fertilized egg implants to the uterine lining and begins to reproduce as a cluster of cells.

Week 5: The pregnancy, in medical parlance, is now referred to as an embryo. When an at-home pregnancy test can be used accurately.

Weeks 5-7: Embryonic electrical impulses can usually be detected with transvaginal ultrasound. When Ohio Senate Bill 23 ban was in effect, abortion was illegal after the detection of electrical impulses.

Week 9 and 6 days: Medication abortion is not allowed after this point in Ohio.

Week 10: Medically speaking, the pregnancy is generally described as a fetus after this point.

Weeks 19-22: All four chambers of the fetal heart have formed.

Weeks 20 through 25 weeks and 6 days: According to the American College of Obstetricians and Gynecologists (2024), this is the range for periviability or when there is a small chance of fetal survival outside of the pregnant person's body with medical intervention.

Week 21 and 6 days: Abortion is currently illegal after this point in Ohio.

Week 39: Fetus is considered full-term.

Week 40: The approximate "due date."

A Brief History of Abortion in the US and the rise of the Reproductive Justice Movement

Abortion has not always been the incendiary topic of public political debate that it is now in the US. Prior to the mid-19th century, midwives and lay-practitioners provided abortions without regulation. The initial movements to criminalize abortion were led primarily by the American Medical Association in the 1860s and 1870s with the intention to legitimize physician control over reproductive health procedures (Ehrenreich and English 2010 [1972]; Ginsburg 1989, 32). By the early twentieth century, many states criminalized abortion after quickening, when a pregnant person can sense fetal movement, unless a physician deemed the abortion necessary, known as a therapeutic abortion exception (Ferree 2002). However, this exception was unevenly applied such that white middle- and upper-class women were most likely to benefit (Reagan 2010, 112). Establishing control over women's reproductive health provided medical doctors with new clientele who had previously relied upon midwives and lay health care providers for their reproductive health needs.

From the late 1800s to the early 1950s, the criminalization of abortion remained consistent. However, after World War II, medical knowledge had increased and abortion became safer to perform at a time when increasing concerns about "fetal abnormalities and unequal access to abortion" mobilized physicians to join the movement to decriminalize abortion (Munson 2018, 30-31). Subsequently, doctors began performing more abortions under a broader definition of "health" and medical necessity (Munson 2018, 29). Sociologist Munson argues that three factors pushed abortion into public debate in the mid-1900s: "the Catholic Church's public opposition to abortion, the increasing political importance of the women's rights movement, and the high-profile media attention given to the plight of a particular pregnant woman, Sherri Finkbine" in 1962 (2018, 32). Sherri Finkbine had taken thalidomide, a morning sickness medication, while pregnant with her fifth child and found that the medication was known to cause severe birth defects. Even though this affected over 10,000 pregnant people, Finkbine's story in particular quickly became a public sensation after she was denied an abortion. Munson provides this context to outline how abortion became a source of public controversy in the 1960s, the decade leading up to the single most influential abortion ruling in recent US history, *Roe v. Wade* (1973).

In 1973, the *Roe v. Wade* Supreme Court ruling established the right to an abortion in the first trimester. However, the extent to which states could regulate the ability to obtain an abortion in the second and third trimesters was not addressed by the *Roe* ruling and was determined by individual states. Indeed, *Roe v. Wade* explicitly conditioned that states may restrict the right to abortion: "the right [to an abortion], nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to protection of health, medical standards, and pre-natal life, become dominant" (*Roe v. Wade* Opinion of the Court). Barriers to abortion

access disproportionately affect low-income pregnant people of color and individuals who live in rural areas (Cohen and Joffe 2020). In other words, the *Roe* ruling also primarily benefitted white upper- and middle-class women in urban areas.

By the 1980s, the wide ranging (what is now known as) neoliberal policies championed by the Reagan administration (also known as "Reaganomics"), affected abortion politics. Part of this new agenda was to cooperate with the New Right to create a narrative to demonize welfare. Mary Ziegler, a law professor, quotes Reagan from a speech in 1981 reciting the story of a young woman who he claims "had become so dependent on the welfare check that she even turned down offers of marriage" (quoted in Ziegler 2015, 149). In other words, Reagan framed women on welfare as defying traditional heterosexual marital norms due to their dependency on state assistance and accused these women of exploiting the system to avoid having to work. In Ziegler's analysis, Reagan presented this parable to assert the need for economic self-sufficiency to "save the family and revive an ailing economy" (2015, 149). According to anthropologist Faye Ginsburg (1989), the New Right was characterized by a mixture of "libertarian celebration of individualism, economic freedom, and capitalism, and a traditionalist emphasis on community, moral order, and the like" (46-47). These values or "new moralisms" led the New Right to unite with the National Right to Life Committee (NRLC), which was a well-organized cross-class social movement with a single issue that had not previously been associated with a particular political party (Ginsburg 1989, 47). At the time, pro- or right to life, or what I refer to as anti-abortion,⁵ movement groups were utilizing "direct action techniques—creating and imposing local ordinances, harassing local abortion providers, picketing facilities or staging sit-ins at clinics" (Ginsburg 1989, 44). According to Ginsburg, as the anti-abortion movement continued

to gain momentum alongside the New Right, feminist arguments for abortion rights were losing the power they once held in the 1960s and early 1970s (1989, 46).

After the anti-abortion movement had created a strong counter-movement and the Hyde Amendment was passed in 1976, a rhetoric of “choice” was adopted by pro-abortion activists in the late-1970s (Ziegler 2015, 129). The Hyde Amendment disallowed the use of federal funds for abortion at home and abroad, which made it even more difficult for low-income individuals to obtain an abortion.⁶ Feminist organizations, such as National Abortion Rights Action League (NARAL), National Organization for Women (NOW), and Planned Parenthood, attempted to counter the anti-abortion movement with their own single-issue platform based on an argument for choice and the right to privacy without government interference (Ziegler 2015, 139).

Beginning in 1978, NARAL held rallies with slogans like "Freedom to Choose Is the American Way" and "Freedom Is the Right to Choose" (Ziegler 2015,139). The focus of these organizations became primarily preoccupied with the right to abortion in an attempt to protect *Roe* from attacks by the anti-abortion movement. Framing abortion as a "choice," however, implies that all Americans are able to “choose” whether or not to have an abortion, which obscures the social and economic constraints that hinder the ability to continue or discontinue a pregnancy. Further, a narrow focus on abortion fails to acknowledge and politically mobilize against other reproductive injustices suffered predominantly by poor women and women of color, such as sterilization abuse (the forced removal of an individual’s ability to reproduce).

In response, in 1994 twelve women of color who were reproductive health advocates developed the phrase “reproductive justice” to encompass the full spectrum of reproductive health services (Leonard 2017, 39). The concept emerged during a meeting to compose a request for full reproductive health services in a response to the Clinton administration's Health Security

Act that had been proposed. Reproductive rights advocates of color formed the reproductive justice framework to account for the problematic nature of choice that discounted other reproductive rights issues. The reproductive justice framework goes "beyond the pro-choice/pro-life debate and has three primary principles: (1) the right *not* to have a child; (2) the right to *have* a child; and (3) the right to *parent* children in safe and healthy environments" (Ross and Solinger 2017, 9). By doing so, they included far more than a call for reproductive health and rights. Instead, reproductive justice links to other social justice efforts such as climate change and housing reform to promote the right to parent in safe and healthy environments. These connections to other aspects of health are integral to the expansive nature of reproductive justice. The decision to shift the discussion from choice to justice, allows reproductive justice advocates to discuss the complications inherent to the lived reality of constrained reproductive decisions.

The problematic language of *Roe v. Wade*, the individual rights-based arguments set-forth by the pro-choice movement, and the fracturing of the reproductive rights movement have contributed to this contemporary moment in which states, especially across the Midwest and South, have enacted complete or near-complete abortion bans now that *Roe* has been overturned. Times of crisis, such as that of abortion access in the US, expose existing structural fault lines in social and political institutions. Yet, I argue that these moments of rupture are also ripe for innovative responses to injustice. In recent years, there has been a particularly strong interest in the current political moment as a *crisis of care* in need of a drastic political reorientation (Fraser 2017; Brugère et al. 2019; Care Collective et al. 2020; Spade 2020). A crisis of care suggests that the current social and political systems that are in place have reached a breaking point wherein change is necessary. Throughout this dissertation, I make connections between state or local policies and the lived realities of the provision of abortion care. In doing so, I aim to demonstrate

how one might learn from this current crisis to better understand previously overlooked dimensions of reproductive governance.

Ohio: A Case Study for the US

Ohio is of particular significance for a study of abortion access and care because the state epitomizes the political polarization encountered in the US, namely debates regarding personhood (Cromer 2019b) and the "War on Women" (Rohlinger 2015), or associated efforts to minimize or prohibit access to abortion (Cohen and Joffe 2020; Foster 2020). In Ohio, where the state population is nearly 12 million (U.S. Census Bureau 2023), over the past decade abortion services have been in sharp decline. For instance, in 2017 there were 17 abortion providing facilities in the state; three years later that number had dropped to 12 (Guttmacher Institute 2021). This significant decrease is further compounded by social, economic, and, most recently, travel barriers to accessible abortions (Fuentes and Jerman 2019; Cohen and Joffe 2020; Foster 2020). By 2017, 93% of the 88 counties of Ohio did not have an abortion provider (Guttmacher Institute 2021). Before and during my fieldwork, restrictive abortion legislation and fluctuations in access to care were persistent issues (see Figure 2 below). As of May 2024, abortion regulations included state-directed counseling designed to discourage the patient from having an abortion and a mandatory ultrasound with a description of the image at least 24 hours prior to a pregnancy termination, necessitating a minimum of two trips to the clinic. For these reasons, I argue that Ohio is illustrative of heated national debates regarding abortion access and women's reproduction.

Importantly, Ohio has been labeled a political bellwether and is known as a "purple state" or a mix of red (Republican) and blue (Democrat) that is not dominated by one political party.

The state has been characterized as a microcosm of the US because of its similar demographic makeup⁷ and strong rural-urban divide, wherein densely populated cities tend to vote for Democratic candidates and less populated areas tend to vote for Republican candidates (Sracic and Binning 2016, 6). Moreover, the state has been implicated in other polarizing national debates concerning voter suppression and gun control (AP News 2021; 2News wdtm 2021). In fact, since 1960 Ohio's presidential voting results aligned with the candidate who won the popular vote until the past two elections in 2016 and 2020. Ohio is the ideal setting to conduct a case study of the politics of abortion care in the US because the state exemplifies the political polarization encountered across the US.

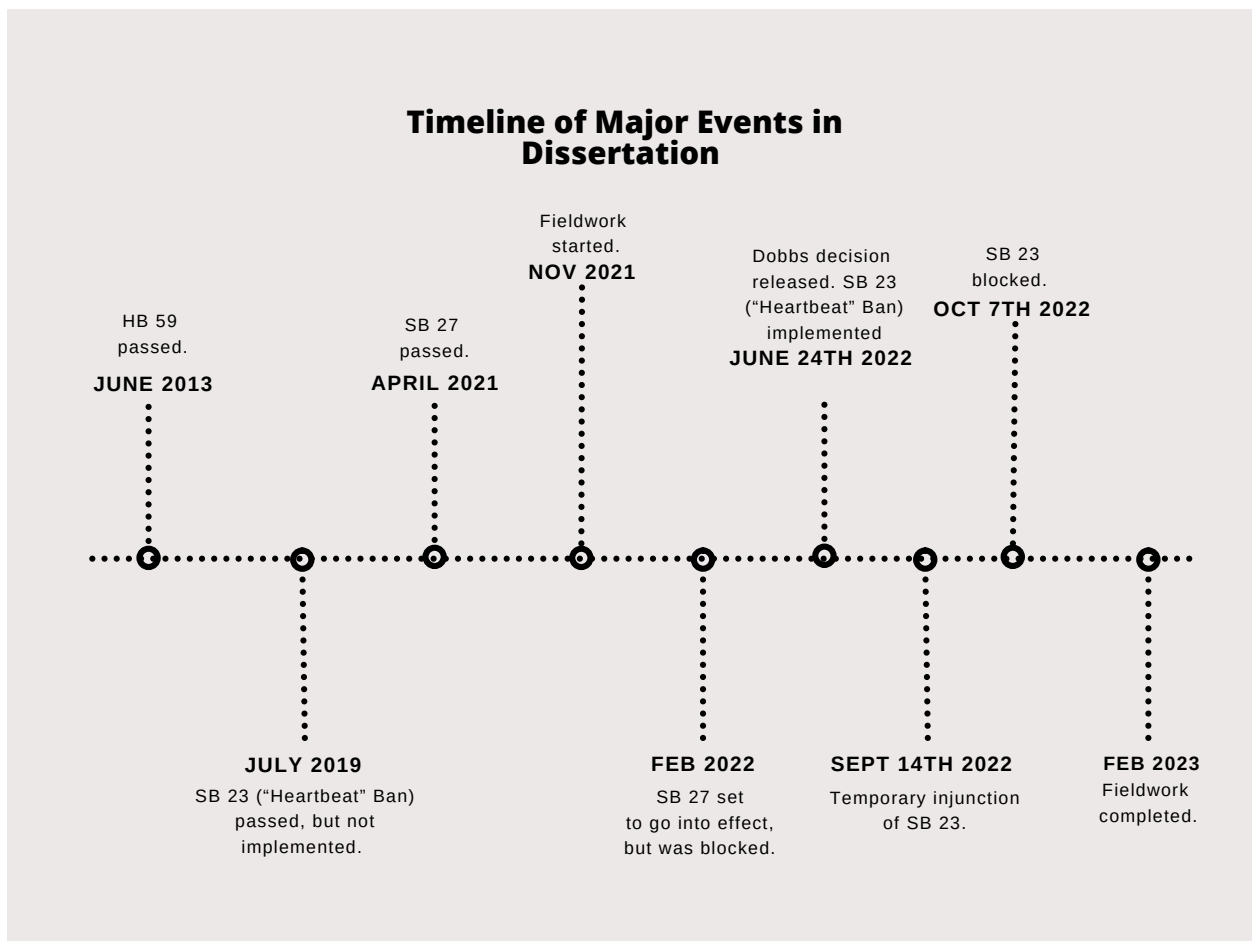


Figure 2: Timeline of Major Events in Dissertation (timeline template downloaded from Canva: Galvez 2024)

KEY: Ohio Legislation

House Bill 59 mandates that physicians determine whether a “fetal heartbeat” is present and require both the physician and patient to sign the form.

Senate Bill 23 banned abortions after embryonic electrical impulses could be detected or what the state deemed a “heartbeat.”

Senate Bill 27 required clinics to have an arrangement with a funeral home to individually cremate or bury the pregnancy tissue from a procedural abortion.

Methodology

I conducted a 16-month ethnographic study on the politics of abortion care in Ohio from November 2021 to February 2023 as abortion policy continued to change before and after the *Dobbs* Supreme Court decision. My research methodologies included participant-observation, semi-structured interviews, textual/media analysis, and policy analysis. Participant-observation involves spending an extended period of time with individuals to be an active participant in their everyday life experiences (Malinowski 2002 [1922]; Bernard 2006; Sufrin 2015; O’Reilly 2012). It takes time to build rapport with informants, especially for sensitive and stigmatizing research topics (Alty and Rodham 1998; Gaglio, Nelson, and King 2006; Boeri and Shukla 2019; Watkins-Hayes 2019). As Kumar et al (2009) have noted, abortion is highly stigmatized and leads those who are involved in abortion care to be secretive about their personal and work experiences (see also Hanschmidt and et al 2016; Sanger 2017; Cohen and Joffe 2020). A central characteristic of ethnography is that the researcher be present for an extended period of time to

gain the trust of informants (Malinowski 2002 [1922], 8-9). For this reason, a long-term ethnographic study was necessary for this research topic.

Instead of choosing one location to conduct my fieldwork, I decided to follow anti-abortion policies across Ohio and surrounding states. As policy ethnographer Yanow states, when conducting an ethnography of policy, “[t]he policy itself is the site, not some geographically bounded entity. A policy issue’s borders are more diffuse than those of a village or city: no civil administrator or planner has drawn a red line around it on a map” (2011, 306). By following a moving ethnographic subject, I did not conduct sustained participant observation in one setting. In order to capture how state-wide anti-abortion legislation affects everyday abortion care, I visited four clinics and conducted interviews with individuals across Ohio and in surrounding states to gain an understanding of how anti-abortion policies are interpreted, navigated, and resisted in different settings.

Because of the COVID-19 pandemic, I attended virtual and in-person events depending on the risk of transmission. I attended abortion doula trainings and meetings (non-medical support volunteers); trained and volunteered as a clinic escort; visited four abortion clinics; attended city ordinance meetings and state-house hearings concerning abortion legislation; and participated in pro-abortion/pro-choice events and rallies. This dissertation was initially envisioned as a project focused on abortion doula care, but quickly transformed into a study of anti-abortion tactics and responses when it became clear that the *Dobbs* decision would completely transform the abortion access landscape. Still, abortion doulas were my entry-point into what would become a radically different terrain for reproductive health care. I attended a total of three abortion doula trainings, including one for virtual support. Virtual doula care includes speaking to individuals who plan to have a medication abortion over phone or text. Each

doula volunteers to provide support during a block of time and uses a shared Google phone number to respond to texts and calls from clients. I volunteered weekly for one year as a virtual abortion doula, though the doula group had very few clients contact the phone line. I do not know why the phone line had few calls because I did not interview patients; perhaps patients were unaware of the work volunteer doulas do, they did not feel empowered to request these services, or were too overwhelmed by the more immediate complexities of accessing abortions to focus on emotional or physical needs. I also trained with a second doula group that provides in-person, clinic-based abortion services where each patient is asked if they would like to be accompanied by a doula for their procedure. I did not volunteer for the second doula group, but according to my interlocutors the in-clinic model of doula care has been successful in securing clients. I have also found this to be the case in a previous study of abortion doulas that I conducted for my master's thesis (Basmajian 2014). Throughout my fieldwork, I collected news articles, doula and clinic pamphlets, clinic forms, doula promotional materials, screenshots of social media posts, and educational resources to conduct textual analysis.

Additionally, I conducted 47 semi-structured interviews with 42 participants (see Table 1), including 18 healthcare workers (physicians, counselors, nurses, and administrative staff), 10 abortion support organizers (individuals who provide practical and/or political support for abortion), 10 abortion doulas, and 4 policy experts. In my discussions with informants, I made it clear that I believe that abortion is healthcare and should be treated as such. It not only seemed impossible to separate my subjective notions about the topic, but making my stance clear allowed a sense of camaraderie between myself and my informants. Had I not made my position on abortion clear, I would not have been able to build rapport with individuals who work in abortion care. As shown in Table 2, I completed 23 of the interviews prior to the *Dobbs* decision

and conducted five follow-up interviews and numerous informal conversations with abortion support organizers and healthcare staff with whom I had interviewed prior to the ruling to gain a comparative perspective of their experiences. By choosing to conduct my fieldwork in Ohio, I was at ground zero to study how individuals were affected by the fluctuation and uncertainty of abortion access as new legislation was introduced.

Both the pandemic and the fluctuations in abortion access made it difficult to access healthcare workers at times. For example, I was unable to conduct sustained participant-observation in the abortion clinics; however, I received tours of four abortion clinics in three Ohio cities and was able to gain a sense of how patient care is handled at each location. During the pandemic, social and digital media became increasingly important realms for sociality and thus offered the ability to study meaning-making in digital forms (Saxena and Johnson 2020). Faced with the challenges of conducting ethnographic fieldwork during a pandemic, I found that it was necessary to pivot from in-person to virtual research depending on the risk of Covid-19 transmission. Even though I had met many of my interviewees in person, nearly all of the interviews were conducted over HIPAA compliant and encrypted Zoom. This allowed me to interview participants who were geographically distant and for my interviewees to find a private quiet place to complete the interview. Despite these difficulties I fostered relationships with healthcare staff, doulas, abortion support organizers, and policy experts across Ohio.

Table 1: Sampling for Semi-structured Interviews

Participants		Interview Type	Sample Size (N)
Healthcare Workers	Administrative staff (6)	Semi-structured	18
	Physicians (5)		
	Nurses (4)		
	Counselors 1		
Abortion Doulas (non-medical volunteers)		Semi-structured	10
Abortion Support Organizers (individuals who provide practical and/or political support for abortion)		Semi-structured	10
Policy Experts		Semi-structured	4
Total			42

Table 2: Semi-structured Interviews in relation to *Dobbs v. Jackson Women’s Health Organization* Supreme Court Decision (2022)

Timeline of Interview	Interview Type	Sample Size (N)
Pre- <i>Dobbs</i> Interviews (November 2021-June 2022)	Semi-structured	23
Post- <i>Dobbs</i> Interviews (June 2022-February 2023)	Semi-structured	19
Follow-up Interviews Post- <i>Dobbs</i> (July 2022-November 2022)	Semi-structured	5
Total		47

Data Analysis

At the onset of data collection, I conducted preliminary data analysis of text and media (for policy and textual/media analysis), interview transcripts, fieldnotes, and timelines to track and organize emerging themes. During participant-observation, I took comprehensive fieldnotes (Wolfinger 2002, 90-92) in two forms: descriptive and reflective (Creswell and Poth 2018, 168). I took descriptive notes to describe the setting and interactions that were taking place, whereas my reflective notes captured my sense of an experience or event. By taking fieldnotes during events and everyday interactions, I generated "inscriptions of social life and social discourse" to analyze with respect to the research questions (Emerson, Fretz, and Shaw 2011, 12). To complement my fieldnotes, I wrote a monthly field report or "in-process memo" to develop initial impressions and unpolished theoretical insights (Emerson, Fretz, and Shaw 2011b). These memos served as a space to document my reflections of the month and to experiment with preliminary theories. During data collection and analysis, I paid particular attention to the themes described in the research questions. For question 1, I examined how social and economic inequalities figured into the provision of abortion care and advocacy. For example, I tracked when informants invoked race, ethnicity, gender, immigration, economic status, and/or geographic marginalization in their discussions of abortion access and care (Emerson, Fretz, and Shaw 2011b). Additionally, I took note of how healthcare workers, abortion support organizers, doulas, and policy experts discussed their personal political orientation in relation to multiple and overlapping forms of oppression. This dissertation focuses primarily on the data collected with clinic staff. As I discuss in subsequent chapters, I found that clinic staff tended to fall back on superficial, anecdotal, or generic statements concerning race and class inequities with respect to abortion access. This may be because they did not want to paint a singular picture of abortion

patients yet, in the day-to-day, these variables were not at the forefront of their thoughts. It is important to realize, too, that in the national discourse, there has been a focus on normalizing abortion by framing the “abortion patient” as anyone you may know, such as the “one in four campaign,” which stresses that one in four women in the US of reproductive age will have an abortion (Guttmacher Institute 2024b). It is also possible that they were focused on navigating a crisis situation and not how patient identities affected access to care: during the SB 23 ban, nearly all patients—regardless of social class, racial or ethnic identity, or age—could not access care in the state. In future publications, I intend to examine the intersections of race and abortion advocacy in Ohio, which will better address how race and class shape access to abortion care. In terms of age, there was little discussion except for a few stories about minors who had abortions. Staff made it clear that these cases were uncommon, but were nevertheless the most memorable patients because of their young age. For research question 2, I tracked how anti-abortion legislation and the violence that results take shape in the everyday provision of care. Finally, for research question 3, I traced transformations in abortion care by noting informants’ descriptions of innovation and improvisation in care practices and in political resistance strategies.

To assist in my data analysis, I utilized Atlas.ti software to assist in coding and analyzing themes. Through the use of semi-automatic coding, Atlas.ti is able search text documents for similar words or meanings as previously coded text to ensure that analysis is systematic (ATLAS.ti and Muhr, n.d.). Atlas.ti promotes a grounded theory approach to data analysis from which the ethnographer develops themes and theories directly from the data (Glaser and Strauss 1967; Charmaz 2014).

Following the grounded theory approach (Glaser and Strauss 1967; Charmaz 2014), I identified potential themes while maintaining that data analysis is an iterative process that will

need to be continuously reworked. With this in mind, I utilized a data analysis spiral (Creswell 2007). First, I organized my files into folders in Atlas.ti for each type of data (e.g., transcripts), which were then arranged chronologically. I then read the documents and annotated in the margins of the text. After reading and annotating, I began open coding by noting different categories to identify common themes (Emerson, Fretz, and Shaw 2011a, 182-183). As new themes emerged, I revisited my original research questions and interview guides and reshaped them as needed. I also viewed my informants as collaborators and discussed preliminary findings in follow-up conversations with a few of them throughout the data collection process (Carpenter 2018; Watkins-Hayes 2019).

Research Ethics

All study participants provided their consent to participate in a recorded semi-structured interview. They were also informed about the plan for dissemination of the study findings and notified of the potential harms of the study as well as the ways in which their anonymity would be protected. For this study, a breach in confidentiality would be problematic because of a loss of privacy, but it might also place informants at risk for violence from anti-abortion organizations (National Abortion Federation 2019). In order to minimize potential harm to participants, I received a waiver of documentation of consent from the Columbia University Institutional Review Board based on regulation 45 CFR 46.117. I also requested and received a certificate of confidentiality from the National Institutes of Health. These additional practices can further protect informants' confidentiality by minimizing the number of documents with their name and lessening the possibility of a subpoena⁸ by gaining federal recognition that this is confidential data. As the sole researcher, only I had access to the audio-recordings to minimize the risk of a

breach of confidentiality. I spent endless hours transcribing the semi-structured interviews to avoid sharing data with another person or uploading it to a digital application where the audio could be leaked. After transcribing the interviews, I erased them to avoid keeping them in my possession longer than necessary. When writing fieldnotes (and throughout this study and related publications), I used pseudonyms for informants and kept a record of their first names and pseudonyms in a Word file on my password protected external hard drive, which was kept in a locked filing cabinet in my place of residence. In addition, I anonymized the specific study locations within Ohio to protect my informants. Due to the sensitive nature of the research topic and interviews, I have taken care to ensure that I am the only individual with access to the research participants' identifiable information.

Outline of the Monograph

I have organized this dissertation into three chapters. In Chapter 1, I argue that partisan gerrymandering and the passage of anti-abortion legislation are intimately connected in what I call *reproductive gerrymandering*. I develop the concept of *reproductive gerrymandering* as an analytic tool for understanding the use of partisan gerrymandering to elect a supermajority of extremist Republican officials who are then able to pass unpopular legislation restricting reproductive healthcare access. In Chapter 2, building upon theories of agnotology or the study of ignorance, I argue that “heartbeat” bans—legislation that advances medical misinformation—manipulates biomedical terms to imbue a particular social meaning to embryos at a very early stage of pregnancy. I explore how biomedical practices, in this case the use of ultrasound technology to detect a “heartbeat,” furthers the cultural production of ignorance around pregnancy and sends a particular message about the beginnings of life. In Chapter 3, I

demonstrate how constant fluctuations in abortion policy shape the temporalities of care and provide insights into how the push and pull of temporal markers shape the care in clinic settings. My dissertation follows the politics of abortion care from within the walls of abortion clinics to the politically heated Ohio statehouse. By doing so, I reveal strategies and impacts of reproductive governance to better understand political control of reproductive bodies.

Chapter 1: Reproductive Gerrymandering, Bureaucratic Violence, and the Erosion of Abortion Access in the US

“Ohio is not a 90% red [Republican majority] state, Ohio is a rigged state and that rigging is happening by very specific people who have a lot of power; power that was not necessarily given to them by the people of Ohio.” —Charlotte, a 28-year-old pro-abortion political organizer

On June 25th, 2022 a day after the *Dobbs v. Jackson Women’s Health Organization* (2022) Supreme Court decision was released, I sat in my Cleveland, Ohio apartment, joining a post-*Dobbs* community discussion over Zoom held by an Ohio pro-choice organization. The discussion was held in response to the decision to overturn *Roe v. Wade* (1973), the landmark Supreme Court case that had determined the right to abortion, and the abrupt implementation of Ohio Senate Bill 23 (SB 23) (2019), known as the “Heartbeat Bill,” banning abortion after the detection of embryonic electrical impulses or at approximately six weeks of pregnancy. In a healthy pregnancy, these cells will later develop into a heart; however, as I explain in Chapter 2, the use of the emotionally-charged word “heartbeat” at this gestational age is medically and scientifically inaccurate. In a matter of hours after the *Dobbs* Supreme Court decision, nearly all abortions in the state were banned. The host of the webinar angrily described how “we have been fighting against the full force of the state government for over a decade. They [the Republicans] gerrymandered the state under their control after the last census [in 2010], and they have a manufactured majority in Columbus... [they have] drawn even worse districts because they’re afraid to face us.” She then began to cry softly and promised to answer questions about the future of abortion access, but there was a sense of despair in her choked voice. As I watched the tears

fall down her cheeks, I was taken aback by how pervasive the connection between gerrymandering and anti-abortion legislation had become in Ohio.

For over a decade, partisan gerrymandering has been intimately linked to the passage of anti-abortion legislation across much of the US. In this chapter, I present *reproductive gerrymandering* as an analytic tool for understanding the disjuncture between the passage of laws restricting reproductive healthcare access and the will of the majority of voters.

Reproductive gerrymandering is apparent in contexts like Ohio where partisan redistricting has been used to elect a Republican supermajority in the Statehouse. Even though these actions are not supported by the majority of Ohio constituents, Republican legislators have passed anti-abortion legislation and manipulated state budgets to fund anti-abortion groups while defunding other reproductive health services.

Gerrymandering, more broadly, is the deliberate manipulation of electoral district lines to benefit one political party or group, and it has been used by both Democrats and Republicans to create an unfair advantage. The term originated in 1812 when Massachusetts governor Elbridge Gerry established partisan districts that privileged his political party, one of which was shaped like a salamander; a local newspaper referred to this by employing the pun of “gerry-mander” (Medvic 2021, 39). Gerrymandering has been a particularly effective tool to dilute the voting power not only of a single political party but also of certain groups, particularly Black voters (Whitby 1997). High profile examples correspond with the Reconstruction era when Black men were first given the right to vote in 1870 and during the Civil Rights era in the 1960s when Black Americans were subject to voting discrimination tactics that made it difficult and, at times, physically unsafe to vote in elections. The Voting Rights Act of 1965 was an attempt to rectify voting discrimination, namely Jim Crow laws, such as poll taxes, literacy tests, and intimidation.

However, new, more subtle strategies emerged in the form of “negative racial gerrymandering” or the rearranging of electoral districts to dilute Black voting power (Whitby 1997). By limiting the voting power of a particular political party or group, gerrymandering shapes whose political interests gain traction.

Reproductive gerrymandering, while related to other forms of gerrymandering, is a useful concept in that it names a particular phenomenon wherein the political power of voters who support reproductive healthcare access is suppressed across political party lines. It gives the false impression that the majority of residents in states that predominately elect Republican representatives—also known as “red states”— want government elimination of abortion and related services. In this chapter, I focus on how reproductive gerrymandering makes it appear as though the majority of residents want abortion to be illegal in most or all cases when, in fact, this is a misconception crafted by partisan groups with legislative power. According to a 2019 poll, only 10% of Ohioans supported a complete ban on abortion, whereas 55% of Ohioans said they would like abortion to be legal in most or all cases (Quinnipiac University Poll 2019). This is further supported by Ohio Issue 1— an amendment to the state constitution protecting reproductive freedom and abortion access—that was passed by popular vote (57% to 43%) in November 2023 (The Guardian 2023).⁹ I use Ohio as an example, but this issue is not specific to this state; legal scholars Landau and Dixon (2022) identify at least 19 other states that have a high threat of gerrymandering and have introduced or implemented abortion bans since the *Dobbs* decision was released. As of May 2024, 14 states have completely banned abortion and three have banned abortion prior to six weeks of pregnancy (Guttmacher Institute 2024a), even though only 13% of Americans support a complete ban on abortion (Gallup Poll 2022). In this chapter, I demonstrate how this disjuncture and the anti-abortion legislation that results causes

everyday structural violence for pregnant people. For this reason, I argue that *reproductive gerrymandering* is a highly effective form of *bureaucratic violence*.

Theories of bureaucratic violence build on the scholarship of Paul Farmer (2004) and anthropologists who work on everyday or structural violence and the way in which social structures or social institutions can harm certain groups (Das and Kleinman 2000; Das et al. 2001; Das 2007). Structural violence is a form of oppression that is applied indirectly and systematically (Farmer 2004, 307), such as policies that result in limited access to basic medical care (Galtung 1969; Scheper-Hughes 1993; Das 1995; 1996; Farmer 1996; Scheper-Hughes 1996; Das 2007; Biehl 2005). As Das and Kleinman (2001) explain, "[e]ven when violence is not present in such dramatic forms, there can be the slow erosion of community through the soft knife of policies that severely disrupt the life worlds of people" (1). Forms of everyday violence are not an aberration, but are normalized and embedded in the moral order of a society (Das and Kleinman 2000, 5). Thus, the very absence of state intervention in despondent conditions is a violent act in itself (Scheper-Hughes 1993, 230). These scholars reveal how political violence not only is made visible through extraordinary events but may also be discerned in the everyday act of neglecting or denying basic needs. One such need is access to essential reproductive healthcare, in this case abortion, which has been slowly eroded through increasingly restrictive policies.

In turn, bureaucratic violence has been conceptualized as a form of structural violence enacted through schematization, paperwork, and procedures (Graeber 2012, 2016; Milne and Mahanty 2019; Heckert 2020). Like Graeber, I view bureaucratic violence to be "boring, humdrum, yet omnipresent forms of structural violence" (2012, 105). Redistricting is a mundane bureaucratic process that does not receive much attention from the general public; however, I

contend that by conceptualizing *reproductive gerrymandering* as a form of bureaucratic violence, one is able to attend to what Heckert refers to as “the specific mechanisms that enable policies to cause harm” (2020, 34). In this case, partisan gerrymandering is the specific mechanism of bureaucratic violence that allows for the advancement of anti-abortion agendas.

State legislation that attempts to minimize or outlaw abortion demonstrates what Morgan and Roberts (2012) deem forms of "reproductive governance" defined as the “mechanisms through which different historical configurations of actors— such as state institutions, churches, donor agencies, and non-governmental organisations (NGOs) — use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices” (243). In other words, reproductive governance is the way in which various actors shape and control reproductive behaviors. Building upon the work of scholars who have demonstrated how the selective collection of health data can serve as a mechanism of reproductive governance (Suh 2018; Strong 2020a; Williams 2020; Saluk 2022), I show how the manipulation of redistricting map data is instrumental to reproductive governance in the US.

In support of this argument, I have organized this chapter into three primary sections. First, I draw on interviews with political organizers and policy experts in Ohio to demonstrate how reproductive gerrymandering has led to a dramatic decrease in abortion access since the 2011 redistricting session. I argue that reproductive gerrymandering occurs in two ways: by increasing the number of Republicans elected to state office and, in another less tangible way, by increasing the number of elected extremist conservatives who promote staunch anti-abortion views. Second, I draw on interviews with abortion healthcare staff to show how reproductive gerrymandering and the erosion of abortion access is a form of structural violence that denies

pregnant people access to basic healthcare needs. Finally, I draw on interviews with both political organizers and healthcare staff to make a direct connection between state bureaucratic budget procedures and the funding of anti-abortion pregnancy centers used to shame and deter pregnant patients from seeking abortion. Ultimately, I demonstrate how reproductive gerrymandering can be used as an analytic tool to draw connections between partisan redistricting and the everyday structural violence that results from legislation denying or restricting reproductive healthcare access.

Reproductive Gerrymandering and the Erosion of Abortion Access

Throughout my time in Ohio, both before and after the *Dobbs* decision, individuals who work in reproductive politics repeatedly shared with me how disenfranchised they felt because of partisan gerrymandering in the state legislature. For example, when speaking about voting in Ohio, Jane, a 27-year-old policy expert who works for a reproductive justice organization, exclaimed “the people that are in power, they don’t look like us, they don’t act like us, they don’t represent us. They got here by gerrymandering.” This was a sentiment that I have heard repeatedly since moving to Ohio, and is what led me to investigate the ways in which reproductive gerrymandering takes hold.

When I first arrived in the state, I had to confront why such a dramatic shift had occurred toward a pronounced increase in anti-abortion legislation, and I quickly found that political organizers draw a strong connection between partisan redistricting and the rapid decline in abortion clinics across the state. Ava, a 28-year-old policy expert and political organizer, describes how gerrymandering causes the erosion of abortion access:

What are the real-life impacts of those bills that get passed by gerrymandered legislators who don't reflect the views of Ohioans?... the impact is that half of Ohio's abortion clinics have shuttered in the last ten years. That is not coincidental that has happened in the last decade given how the gerrymandering looked in 2011 as compared to 2001.

What does it mean when they pass these ambulatory license bills that people don't pay attention to?... it means I call up my doctor and I can no longer go to the abortion clinic that is 20 minutes away from my house and I now have to go to one that is 3 hours away... That is a real-life impact that people then can understand, but maybe at first didn't think that's because of gerrymandering.

Indeed, the Ohio state legislature has passed over 30 reproductive healthcare restrictions since 2011, many of which impede access to abortion (Planned Parenthood Greater Advocates of Ohio 2021). Ambulatory license bills, in particular, are a form of anti-abortion legislation that impose strict regulations similar to that of ambulatory surgical centers, such as the need for larger rooms and wider hallways, even though abortion procedures require lower levels of sedation and minimal risk in comparison. These burdensome and unnecessary requirements are meant to increase operating expenses and, consequently, force many abortion providing facilities to close (Colman and Joyce 2011). Due to such restrictive legislation, since 2010 the number of abortion-providing facilities in Ohio has decreased from 25 to nine, three of which only provide medication abortion (OPEN: Ohio Policy Evaluation Network 2023). However, as Ava highlights, this stark decrease in clinics is not obviously connected to Republican gerrymandering.

Gerrymandering takes place during redistricting sessions, or the redrawing of legislative and congressional districts, which occur every ten years following the completion of the US census count. Political organizers whom I interviewed emphasized the ramifications of the Redistricting Major Project, known as REDMAP, wherein Republicans launched a \$30 million program in 2010 to fund Republican candidate races across the US that were crucial to win in order to control redistricting in their state (Daley 2016b). As a result, Republicans gained 700 state office seats nationwide, and they hired political strategists with advanced redistricting software to successfully redraw state and congressional districts to ensure that they would have a sizable advantage in upcoming elections (Daley 2016b). Just as marketing companies collect data to target advertising, mapmakers utilize geographic information software programs with similar data to build predictive models concerning how individuals, and therefore communities, are likely to vote in future elections (Earle 2018; Williams 2019). With the help of this technology, the Republican party has increased the number of seats they hold in Ohio since 2011 (Daley 2016a); they have gained seven State House seats and three State Senate seats (Ballotpedia 2023a, 2023b, 2023c, 2023d).¹⁰ Currently, Republicans hold a 67-32 supermajority in the State House and a 26-7 supermajority in the State Senate. In other words, Republican representatives hold the majority of the political power at the state level in Ohio, and this allows them to easily pass legislation that aligns with their party's agenda.

However, purely focusing on the number of Republicans elected does not provide a complete picture of how partisan gerrymandering fosters extremism and, therefore, the passage of anti-abortion legislation. Gerrymandering ensures that the competition for a particular political seat occurs during the primary election between Republicans, rather than the general election

between party candidates. Eliza, a 46-year-old political organizer and policy expert, explains how this works:

When you create districts where one party or the other is going to automatically win, it's not the November election that matters... it's the primary that matters. And so, now... if somebody comes more toward the middle to compromise, they are going to get challenged from the right and that person is most likely going to win, so *you keep getting more and more and more extreme candidates* [emphasis added].

Eliza articulates how the small number of constituents who vote in the primary races tend to hold radical conservative values and how, in turn, this pulls candidates further into conservatism in order to win the primary election. The need to appeal to this small portion of ultra-conservative voters advantages candidates who promote anti-abortion rhetoric and the severe limiting or banning of abortion.

Secondly, by manipulating district lines to ensure a particular outcome, gerrymandering creates a situation where winning candidates no longer represent the majority of their constituents, including those in their own political party. It is not merely that there are more Republican representatives, it is that these state officials are also more likely to promote conservative extremism. This also greatly affects Black and Latinx voters who as a whole tend to favor the democratic party (Keena et al. 2021). In Ohio, the Democratic majority districts tend to have a higher percentage of people of color; thus, Republican gerrymandering undermines their political power as well (Gresham 2022) and the anti-abortion legislation that is passed disproportionately criminalizes low-income pregnant people of color (Flavin 2009; Goodwin

2020). Thus, gerrymandering is not just a partisan issue, but also an issue of both racial justice *and* reproductive justice.

Importantly, these policy trends in Ohio exemplify a broader effort to minimize abortion access that is apparent across the US. Despite the lack of majority support for anti-abortion legislation, over 600 abortion restrictions have been passed since 2011 (Nash and Ephross 2022) when the Republican party successfully controlled the redistricting process for State Senate and State House maps in 17 states (Keena et al. 2021, 60). To further demonstrate this connection, since 2011, 73% of states with Republican gerrymandering passed “heartbeat” bans that prohibit abortion after about six weeks of pregnancy (Keena et al. 2021, 125). The mundane bureaucratic processes involved in electoral redistricting conceal what is in fact an organized effort to elect a Republican supermajority, who are then able to pass extremist legislation restricting reproductive healthcare access. As an increasing number of extremist Republican legislators have taken office, the passage of anti-abortion legislation has forced pregnant people seeking abortion to travel increasingly further distances or to endure forced pregnancy and birth.

Structural Harm caused by Reproductive Gerrymandering

The state’s refusal to allow access to abortion care is a form of structural violence that leads to direct harm experienced by pregnant people. These structural harms were no more pronounced in Ohio than when SB 23, known as the “Heartbeat Bill,” was quickly instated after the *Dobbs* decision was released on June 24th, 2022. Ohio SB 23 banned abortion after the detection of embryonic electrical impulses, which the state incorrectly refers to as a “heartbeat.” As discussed later in Chapter 2, these embryonic electrical impulses are emitted from cells that will eventually develop into a heart and can be detected at approximately six weeks of

pregnancy, which is about one to two weeks after most pregnant people have missed their period *if* they have a regular 28-day menstrual cycle. In other words, a “heartbeat” ban is a near-total abortion ban. Such legislation inevitably affects access to both elective abortion and abortion for medical necessity, such as miscarriage management (NPR 2022). This was the most restrictive state-wide ban in Ohio since 1973, and was in effect for nearly three months (June-Sept 2022) until an injunction was placed on the bill, thus halting enforcement until the Ohio Supreme Court determines whether SB 23 would be permitted under the Ohio constitution. As of November 2023, an amendment to the Ohio constitution was passed by popular vote protecting reproductive freedom and preventing SB 23 from being reinstated. Referenda bypass the issue of redistricting by allowing citizens to directly vote on an issue.

During those few months that SB 23 was in effect, healthcare staff stressed how patients had a difficult time understanding that their right to basic reproductive healthcare had been stripped from them. When I asked Vivian, a 40-year-old clinic administrative staff member, about the days after SB 23 was instated, she described the response from one of her patients:

There was a woman who had driven from another state. I knew she had driven a long way. She was crying...she was on her hands and knees begging me to not do this to her [she pauses and looks like she is about to cry herself] saying that I did not know what was going to happen to her. She kept saying “Please, I’ll pay you. What do I need to do?” We were professional [and were] trying to explain to her [that] this just passed and we know that this is horrible. She was outright [on] all-fours sobbing [at my feet]... I had cros [sandals on] with my socks and I remember my socks being wet because she was crying: tears, slob[ber], and drool.

Vivian illustrates the fear and desperation experienced by patients unable to access abortion care in their home state. Prior to the *Dobbs* decision, patients were traveling from Texas and Oklahoma where near-total or total bans were already in effect. This patient, in particular, had already traveled out-of-state, and her ability to access abortion care was further delayed when she was informed that she would need to travel to yet another state to receive care. She was given assistance for this additional travel, but financial resources cannot make up for lost time and mental anguish.

The act of being forced to leave one's own state or, in some cases, region of the country to access legal abortion care is emotionally, physically, and financially taxing.¹¹ Lauren, a 25-year-old clinic administrative staff member, said that she had to engage in "full crisis intervention and suicide prevention conversations... with patients who were absolutely devastated. [Patients] that were terrified and scared because they didn't have resources to leave the state." Healthcare workers and abortion practical support organizers (individuals who fund and/or assist patients in obtaining an abortion) emphasized how critical it was for patients to not only have the legal right to abortion, but also the ability to *access* care. As other scholars have noted, even when abortion is legal not all residents are able to access care, especially those with fewer social and economic resources (Ostrach 2017; Cohen and Joffe 2020; Singer 2022; Kimport 2022). The ability to access abortion care is not just about the cost of the procedure and travel to the clinic; it also includes, for instance, the ability to take time away from work and pay for hotel stays, meals while traveling, and childcare, if needed. The burden of paying for these expenses was placed on the patient, and if they were unable to afford them, clinics and practical

support organizations provided assistance. However, an individual would need to know that they could seek such assistance and feel empowered enough to do so.

In effect, low-income pregnant people without financial and social resources have been and will be most impacted by abortion criminalization. When pregnant people are criminalized for their pregnancy decisions, it is disproportionately those who are low-income, Black (D. E. Roberts 1997; Flavin 2009; Goodwin 2020), Latinx, or immigrants (especially those who are undocumented) (Cromer 2019a) who are more likely to be surveilled and criminalized. The uneven application of such legislation demonstrates the gendered, racial, ethnic, and class dynamics inherent to a country with roots in white Christian nationalist ideologies (Cromer 2019b). Accordingly, the act of the state denying this basic healthcare need is a form of structural or everyday violence that disproportionately affects pregnant people of color and those who are low-income, and is a consequence of reproductive gerrymandering.

Hidden Bureaucratic Violence and the Promotion of Crisis Pregnancy Centers

A further example that demonstrates the intersections of reproductive gerrymandering and the everyday violence it inflicts on pregnant people is the way in which the Ohio biennial budget is used to funnel money to anti-abortion groups, known as crisis pregnancy centers (CPCs). I was first introduced to this issue during an informational presentation on abortion access held in March 2022 before the *Dobbs* decision had been released. At this point, many reproductive health organizations were working to educate communities about the impacts of anti-abortion legislation and the impending Supreme Court decision. Shannon, an abortion political organizer in her late twenties, stood in front of what is normally used as a concert stage at a dive bar with a punk rock vibe in an urban Ohio city and pointed to a makeshift PowerPoint

screen. The audience was a group of about 15 men and women who had come to hear about the current state of abortion access in Ohio. Shannon explained how the biennial budget is crafted such that the state receives funds from the Temporary Assistance for Needy Families program, a federal funding initiative for families in need, that is usually reserved for childcare support and employment programs (Benefits.Gov 2022). To the surprise and distress of the attendees, she described how, in Ohio, a portion of that funding is directed to CPCs through the Ohio Parenting and Pregnancy Program.

CPCs are usually intentionally located near abortion providers (Cartwright, Tumlinson, and Upadhyay 2021), have religious affiliations (Hussey 2020), and despite having no medical licensure misrepresent themselves as health centers providing medical and informational services to pregnant people (Bryant and Levi 2012). Effectively, they function to dissuade pregnant people from seeking abortions, and they frequently provide medical misinformation about abortion risks (Bryant and Levi 2012; Rosen 2012). CPCs are an important tool used by anti-abortion organizations across the US (Munson 2018). Currently, there are about 120 to 130 centers in Ohio (Crisis Pregnancy Center Map 2022), which means that there are about 13 times the number of CPCs as there are abortion clinics. It is important to underscore that CPCs receive taxpayer support in Ohio.

Reproductive policy experts have been tracking these funding changes, and they point to how these budget decisions are part of the broader anti-abortion movement. In Ava's words:

They often find a way to stick anti-abortion or anti-repro health organization provisions into the budget ... All of them in my recent memory include grants to Crisis Pregnancy Centers. They'll gut funding that goes to Planned Parenthood or other similar

reproductive healthcare organizations as virtue signaling. They'll say we're cutting [funding] because we don't want our money to go to abortion and it literally doesn't. It's against federal law, it is against state law, you have made that abundantly clear that none of this funding goes to abortion... instead [they provide]... millions of dollars to go to crisis pregnancy centers.

The state biennial budget, a seemingly neutral document to those who do not work in politics, is a cloaked bureaucratic instrument for the advancement of anti-abortion political agendas. By creating a program with an innocuous title, such as “the Parenting and Pregnancy Program,” it is not obvious that there is a partisan motivation. However, when investigating further, one finds that grant recipients of the program must specify that they will promote alternatives to abortion — i.e., childbirth or adoption — in order to receive state funding (Ohio House Bill 59 2013). To be clear, as Ava mentions, federal funds are banned from being applied to abortion services except in a few rare circumstances due to the Hyde Amendment. Planned Parenthood programs that previously received funding were not related to abortion, instead their funding supported other healthcare needs like cervical and breast cancer screenings that primarily served people of color, residents in rural areas, and low-income patients (Lawrence and Ness 2017). Defunding essential reproductive healthcare means that these underserved communities will not receive life-saving screening and preventive care. Thus, when Ava refers to “virtue signaling,” she is implying that the Ohio state legislature wants to appear morally superior by pulling funding from abortion services, even though this was never the case. Yet, the funding of CPCs is directly related to the promotion of an anti-abortion mission, and the defunding of Planned Parenthood

programs negatively impacts reproductive healthcare access, especially in marginalized communities.

For example, one such recipient is Ohio Pregnancy Options Center, a CPC that is located near an abortion providing facility in an Ohio city. The center received \$150,000 for fiscal year 2023, as detailed in Ohio state budget records. The center's website emphasizes that they provide free pregnancy tests and ultrasounds as well as pregnancy options counseling, including for abortion. However, when asked about Ohio Pregnancy Options Center, Nyra, who has worked at a nearby abortion clinic for seven years told me: "They get in there, [Ohio Pregnancy Options Center], and the person is saying this religious stuff to coerce them to continue with the pregnancy and they are like 'Oh, no! I want to have an abortion' and then they run across the street to come here." Nyra is describing how many patients feel as though they were tricked into thinking the CPC would offer abortion services or, at least, reliable information about abortion. Healthcare staff also described how patients would come into the clinic crying because they were upset by the stigmatizing language the CPC staff would use with them. Many CPCs lure in pregnant people under the guise of providing pregnancy options counseling, yet they operate to deter individuals from obtaining an abortion (Warren et al. 2022).

Another staff member at Grand Plains Clinic described her experience at Ohio Pregnancy Options Center before she began working at the clinic. Jade, a 26-year-old Black and Latinx administrative staff member detailed her personal experience at the CPC: "I went there just to discuss my options... they were more focused on keeping it [the pregnancy]. They gave me baby socks. They gave me prenatal vitamins. They show little diagrams of how big the fetus would be and it's like an actual little baby sculpture instead of a ball of cells... I was just like lady you are nuts." Jade was subjected to medical misinformation when the CPC staff member provided a

diagram that was anatomically incorrect at her stage of pregnancy. Further, she experienced emotional distress due to the anti-abortion tactics utilized by the CPC staff and a delay in access to abortion. In essence, funding CPCs harms pregnant people who are seeking abortion services because they deceive patients into thinking they are licensed healthcare centers with unbiased services.

Even though Jade did not recount race as shaping her CPC experience, it is important to note that CPCs are particularly active in urban areas with high populations of Black women (Kelly and Gochanour 2018). However, as described previously, this also means that these communities are usually in need of affordable healthcare and other social services, and CPCs provide free pregnancy tests and material aid in the form of baby clothes (Kissling et al. 2022). As Rice et al. report, particularly in Ohio, there is a higher prevalence of Black women in the lowest socioeconomic stratum who have ever visited a CPC (Rice et al. 2021). Therefore, pregnant persons who are Black and of a lower socioeconomic status are more likely to seek free reproductive health services at a CPC and be subjected to misinformation and a delay in medical care, which can become life-threatening in cases of early pregnancy complications that are not diagnosed, such as ectopic pregnancy (Montoya, Judge-Golden, and Swartz 2022). As the number of states without abortion care increase, such misinformation and false advertising of healthcare services will become increasingly dangerous.

In total, over \$10.5 million was distributed to the Parenting and Pregnancy Program through the passage of two separate bills and an executive order signed by Governor DeWine for fiscal years 2022 and 2023 (Ohio House Bill 110 2021; Executive Order 2022-09D 2022; Ohio House Bill 45 2022). In this way, complex budget procedures allow legislators to promote partisan agendas without much scrutiny from constituents. By inserting these budget decisions

within multiple administrative processes, it becomes difficult to track where tax money is being directed. Like Ohio, at least 13 other states across the US channel millions of dollars in state funding to CPCs (AP News 2022). This money is usually redirected from reproductive health programs that provide legitimate medical care to communities in need. In states with an extremist Republican supermajority due to gerrymandering, the creation of budget items and funding programs to promote CPCs is an effective strategy to mask the advancement of anti-abortion efforts that negatively impact pregnant persons, especially those who are low-income and Black, who seek abortion or other forms of reproductive healthcare.

Reproductive Gerrymandering as an Analytic Tool

Reproductive gerrymandering, as an analytic tool, highlights the connections between the bureaucratic violence put forth by legislators in statehouses across the US and the violent effects of restricting reproductive healthcare access. Bureaucratic violence obscures the mechanisms of reproductive gerrymandering that make it possible to promote an anti-abortion agenda despite its unpopularity with the majority of voters. The mundane bureaucratic processes involved in electoral redistricting and state budget procedures make it difficult to pin-point the individuals who are responsible for everyday violence or what political philosopher Hannah Arendt has referred to as “tyranny without a tyrant” (1970, 81). In other words, by denying access to a basic healthcare need, state legislators indirectly and systematically cause structural harm to pregnant people—a gendered form of structural or everyday violence. Redistricting maps are manipulated such that they mask how they legitimize and strengthen reproductive governance in places like Ohio. Reproductive gerrymandering makes this connection apparent by highlighting the mechanisms through which the manipulation of redistricting data fuels reproductive governance.

As I have demonstrated, one can see how partisan redistricting has biased the results of state elections to benefit Republican candidates and, in turn, has paved the way for more extremist conservative representatives to hold state appointments. Map-making operations, such as the use of seemingly neutral digital applications, are used to conceal calculated efforts to distort electoral results under the guise of democracy. I reveal how bureaucratic procedures are utilized to manipulate redistricting and budget processes, which ultimately advance anti-abortion agendas through the passage of legislation restricting abortion access and the redirection of budget proposals to supply CPCs with millions of dollars in federal funding. CPCs are instrumental to the anti-abortion movement in the US and promote medical misinformation and ideologies of shame surrounding abortion. Both CPCs and legislative barriers to legal abortion cause physical, emotional, and financial distress to pregnant people. These harmful consequences are experienced in the everyday attempt to access abortion care. However, it is individuals who are most marginalized that suffer the most from reproductive governance in the form of legislative controls. In this way, reproductive gerrymandering is a useful theoretical framework to analyze how the manipulation of electoral outcomes is related to reproductive healthcare access inequities.

While abortion is a cogent example of reproductive gerrymandering, this concept can also be applied to other reproductive health policy changes that are unpopular with the majority of voters. Further research on the ways in which bureaucratic violence operates in state legislatures to manipulate electoral outcomes will become increasingly important in the coming years, including an examination of policy trends connected to other reproductive health issues, such as contraceptive access. In the example I provide, anti-abortion legislation was coupled with the defunding of other reproductive healthcare programs. These attacks on abortion access

are indicative of a broader effort to advance ultra-conservative interests concerning reproductive healthcare access.

Finally, reproductive gerrymandering makes it appear as though the majority of people would like constraints on reproductive healthcare access, which might silence those who oppose legislative controls. Further analysis of other geographic contexts where there is a disjuncture between governance decisions and the will of citizens will be important to understand how reproductive governance is legitimized and reinforced. In this way, reproductive gerrymandering is a mechanism that can be used to mask the actors and the power they hold to enact reproductive governance and, therefore, is able to reveal both the political stakes at hand and the everyday violence experienced by individuals when regulating abortion and reproductive healthcare access more broadly. As Ava put it, this is the “real-life impact that people then can understand, but maybe at first didn’t think that’s because of gerrymandering.”

Conclusion

My examination of reproductive gerrymandering and budget processes in Ohio speaks to a broader literature concerning the manipulation of data to advance reproductive governance. I expand upon existing literature demonstrating how non-governmental organizations (NGOs) and government programs utilize data collection as a tool for reproductive governance (Suh 2018; Strong 2020; Williams 2020; Saluk 2022). Databases, statistical analyses, and bureaucratic operations are not neutral instruments, instead they are imbued with the biases of their users. Data can be framed such that existing health inequities are bolstered. This chapter adds to these broader conversations by underscoring how, in addition to health data, census and redistricting data can also be used as a mode of reproductive governance. As demonstrated, data used to

inform map-making applications used in electoral redistricting can serve as a tool of reproductive governance and strengthen existing racial, ethnic, and class hierarchies. I draw attention to the ways in which redistricting and budgetary processes can be utilized as mechanisms of reproductive governance. In the next chapter, I study the after effects of reproductive gerrymandering by examining legislation passed by extremist politicians.

Chapter 2: Agnotology, the Weaponization of Science, and the Manufacturing of a “Heartbeat”

In this chapter, I examine how state legislators weaponize science and culturally produced ignorance around abortion to manufacture a “heartbeat.” In Ohio, the day the *Dobbs* decision was released, Senate Bill 23 (SB 23 2019) was implemented for three months, banning abortion after an embryonic electrical impulse is detected, which legislators call a “heartbeat.” This occurs at approximately six weeks in a normal pregnancy or about one to two weeks after most pregnant people have missed their period *if* they have a regular 28-day menstrual cycle. Despite the use of the term “heartbeat,” at this point in gestation the heart has not yet developed; the doppler sound waves from the ultrasound are due to a cluster of cells emitting electrical signals that will later form the heart. At this early stage the cells merely beat rhythmically rather than serve any functional purpose of pumping blood throughout the body. In this chapter, I focus primarily on SB 23 and the complete ban on abortion after embryonic impulses are detected. By mandating clinic staff to search for a “heartbeat,” state legislators create uncertainty around the timeline for pregnancy development, i.e., when the heart develops a distinctive form and function. In this process of rhetorically creating a “heartbeat,” I argue that, in the words of Richardson (1996), the “semantic massage” of such terminology is a deliberate and calculated attempt to induce moral fear and doubt in patients.

Twelve other states in addition to Ohio passed similar legislation between September 1, 2021 and March 20, 2023 (Congressional Research Service 2023), and many others introduced and/or passed similar legislation prior to 2021. Of note, throughout this chapter, when I state “[x-number] weeks of pregnancy,” I am referring to the number of weeks since the first day of the pregnant person’s last menstrual period. They were not, in fact, pregnant for the first couple of

weeks during menses and prior to ovulation. However, the use of dating one's last menstrual period is the standard method of determining gestational age in most cases. Further, throughout this chapter, I refer to the "heartbeat" discussed in legislation as electrical impulses. To be clear, I do not point to the scientific inaccuracy of these bans to argue that the appropriate use of "heartbeat" should be used as a guideline for future bans; rather, I highlight these inconsistencies to demonstrate how state legislators introduce and utilize a slipperiness of terminology to undermine, replace, and reshape medical language to further their political agendas.

In order to explore the purposeful production of ignorance amidst messaging around the "heartbeat," I first review relevant literature concerning agnotology and the weaponization of science. Second, I turn to Ohio SB 23 and how state legislators manufacture a "heartbeat." Then, through my interlocutors, I demonstrate how finding embryonic electrical impulses is an interpretive process and how the discursive power of law shapes medical and colloquial terminology around embryonic cardiac development. Finally, I provide an analysis of "heartbeat" terminology as a semantic strategy.

Agnotology and the Weaponization of Science

Knowledge can be produced and, at times, obscured to promote a particular worldview. The study of ignorance or agnotology (sometimes referred to as agnatology) is informative in this regard (see Proctor 1995). Proctor (1995) highlights how ignorance is not merely the absence of knowledge; it also defines what knowledge is considered important (8n). In turn, feminist philosopher Nancy Tuana (2006) argues for the utility of developing a taxonomy of ignorance to trace how ignorance is produced and can be a source of oppression (3). As philosopher and science and technology studies scholar Annemarie Mol (2002) argues,

knowledge takes shape in practice. Building on these scholars' works, I trace how "heartbeat" language becomes pervasive in practice in abortion clinics and how, ironically, associated ignorance of the biology of pregnancy facilitates gendered oppression in the very spaces that seek to counteract this.

Historians of science Proctor and Schiebinger (2008) describe three forms of ignorance: 1) native state or innocent ignorance; 2) selective choice of the information that is presented; and 3) strategic ploy. Here, I focus on ignorance as strategic ploy and how it is "made, maintained, and manipulated by means of certain arts and sciences... namely, that certain people don't want you to know certain things, or will actively work to organize doubt or uncertainty or misinformation to help maintain (your) ignorance" (Proctor 2008, 8). The cultural production of ignorance has been studied in relation to other health related issues, such as the harmful effects of tobacco and climate change, to show how scientific evidence can be manipulated or misrepresented to produce ignorance around a particular topic (Fernandez Pinto 2017). I build upon this body of work by studying the strategies used to maintain and promote ignorance around reproductive bodies and pregnancy. I examine the ways in which promoting ignorance is a technique of "reproductive governance" (Morgan and Roberts 2012) or the way in which governments control or shape reproductive behaviors. In other words, the importance of studying the gendered aspects of agnotology is to better understand mechanisms of political control.

Abortion agnotology, in particular, is the study of ignorance around the termination of pregnancy. Historians Schiebinger (2004) and Marcotte (2016) have examined how histories of abortion and abortifacients have been erased or neglected. For example, in her book, *Plants and Empire: Colonial Bioprospecting in the Atlantic World* (2004), Schiebinger argues that the exclusion of eighteenth-century colonial bioprospectors' (individuals who search for plants for

medicinal purposes) writings on West Indian abortifacients was a form of culturally induced ignorance. Schiebinger contends that decisions were made not to transfer knowledge of abortifacients from the Dutch, English, and French colonies back to Europe, most likely in response to the pronatalist principles of the time. These scholars demonstrate the importance of studying the propagation of ignorance specifically around pregnancy and abortion.

The cultural production of ignorance can also be found in the use of a particular word or phrase used to describe a biological or scientific process. The implicit meaning evoked by a word or phrase is what Ruth Richardson (1996) calls a “semantic massage.” Not unlike tactics used in advertising to persuade consumers to buy products, various terms and expressions in scientific contexts may serve to shift sentiments and beliefs. Consider, for instance, the contrasting emotional registers of “comatose” versus “vegetable,” or cancer “survivor” versus “victim.” Within the context of abortion politics in Ohio, I argue that “heartbeat” terminology is used as part of a potent semantic strategy. Richardson examined language substitutions used to describe the retrieval of cadavers for anatomical study in the early 19th century United Kingdom and in contemporary organ harvesting by medical institutions. For example, HBP was used instead of human body part. Richardson notes how the meaning changes with this substitution: “To refer to a human heart as an HBP is to edit out its physical and emotional resonance, to annul the cultural import of the enterprise involved in its removal” (1996, 86). In the inverse of how Richardson speaks of the dehumanization process of human bodies, I argue that anti-abortion legislators humanize a cluster of cells by using the term “heartbeat.” In this way, I question what work is being done with this particular semantic strategy and the political project it supports.

Throughout my fieldwork, I tracked how healthcare staff determine whether there are embryonic electrical impulses and how they refer to this type of legislation in interactions with

patients. Although the implementation of SB 23 is a well-known contemporary example of a state mandating an arbitrary guideline based on when legislators determine a “heartbeat” exists, this was not the first piece of legislation to do so in Ohio. In fact, Ohio was the first state in the nation to introduce “heartbeat” legislation with Ohio House Bill 125 in 2011 (The Center for Public Integrity 2019). Ultimately, this first bill did not become legislation, but it was highly publicized due to anti-abortion organization Faith2Action’s slogan “Abortion Stops a Beating Heart” and with the orchestration of heart-shaped balloons delivered to Ohio Republican lawmakers (USA Today 2022). In 2013, anti-abortion activists succeeded in their efforts with the passage of Ohio House Bill 59 (2013), which mandates that the abortion providing physician must sign a Fetal Heartbeat Determination form stating whether embryonic electrical impulses have been recorded. Medical misinformation, such as these sorts of “heartbeat” bills, reshape clinical care for abortion because medical staff must determine whether or not an ultrasound has detected what the state deems a “heartbeat.”

Science exists within a cultural system that shapes one's understanding of what is considered a scientific fact (Martin 1987; Latour 1988; Haraway 1991; Franklin 1995; Lock 2001), and associated lexical categories hold significant meaning for the politics of abortion care within clinics. However, these lexical categories can be changed or framed differently to produce ignorance. Scientific knowledge, like any other epistemic process, is developed with historical and cultural specificity. For example, Martin (1991) examined biology textbook descriptions of the human fertilization process to show how sperm are characterized as masculine and aggressive, whereas ova are described as feminine and passive. As this example illustrates, systems of belief concerning gender that are so deeply entrenched as to be hegemonic are implicated in how the human fertilization process is framed scientifically and socially. Thus,

Western assumptions about gender and sexuality are embedded in explanations of seemingly neutral biological processes (Martin 1987, 1991; Jordan-Young 2010; Jordan-Young and Karkazis 2022). Here, I apply this science studies optic to the intersection of the legislative and medical, examining how biological processes are framed in law to determine the social and political motivations behind them.

The social meaning of the embryo and the fetus has changed over the past century with medical and scientific advances. With this in mind, medical professionals and embryologists have crafted a lexicon to describe embryos and fetuses as comparable to an infant to promote their importance in medical and scientific studies. Embryologists in the early to mid-twentieth century began to assert the importance of embryonic material for scientific purposes, and advanced the notion that embryos are valued, not merely as scientific specimens, but as "icons of life" (Morgan 2009). Similarly, sociologist Nicole Isaacson examined the differing language in obstetrics textbooks from the 1960s to the 1990s to show the historical context of how terms, such as "fetus" and "infant" became interchangeable in medicine. As she explains, "the fetus and baby are lumped together to create the fetus-baby, this new category [of fetus-baby] gains status as a separate being legitimately entitled to rights" (Isaacson 1996, 460). As Casper (1998) has shown, too, the advent of fetal surgery has also served to create the *unborn patient* with its own needs that may, at times, be in conflict with the pregnant person. These ways of viewing the fetus-as-baby and patient blurs the differences between the embryo or fetus in utero and the baby ex utero. Importantly, this jargon is used by medical specialists and embryologists, which provides them with the cultural capital "to define what are significant categories of meaning" (Isaacson 1996, 462); in this case this involves the amalgamation of embryo, fetus, and infant into one category. The fetus and the embryo are collectively perceived as an infant because of

this confounding terminology, which has since been used by anti-abortion activists and policy makers to make a political distinction using apolitical technical language. The imprecise language used by medical professionals and embryologists set the stage for culturally produced ignorance around pregnancy development.

Anti-abortion organizations and conservative politicians have leveraged this conflation of the embryo, fetus, and infant in scientific and everyday lexicon to enforce notions of personhood in legal language. Through the creation of new legal categories and criteria, lawmakers are able to enforce discursive authority through the power of law (Merry 1992; Mertz 1994, 441). A contribution of my work is to highlight how that functions as a strategy of reproductive governance. By using the term “fetus” instead of “embryo” in legislation, lawmakers promote ignorance around pregnancy development. As linguist Mertz (1994) highlights, language “provides a window on social process” to interrogate the ways in which legal language both reproduces and shapes social power structures (437). This ignorance is not innocent—obscuring the boundaries between embryo and fetus changes the social value of what constitutes life. Conservative lawmakers are able to pass abortion bans by sowing ignorance and manipulating scientific facts to their benefit.

Similar to the amalgamation of the embryo, fetus, and infant, there is no standard way to discuss embryonic electrical impulses. Even though there is no standard term, texts from medical biologists and embryologists make it clear that in early embryonic development the heart begins as a grouping of cells that form a singular linear cardiac tube (Sylva, Van Den Hoff, and Moorman 2014; Buijtendijk, Barnett, and Van Den Hoff 2020), which differs significantly from the final form: a four-chambered multi-valved organ that intricately pumps blood in an ex-utero baby. The movement of “primitive cardiomyocytes,” the earliest stage of the individual cardiac

cells that will eventually compose the heart, is due to electrical signals from these rudimentary cells interacting with one another (Buijtendijk, Barnett, and Van Den Hoff 2020). As medical biologists Buijtendijk et al. describe:

It should be noted that at this stage of development, there is no morphologically distinguishable cardiac conduction system. The slow and long lasting contraction is the result of poorly electrically coupled cardiomyocytes [cardiac cells], and at the same time the sarcomers [muscle fibers] and sarcoplasmic reticulum [cells needed for muscle contraction and relaxation] have yet to fully develop (12).

This makes clear that an embryo does not, in fact, contain a heart—rather, it contains the beginnings of the cells that will later form the heart and those cells interact to generate electrical activity. As shown in Figure 3 below, the embryo is merely a grouping of cells at approximately six weeks of pregnancy (The New York Times 2023). Importantly, the American College of Obstetrics and Gynecology, the leading authority for obstetricians and gynecologists in the US, states that heart is not completely developed until 19 to 22 weeks of pregnancy when the four chambers have fully matured, and that it is incorrect to classify cardiac development as a heartbeat before this later gestational phase (ACOG: The American College of Obstetricians and Gynecologists 2023a).

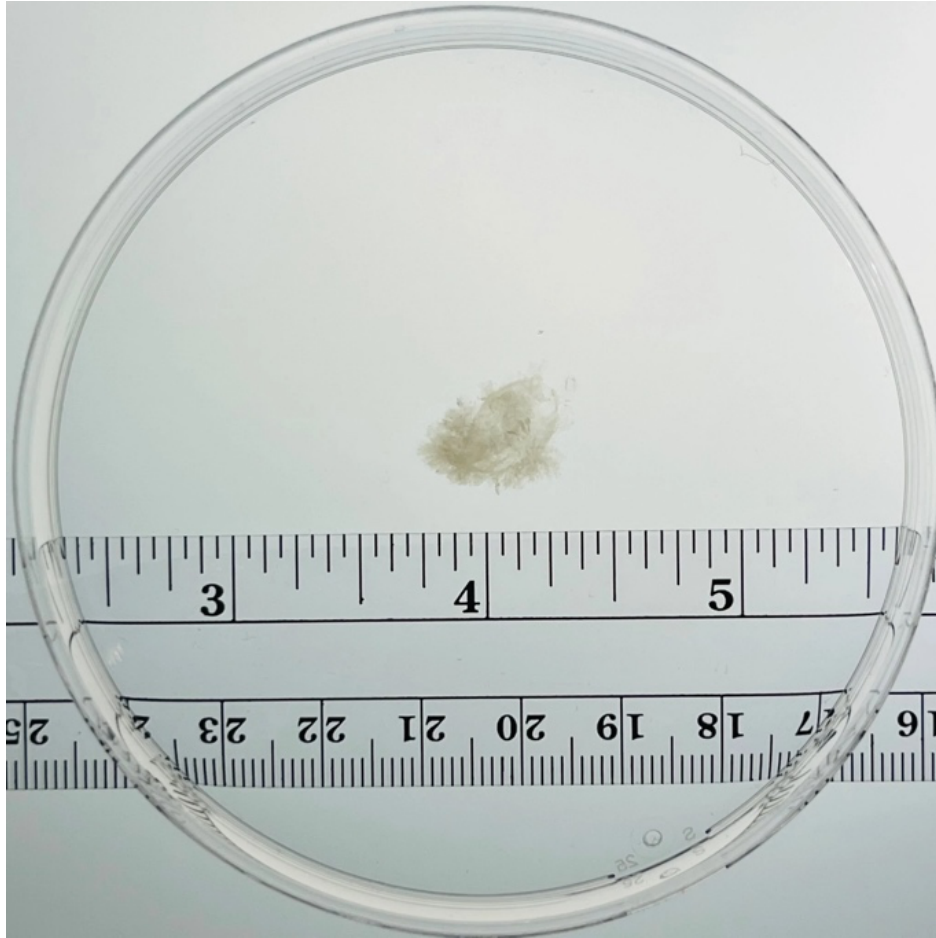


Figure 3: Pregnancy tissue at six weeks of pregnancy (The New York Times 2023).

This image was printed in a New York Times opinion piece by three physicians who founded My Abortion Network, a group of clinicians who provide early abortion care up to 12 weeks of pregnancy. The piece was titled “Early Abortion Looks Nothing Like What You’ve Been Told.”

Manufacturing a “Heartbeat” in Ohio

In contrast to the American College of Obstetrics and Gynecology (ACOG), Ohio state legislation enforces the use of the scientifically incorrect term “fetal heartbeat.” For example, one of the most onerous state-mandated forms for both physicians and patients is the Fetal Heartbeat Determination (FHD) form, which requires an ultrasound at least 24-hours prior to the abortion and for both the patient and physician to document and sign whether a “heartbeat” was

detected. This mandatory form was created in 2013 as a rider attached to Ohio HB 59, a 699-page document that focuses on a number of different state agencies and departments, such as the Department of Aging, Department of Agriculture, and the Office of Budget and Management. Embedded in the middle of this document, on pages 302-308, the bill outlines “Abortion informed consent and fetal ultrasound requirements” (302):

Under the act, a person who intends to perform or induce an abortion on a pregnant woman must determine whether there is a detectable fetal heartbeat of the unborn human individual the pregnant woman is carrying...The act requires the person who determines the presence or absence of a fetal heartbeat to record in the pregnant woman’s medical record the estimated gestational age of the unborn human individual, the method used to test for a fetal heartbeat, the date and time of the test, and the results of the test (304).

Notably, the act refers to the “fetal heartbeat” and the fetus as an “unborn human individual.” Similar to what Isaacson (1996) and Casper (1998) describe in their work, state legislators are blurring the boundaries that in medical parlance distinguish embryo, fetus, and baby. Further, physicians who do not follow these requirements may be subject to civil action lawsuits for wrongful death and can receive disciplinary action from the State Medical Board. The act of allowing wrongful death civil action lawsuits suggests that the embryo and fetus are the same as or, at the very least, comparable to an infant.

In HB 59, the state defines a “fetal heartbeat” as “cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac” (307). As described above, this terminology is incorrect according to ACOG when applied prior to the later stages of

pregnancy when the four chambers have formed. Further, the “fetus” is defined as “the human offspring developing during pregnancy from the moment of conception and includes the embryonic stage of development” (307). The use of the term “fetus” prior to 10 weeks of pregnancy is also scientifically inaccurate and suggests that the embryo is far more developed than it is at this stage (ACOG: The American College of Obstetricians and Gynecologists 2023c). These terms are utilized to separate the embryo from the pregnant person, thus bestowing the embryo with its own rights. Those producing medical knowledge laid the groundwork for legislators’ collapsing and misuse of terms by not being clear about the distinct differences between each category. The subsequent political manipulation of scientific language to advance anti-abortion political agendas began in Ohio over a decade ago, making it a routine practice to document whether there is a “heartbeat” in Ohio abortion clinics.

After nearly a decade of requiring the “Fetal Heartbeat Determination” form, Ohio Senate Bill 23, which was originally passed in 2019, went into effect only after the federal *Dobbs* Supreme Court (2022) ruling. SB 23 supplemented the HB 59 heartbeat detection language that was already in place to state that “no person shall knowingly and purposefully perform or induce an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn human individual the pregnant woman is carrying and whose fetal heartbeat has been detected” (9). The difference between HB 59 and SB 23 was that physicians could no longer provide abortion care after embryonic electrical impulses were observed. State legislators take advantage of this obscuring of lexical categories to refer to embryonic electrical impulses as a heartbeat and to refer to an embryo as a fetus, therefore shaping how abortion clinic staff and patients must speak about pregnancy gestational stages and abortion.

Whereas SB 23 was far more damaging to patients than Ohio HB 59, it is vital to understand that HB 59 laid the groundwork—both through advancing a set of language categories and developing a set of administrative forms and monitoring procedures—that enabled the enforcement of SB 23 nearly ten years later. Indeed, Vivian, the Franklin Clinic manager, responded to a question about how clinic staff were able to handle needing to implement SB 23 this way: “I wholeheartedly believe the reason why is because we were already having to use that language in some forms so it was not jolting. It was just kind of like every day.” This is not to say that the staff did not suffer emotionally from this legislative change, but that the administrative tasks and use of the term “heartbeat” was already familiar in Ohio. The addition of bureaucratic forms concerning fetal heartbeat detection made the practice of searching for a “heartbeat” an ingrained practice in Ohio abortion clinics before the passage and implementation of SB 23. Clinic staff members were subjected to purposefully providing misinformation through mandated “heartbeat” language in clinics with the passage of HB 59 nearly a decade prior.

Weaponizing Science through Legislation

During participant-observation and interviews I found that both searching for the “heartbeat” and describing associated phenomena was an interpretive process. Medical knowledge has been referred to as "authoritative knowledge" (Jordan 1997) to describe how particular epistemic traditions are valued over other forms of knowledge, especially information derived from technology, and ultrasound in particular (Davis-Floyd 1992; Browner and Press 1996). Through ethnographic research on contemporary childbirth in the US, anthropologist Brigitte Jordan (1997) found that the dominant epistemic traditions used to make decisions

during contemporary childbirth in US hospitals are characterized by a reliance on technology and technical monitoring. Notably, Jordan (1997) warns that one outcome of valorizing authoritative knowledge or elevating one form as “authoritative” is that it devalues other forms of knowing (74). The appearance of embryonic electrical impulses generally occurs between five and seven weeks of pregnancy, but they can appear at different times for each patient. The physician or ultrasound technician’s ability to detect them may also depend on the technology they are utilizing: abdominal vs. transvaginal ultrasound. This contradicts the assumption that technology and biomedical tests result in definitive answers.

For example, when I asked the sonographer at Grand Plains Clinic how she determines whether there is electrical activity, she says that this is done by seeing if there is a beat through sonar. She describes a visual flutter or subtle flashing of light when you look at the image on the screen. However, according to Dr. Webber, who has been an abortion provider for 13 years, visualizing this flutter can be unclear. She says, “I had several patients where it was kind of ambiguous whether there was a heartbeat there... It can be sort of subjective sometimes.” Similarly, nurse Alina said, “I had to peer at it [the sonogram screen], for five minutes so that I could see it.” At such early gestations, it can be difficult to detect cellular activity on the sonogram screen. Importantly, as Donna Haraway aptly highlights, Western societies prioritize the visual despite the impossibility of technological objectivity (1991, 188-189). State legislators, who may not understand the nuances of interpreting sonographic images, write “heartbeat” ban legislation as if ultrasound machines can provide an objective result indicating whether there is a “heartbeat.”

Sonography in early pregnancy is not considered medically necessary prior to an abortion (Upadhyay et al. 2022), but abortion providers conduct ultrasounds to confirm the gestational

age and to determine whether they can legally provide an abortion. In pregnancies that patients plan to continue, sonography is used to determine the gestational age, whether a pregnancy is intrauterine, if there are multiple gestational sacs (a single or multiple pregnancy), and to determine whether there are embryonic or fetal electrical impulses. However, this initial ultrasound occurs on a different timeline depending on whether the patient plans to have an abortion or continue the pregnancy to term. Most obstetricians in the US will not see their pregnant patients until 7-12 weeks of pregnancy when it is easier to view the embryo or fetus by ultrasound (Cleveland Clinic 2024). According to Cleveland Clinic (2022), a doppler ultrasound is usually unable to detect electrical impulses until about the 10th or 12th week of pregnancy (8). In contrast, abortion patients may undergo transvaginal ultrasounds to detect electrical impulses much earlier, usually around five to seven weeks of pregnancy. Patients who plan to continue their pregnancy as compared to those who intend to have an abortion are undergoing these initial sonograms and detecting electrical impulses on a dramatically different timeline, which further demonstrates how the determination of when a “heartbeat” begins is socially constructed for political means. By mandating that physicians provide ultrasounds prior to six weeks of pregnancy to determine whether there is a heartbeat they are constructing a different pregnancy development timeline than is established for patients who plan to continue their pregnancies.



Figure 4. Transvaginal ultrasound image of an embryo at seven weeks and six days since the first day of the patient’s last menstrual period. The embryo, at this stage and gestation, is nearly two weeks further along than the approximately six weeks at which electrical impulses usually begin to appear. Source: the author.

I found this to be true of my own pregnancy experience in Ohio. As shown above in Figure 4, which is from my first sonography appointment for a pregnancy I planned to continue, this transvaginal image does not contain a heart or any other distinguishable features that one would associate with a fetus or infant. In fact, during my appointment the midwife was unable to detect the embryonic electrical impulses using an abdominal approach. Then, it took her five attempts with the transvaginal sonogram view to get an image that was clear enough to determine that there was cellular activity. Importantly, my midwife called the figure in the image a “little bean” and referred to the cellular activity as “fetal heart tones” rather than a “heartbeat.”

When Senate Bill 23 was in effect, abortion patients would arrive at clinics for what was referred to as “Day 1” when they would receive an ultrasound to determine the gestational age and whether electrical impulses were present. If the impulses were not detectable on Day 1, then

the patient could return for Day 2 to undergo a second transvaginal ultrasound when a transducer is inserted into the vagina to check if the electrical impulses had developed in the time between their first and second visit, usually around 24-48 hours apart. If electrical impulses were not detected, then the patient would be able to have an abortion.

In order to confirm whether the patient developed electrical impulses since their Day 1 visit, patients were required to consent to undergo a second transvaginal ultrasound on Day 2. Transvaginal ultrasounds are generally not painful, but they are invasive and can be uncomfortable. In cases where patients have a history of sexual trauma, however, this can be especially disturbing. In fact, mandatory ultrasounds have even been described as state-based rape by legal scholars (Green 2013). As Dr. Shepherd, a professor and physician at Bluegrass Clinic for six years, outlines,

[SB 23] led patients to have a second transvaginal ultrasound because when they are this early [in pregnancy] an abdominal approach isn't good enough. You don't get the same penetration and the same view. You are putting patients through another vaginal probe, which is not comfortable. [For] patients who maybe have had a history of sexual trauma, it can be very distressing to have to do that. And so, you're putting people through procedures that they don't need.

Dr. Shepherd highlights how detecting the electrical impulses relies on transvaginal ultrasound because the view from the abdominal approach is not clear enough to detect embryonic electrical impulses in the uterus at early gestational ages. Transvaginal ultrasound or the insertion of an ultrasound probe into the vagina began to be used in 1980 prior to 12 weeks of pregnancy

(Campbell 2006). With the development of transvaginal ultrasound, physicians were able to conduct a more detailed examination of the uterus and its contents due to the closer proximity to the embryo. Importantly, the type of technological instrument used (transabdominal or transvaginal) affects whether sonography can detect embryonic electrical impulses, especially prior to 12 weeks of pregnancy (Mitra et al. 1996); thus, the existence of a “heartbeat” at about six weeks of pregnancy relies on the accuracy of a particular type of ultrasound technology.

In the abortion clinic setting when SB 23 was in effect, patients were undergoing unnecessary medical testing in the form of multiple transvaginal ultrasounds in order to prove that the embryo had not developed electrical impulses. Technological objectivity is assumed in anti-abortion “heartbeat” ban legislation, but it becomes clear that searching for embryonic electrical impulses is a subjective process and a productive search. This illusion of scientific objectivity enables anti-abortion lawmakers to advance the idea that the detection of a “heartbeat” is a definitive sign of personhood, when, in fact, it is a politicized framing of a basic cellular activity. These unscientific interpretations of gestational age and cardiac formation become routine in clinics. As Mertz (1994) notes, legal language shapes social power structures. In this case the use of the term “heartbeat” becomes commonplace in clinics and causes uncertainty concerning the gestational age process for patients.

Semantic Massage

Legal language gets picked up in everyday clinical care. Dr. Gray, a 39-year-old abortion provider in Ohio, was quick to call attention to how pregnancy was not conceptualized in terms of trimesters until the *Roe v. Wade* Supreme Court case was determined in 1973. The *Roe* decision stated that abortion would be legal in the first trimester, could be regulated by states in

the second, and could be banned in the third trimester after “viability” (Beck 2011). Dr. Gray explains,

It’s the same way that trimesters were made up with *Roe v. Wade*. Prior to *Roe v. Wade* there was no such thing as a pregnancy trimester. You were just pregnant until you gave birth, then all of a sudden when they had to legislate pregnancy, they had to make a way to legislate it because you can’t just legislate medicine, except it turns out you can if you just make things up... we accept them, and they become part of medical vernacular.

It was only after *Roe v. Wade* was decided that there was a need to distinguish between when abortion would be legal and when it could be regulated by individual states. Over fifty years after the *Roe v. Wade* ruling, the demarcation of pregnancy into trimesters is not questioned by medical staff or patients. In this way, trimesters have become biomedically hegemonic within pregnancy management. Similarly, the legal language of “heartbeat” bans is becoming part of medical vernacular in ways that are consequential for reproductive governance. Moreover, careful attention to the language healthcare staff use suggests that there is a disjuncture between staff who perpetuate the term “heartbeat” and those who use alternative terms.

When there are embryonic electrical impulses present, I have found that there seems to be an unease and, at times, friction over what terminology medical staff use with patients. There is no consensus among healthcare staff concerning how to refer to embryonic electrical impulses at about 6 weeks of pregnancy. Clinic staff with whom I spoke used different terms, such as “cardiac activity,” “cardiac motion,” “fetal heart tones”, and “FH” to replace “fetal heartbeat.” After visiting two different clinics in September 2022, I found that there are differing viewpoints

concerning how to refer to the electrical impulses across the clinics and across the individuals with whom I interviewed. At Franklin clinic, everyone I spoke to referred to embryonic electrical impulses as a “heartbeat.” Vivian, a manager at Franklin Clinic, informed me that she was overly cautious about having her staff avoid using the term “heartbeat” because she feared that they would be perceived as not following Ohio law. At the same time, she described this as upsetting particularly for the physicians because they have a medical degree and a scientific understanding of the cardiac development process. In contrast, during my time at Grand Plains Clinic, I did not hear a single individual refer to the “heartbeat”: instead, they would say “cardiac motion.” Also, when referring to the Fetal Heartbeat Determination form, many staff members would use the acronym “FHD” when speaking to coworkers to avoid saying “fetal heartbeat determination.” Importantly, there appears to be disunity among medical staff struggling with how to provide accurate medical information to their patients. While all of the clinics were following Ohio state law, this discontinuity in language highlights the difficulties involved in interpreting and navigating legislation that polices healthcare professionals in this way.

This becomes especially confusing for patients who have heard SB 23 referred to as a “six week ban.” Some advocacy groups and healthcare staff contribute to misinformation around embryo development by calling it a six week ban to avoid saying “heartbeat”; however, this provides a false notion that electrical impulses will develop at precisely six weeks. Patient navigator Nadia who assists patients in leaving or entering the state for abortion care describes how this misrepresents how the legislation is enacted and further convolutes when patients believe they can receive care. She says,

[I]t's definitely difficult to understand for a lot of people when they hear this is the heartbeat bill and... it's at six weeks [gestation] and they are like "okay, if I'm under six weeks I'm good." But fetal heart tones can show up at any moment, especially between the five-to-six week [gestation] mark. I've had someone as early as five weeks and one day or I've had people passed six weeks where fetal heart tones have not shown up. It's definitely something that's difficult to explain to patients. Like yeah, it's called this but this is what it really means.

In other words, these attempts to avoid utilizing heartbeat language can further confuse patients, and, ironically, contribute to abortion agnotology, which leads patients to assume that six weeks is the marker for when they can no longer have an abortion. Of note, Nadia critiques how SB 23 is referred to as a six week ban, yet she states that they are observing "fetal heart tones" when at six weeks of pregnancy these would be embryonic electrical impulses. Further, the use of "heart tones" instead of "heartbeat" still presumes that the source of cellular electrical activity should be considered a "heart" and likely evokes similar imagery for patients.

Even within the same story, clinic staff would use different terminology. In the quote below Nadia is describing a situation where a patient had returned on Day 2 to find that electrical impulses had developed in the time between her visits:

I hear wailing from one of the ultrasound rooms. It was a patient who had come in the day before and she was five weeks and four days [pregnant]. And so, really at that point it could have gone any way. And then, the ultrasound showed that there were "fetal heart tones" and [she had a] total breakdown... She was like "I'm a college student. I can't do

this. I can't have a baby right now. I won't graduate. Nothing in my life can support this.”
... [I] got her an appointment out-of-state. She was someone who needed a lot of additional support. We got her a Greyhound [bus] ticket. We got her a hotel and then she went to [another state] and had her abortion.

Hopefully, she's doing well now and thriving in school [Nadia smiles at this thought]... I have no clue what a person's mental state is afterwards because it can be traumatic to have a medical decision taken away from you just because there are electrical impulses on an ultrasound.

Notably, Nadia first refers to the “heartbeat” as “fetal heart tones” and then as “electrical impulses” a few moments later. In other words, she demonstrates how difficult it is for healthcare staff to find appropriate terminology when navigating legislation that enforces medical misinformation while also striving to provide abortion-related care. In addition, through Nadia's words we realize that even when clinic staff speak with a social science researcher, they use the term “heartbeat,” indicating that they have become accustomed to using this language despite its inaccuracy.

Further, what is also illustrated in this story is how once the massaged term—“heartbeat”—takes hold, it can have significant and, in this case, devastating emotional and physical, and financial consequences. To the patient's dismay, she was forced to travel across two states and about 300 miles to obtain a legal abortion. Richardson speaks about the act of deliberately substituting words with others that are recognizable to evoke a particular feeling or imagery. The use of the term “heartbeat” at approximately six weeks of pregnancy

simultaneously humanizes the embryo while dehumanizing the pregnant person. As feminist scholars have long argued, such shifts in language flag the processes that enable the pregnant person to be denied bodily autonomy and become an incubator for a potential life (see Petchesky 1987; Casper 1998; Mitchell 2001; Taylor 2008; Morgan 2009). This choice in terminology has human costs.

Further, the difficulty with perpetuating the use of the term “heartbeat” reflects in part how this terminology plays on the moral and social meaning of a “heart.” Associated legislation evokes embryo personhood and as illustrated below, on an imagined fetal body. For example, Jessica, a patient navigator who assists patients with their travel plans to obtain an abortion in another state, expressed her views on the legislation:

[SB 23 is] intended to... make our patients feel that they are murderers. Because when we're not having an honest conversation about a cell cluster or a blood clot...but then we tell people when you go home to complete your medication abortion, you're going to see clotting and you're going to see lots of gooey bloody stuff...but at six weeks there's a heartbeat so then does that mean that I have this fully formed [baby], even if it's little? [T]hat makes people believe that there is what we conceptualize as a living baby that they are destroying in their bodies. ...

[T]hat all contributes to how hard it is already for people to make these emotional decisions for themselves and their futures when we tie pregnancy and [a] living baby so close together. Of course, that contributes to guilt and shame... because it's arbitrary. It's still a cell cluster that looks really clotty when there's a heartbeat. That's the whole point.

How can it have this beating heart and be a blood clot? That, again, is all going back to instilling that fear and doubt.

Jessica is describing how when patients hear that there is a “heartbeat,” they assume that there is a small but developed baby at about six weeks of pregnancy, and how this terminology is meant to evoke an emotional and moral response in patients. Similar to Faith2Action’s slogan “Abortion Stops a Beating Heart,” such language imposes a moral judgment on abortion patients. The act of stopping a beating heart is associated with death and, in this case, murder. There is no clinical indication that necessitates searching for embryonic electrical activity prior to having an abortion and having that information does not affect the clinical care an abortion patient is provided. By forcing patients to sign a “fetal heartbeat determination” form and disallowing abortions after a “heartbeat” is detected (when SB 23 was in effect), patients receive the message that they are immoral if they move forward with an abortion after that point. Despite research showing that similar legislation such as mandatory ultrasound viewing generally does not affect whether the patient chooses to continue with their abortion (Upadhyay et al. 2017), my research suggests that such legislation exacerbates abortion stigma.

And, for some patients, it does evoke the emotional response intended by legislators. Alina, a 30-year-old nurse at Bluegrass Clinic who has been working in abortion care for five years, says

[F]or some people it’s working. They are hearing that it’s a heart and they’re like... “if it has a heartbeat, I’m not going to have an abortion.” That is morally meaningful for them, which, if that’s the case, that’s totally fine... but do you understand that it’s not a heart

and that this is something that people are telling you?... I say “yes, I totally support you if that’s what [you want]... [but] I want to make sure that you know this is not a heart... just so you know nothing has changed medically... I want to make sure that you know that”... It is a fairy tale... we just have to click a different box in the computer.

In some cases, patients find the delineation of when a “heartbeat” begins to have significance in their decision-making process. As Alina describes, she attempts to counter misinformation about the “heartbeat” by explaining that this is an imaginary designation or in her words “a fairy tale.” Abortion clinic staff are careful to support their patients’ reproductive decisions whether that means having an abortion or not, but, importantly, some staff emphasize the importance of ensuring that patients are fully educated about pregnancy progression and their options.

When I asked clinic staff how they felt about the SB 23 “heartbeat” ban legislation, they expressed how, at times, they would try to educate their patients about medical misinformation concerning the development of an embryo. Nadia describes how misleading SB 23 is because she says her patients are “like ‘oh, it’s a *heartbeat!*’ and we’re like ‘it’s not really a heartbeat, it’s heart tones. It’s not a fully formed heart. There’s nothing happening there. It is not even a fetus at that point.’ It’s really difficult to use medical terminology without making it even more confusing for them.” I interpret healthcare staff’s attempts to educate patients about embryo development to be a soft form of resistance to counter the misinformation enforced by anti-abortion legislation. Clinic staff who utilize other terms to describe the “heartbeat” are performing forms of soft resistance or refusal to state legislation while still allowing providers to comply with state legal requirements.

To avoid patient confusion, in some cases, healthcare staff explain that they may need to use the term “heartbeat” when they have a patient who does not understand other terms. Dr.

Pierce, an abortion provider and obstetrician, explains,

I do not think our patients understand cardiac activity. I think that’s super jargony and patients just don’t know what [terminology] I’m using. [They] literally cannot understand what I’m saying... I don’t think it’s as politically charged [for the patient] as it is for us. I get why people don’t use that word because heartbeat is very politically charged and bestows some kind of quality on the fetus that we know scientifically isn’t there, but ultimately, I just want the patient to understand what I’m saying. So, I do say heartbeat because I think that is the best way that it’s understood by patients.

This physician prioritizes whether the patient understands her language and therefore whether or not they are able to have an abortion. Importantly, it can be difficult for healthcare providers to be tasked with educating patients when they are responding to a healthcare crisis, and may need to prioritize patient comprehension over taking additional time to explain embryo development to a patient who may only be concerned with whether or not they can have an abortion.

However, one could argue that there might be other ways to educate patients using lay terms, such as “heart-like pulse,” and that the decision not to inform less educated patients likely further disadvantages patients with less social and economic resources. At the same time, it can be difficult to counter years of inadequate instruction in biology and sexual health education alongside anti-abortion propaganda in one or two clinic visits.

Healthcare workers who provide abortion care face legal and financial penalties if they do not follow state-mandated policies which promote medical misinformation. As nurse Alina points out, SB 23 “is a fairy tale” and the designation of a “heartbeat” is manufactured to evoke an image of a fully developed beating heart to promote embryo personhood. In this way, state lawmakers, through legislation, generate ignorance and produce a strategic message around embryo development in ways that further their political agendas. “Heartbeat” ban legislation not only bans abortion after an early gestation, but as I have shown here it also punishes pregnant people by producing moral fear and doubt. The words one uses “reveal unspoken attitudes” (Richardson 1996, 87). The heart, arguably, is one of the most human characteristics. By using the word heart or heartbeat, one thinks of emotions like love. I argue that the meaning evoked by the substitution of embryonic electrical impulses for heartbeat simultaneously humanizes the embryo and dehumanizes the pregnant person.

Conclusion

Legal language shapes biomedical terminology. The political landscape for abortion access and “heartbeat” ban legislation affects the way in which medical staff speak to patients about their abortions. US state legislators, including those in Ohio, have mandated anti-abortion legislation that deliberately advances misinformation around embryo and fetal development. They deploy false notions of technological objectivity and manipulate scientific lexicon to make it appear as though an embryo contains the same organs and capabilities as a fully developed infant. Lawmakers who pass anti-abortion legislation concerning the detection of a “heartbeat” also shape how ultrasound technology is utilized to create social, moral, *and* political meaning. As demonstrated, this misinformation around embryo and fetal cardiac development shapes

medical and colloquial language around the developmental stages of pregnancy and promotes embryo personhood. In other words, anti-abortion legislation that relies on the construction of a “heartbeat” weaponizes science and medical technology for political gain. Seemingly objective scientific processes, such as when a heart begins to beat, are utilized to advance anti-abortion political agendas.

The manipulation of a scientific lexicon concerning embryonic and fetal cardiac development contributes to abortion or embryo development ignorance. A taxonomy of ignorance (2006) as it relates to “heartbeat” language in Ohio begins in 2013 with the passage of HB 59. For nearly a decade prior to the implementation of the “heartbeat” ban, physicians were required to scan patients and detect whether or not a “heartbeat” was present even though, for that decade, it did not affect whether or not the patient could obtain an abortion. Through a process of habituation, physicians at all times of the day (and night) must check a box that states whether or not a “heartbeat” is present. This compulsory act of searching for and documenting the “heartbeat” may explain why clinic staff used the term even in conversations with me. As Mol (2002) teaches us, knowledge is disseminated and takes shape in practice. Over time, through the physical act of searching for and documenting the presence or absence of a “heartbeat” clinic staff appear to have become desensitized to the emotionally laden term and inadvertently perpetuate ignorance around embryonic development.

This form of not knowing is what Tuana (2006) would consider a form of gendered oppression denying women with information about their own bodies. Patients become confused about when an embryo becomes a fetus and when cardiac development becomes more than mere cells interacting. One must parse the language applied in anti-abortion legislation because the confounding of pregnancy development categories advances misinformation with the goal of

stigmatizing and morally shaming abortion patients. Just as the formation of pregnancy trimesters became hegemonic to obstetrics and gynecology after the 1973 *Roe v. Wade* Supreme Court decision, anti-abortion legislation holds discursive authority through the power of law. By allowing misinformation in anti-abortion legislation around embryonic electrical impulses one risks legitimizing guidelines for when an abortion is considered “acceptable” or “moral.”

Word choice matters. By using the phrase “fetal heartbeat,” state legislators who sponsor “heartbeat” legislation evoke an image of a much more developed pregnancy. As Richardson states, “Dishonest language bespeaks dishonest intentions” (Richardson 1996, 86). Though this chapter does not explore the overtly violent effects of how anti-abortion ban legislation forces many pregnant people to either leave their state or region of the country for care or to be forced to carry their pregnancies to term, I argue that it is essential to interrogate these insidious tactics because, over time, these views of embryo development become hegemonic and facilitate the passage of increasingly restrictive legislation just as how HB 59 paved the way for SB 23 in Ohio.

The semantic massaging of scientific terms assists in the development of culturally produced ignorance in biomedical realms. In this way, knowledge production is shaped through law and is what Proctor and Schiebinger (2008) would consider a strategic ploy of ignorance. I advance Proctor and Schiebinger’s (2008) work to argue that ignorance as strategic ploy is also an important dimension of reproductive governance. The process of manufacturing terms and producing ignorance around scientific and biological processes is used to exert control over reproductive bodies. In the next chapter, I explore the impacts of restrictive legislation and uncover another mechanism of reproductive governance, the political construction of time.

Chapter 3: Shifting Policies and Temporalities of Care

Fluctuations in the legality of abortion access force clinics to adapt to new policies on short notice. The only constant for abortion clinics that are located in precarious political settings is that they are perpetually maneuvering around new regulations and court case proceedings. Whereas Chapters 1 and 2 focused on the strategies of reproductive governance, this chapter attends to the impacts. As demonstrated in the first two chapters, Ohio abortion providing facilities have been navigating an uncertain legal terrain for over a decade. The *Dobbs v. Jackson Women's Health* (2022) Supreme Court decision exacerbated existing uncertainties about the passage of anti-abortion legislation and access to care. In this chapter, I demonstrate how anti-abortion legislation develops a life of its own in clinic settings, especially with respect to the temporal aspects of policy and care. These shifts in abortion access were characterized by weeks when clinics had very few patients and a slower pace and then others when the volume of patients had increased suddenly along with the pace of the clinic. I refer to these changes in pace as a *quickenning of care* or a *slowing of care* to depict the stark contrast in how care is experienced. These temporal clashes were deeply unnerving for both clinic staff and patients. To fully understand what happens when healthcare access is in a constant state of uncertainty, I attend to the temporalities of policy to help us see how the push and pull of temporal markers shape the logic of care in clinic settings

I had the unfortunate advantage of conducting my fieldwork during one of the most tumultuous times in close to five decades for abortion access and care in Ohio. During the months following the *Dobbs* decision and the implementation of Senate Bill 23 (SB 23), it teetered from being in effect to being blocked by an Ohio lower court judge. This uncertainty greatly affected the abilities of providers to serve their patients. On September 14th, SB 23

received a temporary injunction for two weeks. Then, just before the temporary injunction was set to expire, the judge granted another temporary injunction for an additional two weeks. On October 7th, the judge ruled that the bill would be blocked until a final ruling would determine whether SB 23 is legal under the Ohio constitution. The plaintiffs in the legal case, *Preterm-Cleveland et al. v. David Yost et al.*, argued that the Ohio constitution deems healthcare a right, and therefore SB 23 denies access to healthcare on the basis of sex. In the end, the legal case became irrelevant because Ohio voters passed Issue 1 referendum by majority popular vote to protect the right to an abortion in November 2023 (The Guardian 2023). SB 23 was in effect for nearly three months, from June 24th to September 14th, 2022, but for those who work in abortion provision, these shifts in legislation resulted in uncertainty in their ability to confidently tell abortion patients that they could provide them with care. Policy uncertainty or policies in-flux shape care within clinics.

Throughout this chapter, I interweave literature on the anthropology of policy and the anthropology of care to trace the quotidian ways in which anti-abortion policies are navigated and challenged. By integrating anthropology of policy and care literature, I illuminate how temporal uncertainties have profound effects on the logics of care. The logic of care framework, as conceptualized by Mol (2008), is the way in which care integrates the lived patient experience. I use the phrase “logic of care” to describe how providers and clinic staff must shape their care to the political moment. I ask, how do shifting policies shape temporalities of care and affect the ability to provide “good” care? And, how do reproductive health care providers tinker, innovate, and creatively navigate the challenges of providing care in politically hostile contexts? In other words, I ask what might we learn from the provision of care in a crisis situation.

In response, I offer several interventions. First, I integrate theories of policy, the social construction of time, and care to lay the groundwork for how I theorize shifting policies and associated temporalities of care. Second, I outline how restrictive abortion legislation affects healthcare staff and doulas through structural policy changes in the political construction of time within clinics. Third, I examine how patients experience the temporal aspects of care due to the sudden shifts in abortion legality. Finally, I provide an analysis of how clinic staff improvise their care practices to provide “good” care. I show how studying policies in-flux reveals hidden harms and possibilities for improvisation in care practices. Ultimately, I argue that the political construction of time in anti-abortion legislation is yet another form of reproductive governance (Morgan and Roberts 2012).

Theorizing Shifting Policies and Temporalities of Care

Policies have a life of their own in how they are interpreted, enacted, and contested (Shore, Wright, and Però 2011). To be clear, I distinguish between laws and policies, in that laws are designed by legislators and policies are created and implemented at institutions by individuals on a local level (Tate 2020, 84). Policy, throughout this chapter, refers to both the guidelines created by clinic staff and the everyday interpretation of those guidelines—what one feels they can say and do within the confines of the law. Policies develop a fluidity in how they are interpreted in the everyday provision of care. I view an anthropology of policy similar to Tate (2020) in that “policy is a generative realm of cultural production, producing and shaped by values, norms, identities, and practices... Policy action does not have discrete beginnings and endings; such temporal markers must be produced through the stories told about policy” (85). By paying close attention to the narratives that emerge about policies, one can gain insights into the

lived experiences of those individuals affected by policy. More specifically, I contend that an ethnography of policies in-flux provides insights into how individuals interpret and navigate harmful healthcare restrictions.

Abortion providers have been inundated with administrative burdens due to restrictive anti-abortion legislation. According to Herd and Moynihan (2018), administrative burdens arise in contexts where the state governs a private behavior, such as abortion, through bureaucratic regulations (see also Heymann et al. 2023). What I add to this conversation is how such legislation not only burdens clinic staff in terms of paperwork and bureaucratic hurdles, but also via the temporal aspects of adjusting to policy changes and new guidelines. The need to adjust to these new policy changes and guidelines shapes temporalities of care in unintentional and unexpected ways for clinic staff. Time is of particular importance for reproductive care, especially with respect to pregnancy and abortion. As I explored in Chapter 2, pregnancy is marked by the measurement of trimesters, and the ability to obtain an abortion in most states across the US is constrained by gestational limits in the number of weeks pregnant. In other words, time is of the essence when one is pregnant and needs an abortion. As Rayna Rapp astutely points out, “Time is always a social metric” (2020, 256). The way in which time is measured, given meaning, and experienced are critical aspects of abortion care. The political construction of time is the way in which laws (passed or proposed) shape the clinical organization of time. With this in mind, I view the political construction of time in anti-abortion legislation as a tool used to shape and control reproductive behaviors, possibilities, and outcomes.

Time is also a critical resource, especially in healthcare settings. Crucially, when time is scarce, social inequities are amplified such that there is an increased burden along the lines of

gender, race, class, and citizenship status. As such, I pay particular attention to how policy uncertainty and the resulting temporal disruptions in abortion legality shape the provision of care. I build upon the work of scholars who have studied "clinical temporalities" or the social organization of time within medical settings (White 2016; Andaya 2019b). For example, anthropologist Elise Andaya (2019b) notes how lengthy wait times in a public prenatal clinic demonstrate how histories of racism and classism are present in the devaluation of time for low-income pregnant people of color. The social organization of time signifies what and who is valued. With this in mind, I examine how the political organization of time enforced by Ohio law affects the social organization of clinical time. Essentially, time is organized in healthcare settings by structural forces, such as laws and policies, but it is also shaped by the localized logics of care within a particular setting.

Contemporary feminist scholars question the meaning of care in order to "unsettle" previously assumed notions of care as inherently good and apolitical (Murphy 2015). Inspired by feminist political scientist Joan Tronto (1993), Puig de la Bellacasa (2017) broadens academic understandings of what she deems "matters of care" to be ethico-political issues derived from socially constructed assemblages of social and political interests. Through an attention to the "mundane, ordinary, and pragmatic ways" in which care is assembled, one is able to locate how providing care can be considered a transformative ethos (Puig de la Bellacasa 2017, 67; see also Mattingly 2014). In this case, the provision of care can be transformative in how one views themselves or how their time is valued. I pay particular attention to the mundane or ordinary aspects of care to gain insights into how providers transform their care practices in response to the political organization of time.

The provision of medical and non-medical care has been characterized by improvisation in challenging and precarious settings (Mol, Moser, and Pols 2010; Garcia 2010; Livingston 2012; Strong 2020). I consider Ohio and similar states where abortion legality has been under attack to be in a state of precarity. The scarcity of resources is significant here: there are only nine abortion clinics remaining throughout the entire state (there were 25 clinics in 2010) (OPEN: Ohio Policy Evaluation Network 2023), which has a population of nearly 12 million residents (U.S. Census Bureau 2023). Clinicians are capable of providing care in precarious medical contexts despite substantial institutional challenges to providing appropriate medical treatment (Wendland 2010; Livingston 2012). Abortion clinic staff face significant obstacles to their provision of care as abortion bans and related legislation limit their capacity to provide services. The number of abortion clinics continues to decline across the Midwestern and Southern US producing a scarcity of providers. As Livingston reminds us, in contexts of scarcity, the provision of care should be understood as an "inherently political act" and may well inspire improvisation in biomedical realms (2012, 96). Following this line of thinking, I attend to care as "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol, Moser, and Pols 2010, 14). In particular, I investigate how healthcare staff tinker with the care they provide in response to an increasingly hostile landscape for abortion access characterized by uncertainty.

The Political Construction of Time within Clinics

This section examines how legislation restricting abortion shapes temporalities of abortion access and care. For example, since 2013 Ohio mandates a 24-hour waiting period between a patient's first appointment and their abortion (*Ohio House Bill 59*). As described

earlier in this study in Chapter 2, an added burden to the mandatory waiting period in Ohio is the Fetal Heartbeat Detection (FHD) form that must be signed by the physician who will perform the abortion and then by the patient (*Ohio House Bill 59* 2013). After both signatures are documented, the patient must wait at least 24 hours before they can have an abortion. Even though the initial counseling appointment is referred to as Day 1 and the abortion appointment is referred to as Day 2, it is not generally 24 hours between the two appointments. Depending on the patient volume, there may be several days in between the Day 1 and Day 2 appointments. Additionally, when the form is not appropriately signed, the patient cannot proceed with their abortion. In this way, mandatory waiting periods and the FHD form are examples of institutional challenges that cause a slowing of care. In other words, the social organization of time within the clinic is shaped by the political organization of time mandated in House Bill 59.

These temporal constraints mandated by House Bill 59 by way of the mandatory waiting period and the FHD form affect patients' abilities to access abortion. During my visit to Grand Plains Clinic, I was sitting at the front desk when a staff member told a patient that she would need to return another day because she had failed to sign her FHD form at least 24 hours prior to her appointment. As patients are leaving their Day 1 appointment, they are often reminded by clinic staff to download the digital health portal in order to sign their paperwork electronically. However, sometimes patients forget to sign the consent or have difficulty navigating the online portal. Patients with low literacy or low digital literacy may find this task to be particularly burdensome. When the patient was told that she would not be able to have her abortion that day, she appeared disappointed but, in the end, she was relieved that she was able to reschedule her appointment for two days later. To avoid a future issue, the staff member had her sign a paper copy of the consent to ensure that it would be completed in time. The human cost of these

temporal constraints on the need to complete FHD paperwork at least 24 hours prior to their appointment is that a patient may not be able to obtain an abortion in Ohio if their pregnancy has advanced beyond the state time limit.

When Ohio Senate Bill 23 (SB 23)—the “heartbeat” ban—went into effect, patients needed to sign the FHD form twice because the state mandated that they have two ultrasounds to confirm that there were no detectable embryonic electrical impulses just before the abortion on Day 2. Many staff members informed me that they would complete the ultrasound and quickly move on to provide the abortion for fear that the Ohio Department of Health would determine that a “heartbeat” could have developed in the time between the ultrasound and the abortion. As Puig de la Bellacasa states, “[a]s a transformative ethos, caring is a living technology with vital material applications” (67). In this pragmatic example of physicians performing ultrasounds at a quicker pace, one can see how clinical temporalities are transformed. The material implications of failing to perform the ultrasound quickly enough could result in the patient not being able to have the abortion or, if there is an ambiguous interpretation of the ultrasound documentation, the physician could face legal action or lose their medical license.

Administrative tasks that are bounded by time can cause anxiety and work can bleed into employees’ leisure time. In the middle of my interview with Dr. Pierce, I hear a ding and she holds up her phone to the computer screen to show that she has received an alert to sign an FHD form. She says,

Every few minutes throughout the day we get some form that looks like this... We have to view the fetal heartbeat on the screen and acknowledge that we saw the fetal heartbeat. Then, once all of the providers have signed it electronically it gets sent to the patient, and

so constantly throughout the day we're getting alerts on our phone that we need to sign one of these. It's much much much better than how it was. When I started, we would have to swing by the clinic every week and sign a stack this tall on paper [holds her hand a few feet above the table] ...

Every night before I go to bed, I'm like did I sign all of my things? And then I pull it up and I'm like "oh! There's one that I didn't sign" [speaks in a hurried and frantic tone]. It's kind of always in the back of my head.

In practice, this clinic used to have the physician scheduled for that day's abortion sign the paperwork, but in the middle of my fieldwork they changed their clinic policy to have all physicians sign all FHD consents. This new policy of having all clinic physicians sign the FHD forms is beneficial for patients if they need to change their appointment or if a physician is sick: now they no longer need to sign a new form and start the clock again. However, this means that physicians are required to sign even more FHD forms when they are not in the clinic. Physicians must always have their phone or iPad available to sign FHD forms or patients will not be able to have their abortion. Importantly, Dr. Pierce highlights how the need to complete FHD forms as quickly as possible shapes the organization of time by blurring the boundaries of her work and leisure time. The need to be prepared to sign FHD forms at all hours of the day and night exudes a haunting sense that one's work is never done: in other words, the work clock never stops. In this case, the clinic interpreted the law by creating a policy for all physicians to sign all FHD forms, which in practice is better for patients but greatly burdens physicians. The need to sign the FHD form not only increases the administrative burden for physicians and staff, it also creates a

hurried or frantic sense of urgency to complete paperwork as quickly as possible merely to be able to serve their patients. Policies that appear straightforward are much messier in practice than expected.

Physicians and clinic staff challenged these temporal policy restrictions by adjusting the social organization of work time. This became evident during my four visits to two Ohio clinics; it became apparent how necessary it was for staff to improvise their care by filling multiple positions. For example, at Grand Plains Clinic, I watched as the clinic director hurried around the facility performing various administrative and clinical roles. She was the only person present that day who was trained to perform ultrasounds, which meant that she was completing both her administrative tasks and providing ultrasounds for patients who had arrived for their Day 1 visit. This is partially due to the fact that fluctuations in the ability to provide care make it difficult to train new employees. If the clinic is only able to provide abortions until approximately six weeks of pregnancy, then they are unable to train new staff in how to perform ultrasounds on patients who are further along in their pregnancy. I found that clinic staff met these challenges by improvising their roles and working additional hours to accommodate as many patients as possible.

A few physicians also mentioned how they chose to add hours to their normal schedule to serve as many patients as possible when SB 23 was not in effect. In fact, Dr. Shepherd described how this happened once the law was blocked:

I think those two weeks it was literally how many people can we take care of before it changes again. People in the clinic were fantastic. Everyone pitched in. Everyone worked extra shifts. I went in on a Sunday... I remember saying “why aren’t we open? If you

need someone to staff it, let's do this" and so for those two weeks we worked hard to get as many people taken care of as we could until whatever came next.

During a time when it felt as though providers had little control over what they were able to do for their patients, this was one way that they were able to regain control and serve their patients.

The ability to receive abortion care is centered around the political construction of time within a given state, and shows how legislators manipulate time to regulate reproductive behaviors. The political construction of time shapes clinical temporalities with respect to how physicians and healthcare staff must spend their time completing administrative tasks, such as the need to sign FHD forms at all hours of the day. The enforcement of gestational limits and mandatory waiting periods are additional examples of how reproductive governance is deployed in relation to time. Similar to contexts with minimal physical resources, such as limited medical supplies, it is difficult for providers and staff to deliver care in a setting where time is a limited resource. Importantly, challenging settings such as these bring about improvisations and innovations in care practices (Wendland 2010; Strong 2020).

Policy Uncertainty and Temporal Disruptions in Everyday Care

Laws and policies are not stable objects; they can be passed or implemented and later be revoked or overruled. When I first began my fieldwork in Ohio in November 2021, I found that it was difficult to discern what abortion legislation had been introduced, blocked, or passed, and subsequently what that might mean in the future for abortion access and care in the state. I began my research at a point when most individuals who work in abortion advocacy and care knew that the impending *Dobbs* Supreme Court decision would fundamentally change the abortion access

landscape across the US, but were unsure of the particularities of that change. Many of my interlocutors speculated: how far would the US Supreme Court go? Would *Roe v. Wade* (1973) be completely dismantled or would there remain some protections for abortion access?

Ultimately in June 2022, the *Dobbs* decision delivered a sudden blow to the protections *Roe v. Wade* had afforded for nearly five decades. Over the course of my fieldwork, at times abortion was legal in Ohio until 21 weeks and 6 days¹² of pregnancy and, at others, until approximately six weeks of pregnancy. This new landscape of extreme uncertainty and ever-shifting legislation meant that healthcare providers were (and continue to be) tasked with responding to sudden and unpredictable changes in access to care.

Even though overturning *Roe v. Wade* was by far the most extreme shift in access, the landscape for abortion has been characterized by increasingly restrictive legislation for over a decade in Ohio. Several of my interlocutors mentioned multiple periods of time over the past few years when they had been concerned about their ability to continue providing care. For example, in March 2020, early in the COVID-19 pandemic, the Ohio Attorney General deemed abortion non-essential care and ordered providers to cease within-clinic procedural abortion services¹³ for six weeks (Carpenter et al. 2023). In effect, this meant that medication abortion was still legal and available until 10 weeks of pregnancy, but procedural abortions were banned at any stage in pregnancy. These shifts in the ability to provide care may appear trivial as compared to complete or near-complete bans; however, as Jessica, a clinic administrative staff member notes, “When someone needs an abortion it’s an emergency, they need to be unpregnant as soon as possible. Being pregnant when you don’t want to be is physically uncomfortable, emotionally uncomfortable, [and] can be dangerous depending on confidentiality.” The state of being pregnant is a temporal experience that is vastly different from person to person, but there are

common symptoms of physical discomfort. For instance, over 70% of pregnant people experience nausea and vomiting (Bazarganipour et al. 2015) and undergo a transformation in hormone levels as their body prepares to grow an embryo and later a fetus. Jessica also alludes to more extreme circumstances, such as intimate partner violence, where a patient may need to hide their pregnancy for safety reasons. Pregnant patients in intimate partner violence situations are at higher risk for homicide than if they were not pregnant, and this risk increases in states with abortion restrictions (Keegan et al. 2024). Further, depending on how far along the pregnancy is, a procedural abortion becomes more expensive (Roberts et al. 2014) and potentially more clinically complex. For these reasons and more, the need to have an abortion tends to be considered an emergency socially, even if it is not considered an emergency in the clinical sense.

Further, moments when a law is set to go into effect, but is then blocked by a state or federal judge, create a strain on clinic resources and produce anxieties around the ability to provide care. In the early months of my fieldwork, Ohio Senate Bill 27 (SB 27)— legislation that established stringent rules for the disposal of fetal remains after a procedural abortion— was set to go into effect in February 2022. The bill required clinics to have an arrangement with a funeral home to cremate individually or bury the pregnancy tissue from a procedural abortion. Even without considering the initial difficulty of finding a funeral home that would be willing to work with an abortion clinic, a funeral director informed Greenwood clinic administration that it would not be feasible to individually cremate such small amounts of tissue because this would take an inordinate amount of time. Beyond the fact that this is a nearly impossible request logistically, the financial manager at Greenwood clinic also informed me that it would have cost the clinic over \$100,000 a year to follow state guidelines in the burial and cremation bill. In a

turn of events, one week prior to the implementation of SB 27, an Ohio judge halted the implementation of the new fetal remains guidelines.

As this example demonstrates, each time a new piece of legislation is introduced, clinics are forced to (re)formulate policies and draw on financial and other resources in response to the legislation and/or to change their existing infrastructure in order to remain open. The obvious or surface level goal of this legislation is to enforce notions of fetal personhood by treating pregnancy tissue the same as a deceased body. The underlying policy implication is to financially and administratively burden abortion-providing facilities into closing. Yet a third clinic resource is also utilized when legislation, such as the fetal remains bill, threatens their ability to operate—time. Even though the fetal remains law did not go into effect, the threat of a shift in abortion regulations means that clinics spent weeks, if not months, preparing to adapt to the impending legislation or close their doors and no longer serve patients. Legislation intentionally deflects clinic staff's attention from their work through the accumulation of unnecessary labor and cost. It is important to note that legislation regulating abortion *always* involves a time investment, regardless of whether it ultimately comes to fruition. In sum, policy uncertainty and fluctuations in the legality of abortion cause temporal disruptions in care.

In yet another moment of uncertainty for abortion access, after the *Dobbs* decision was released on June 24th, 2022, Ohio Attorney General Dave Yost swiftly filed to have the injunction lifted from SB 23, which banned abortion after embryonic electrical impulses are detected at approximately six weeks of pregnancy. The day the *Dobbs* decision was released, healthcare workers and advocates with whom I had spoken were shocked at how quickly the injunction placed on Ohio SB 23 was lifted. All of the healthcare staff, doulas, advocates, and

policy analysts with whom I spoke anticipated that they would have weeks between the *Dobbs* decision and the implementation of SB 23.

Five days after the *Dobbs* decision was released, I interviewed Dr. Patel who works at Franklin Clinic. Dr. Patel shared with me how difficult it has been for his staff and patients since the *Dobbs* ruling, and how they were taken by surprise with how quickly SB 23 went into effect:

The state acted so quickly and so swiftly. Even though we had done all of this preparatory work, we were caught unprepared. It literally came down that Friday of the decision, a last-minute call at about one o'clock or so saying "get your patients in today by three o'clock because we're presenting our arguments for our federally blocked cases at three o'clock and we suspect the judge is going to shut our arguments down immediately and any patient that you provide care to after three o'clock will fall under the six week ban."

So, you are calling staff and saying "who is coming in? How soon can they get there?" And, as a patient...I'm sure you are getting yourself mentally prepared to come to the center and to get this call to say "I know you were planning to be here at two o'clock and we told you it might be an hour before your procedure. We need you to get here as quickly as you can in order to provide you the care that you deserve." It just really created a lot of challenges that way and a lot of fear for the staff and patients as well. Of course, then we were faced with the reality of how do we operationalize the six week ban come Monday.

Notably, clinic staff at three different clinics across the state were conservative in deciding the cut-off time to serve patients because the clinic lawyers were unsure of the exact time when the injunction would be lifted and the ban would go into effect. As other scholars have noted, medical personnel tend to be overly cautious in their interpretation of the law for fear of legal repercussions (Czarnecki et al. 2023). This is a case where the uncertainty of when a state law would be implemented led to localized policy interpretations grounded in the threat of prosecution.

This unpredictability created an air of fear. A consistent theme among healthcare staff in Ohio was that they were concerned about their patients' ability to access care. Nyra, a clinic administrative staff member, encapsulates how the ever-changing landscape of abortion care feels:

The feeling is basically walking on eggshells. This idea of you can come in here one day and have a job and be able to provide care, and you don't know if the next day is going to be some type of random law that they put into effect that says you can't receive this care... We just come and work every day under the fear of the unknown. If the next day, I'll be calling somebody [and saying] you can't receive this care or I'll see you the next day and be able to provide it. You just don't know. It's literally a daily walk of walking on eggshells or that feeling that you're about to get into a car accident and you press the brakes... It's a constant feeling.

Nyra is eliciting a feeling of a lack of control—a car crash one cannot stop. This epitomizes how many staff members feel powerless as state-mandated guidelines concerning abortion care are

thrust upon them. Both their ability to provide care and their own livelihood are at stake. Further, Nyra refers to “random laws” to express how such legislation appears arbitrary except to minimize or ban abortion. In this way, one can see how the unexpected implementation of laws is a tool of reproductive governance.

Whereas the issuance of the temporary restraining order, which halts the implementation of legislation until a hearing has taken place, on SB 23 was a welcome change, many staff members experienced unease about whether it would hold or be dismissed at the next hearing date. Patients who were scheduled after a court decision was supposed to be released may not be able to have their abortion. This created concerns when scheduling patients who were supposed to return after the next court hearing. Nadia, a clinic administrative staff member, shares her thoughts on how the day-to-day uncertainty in the ability to provide care is unsettling:

Now that it's gotten to the point where [abortion] services are back right now. Since we don't know the next steps, a lot of other people don't know the next steps. A lot of people know that this is just temporary; [whereas], some people have no idea that it's just temporary. Recently, it has been more difficult because a lot of people know that October 12th date and [it] is coming up on Wednesday. We're like “we have to schedule you after that but if something does happen, we're going to give you a call to make sure you come in soon[er].” It can give [patients] a lot of anxiety because they are like “well if I'm scheduled on the 14th and this is happening on the 12th, what's going to happen to me?”

When people don't know about it, I don't bring it up because I don't want to cause any unnecessary stress in their life in an already stressful situation but if they do ask about it

our administrative staff has been really good about telling us how to explain things and telling them no matter what they will get what they need.

According to some staff, patient knowledge of the political climate surrounding abortion varied widely in the clinics. Notably, Nadia, an administrative staff member, chose not to notify patients who were unaware of upcoming court dates to avoid potentially unnecessary stress. However, by failing to notify patients that abortion access after approximately six weeks of pregnancy may suddenly become criminalized again means that these patients may not understand that a state judge holds the power to decide whether they will have reproductive autonomy. Further, it is unknown whether some patients do not share their anxieties with clinic staff but are aware that they may be unable to have their abortion when their appointment is scheduled. Under these conditions, clinic staff are in a difficult position because they must decide whether to cause potentially unnecessary stress to their patients or to educate them on the politics behind their ability to receive reproductive care. The logic of care appeared to shift with temporal restrictions and with patient knowledge of the political climate creating extra burdens for staff to navigate.

These temporal restrictions also caused some physicians and staff to feel as though they were rushed to provide less than optimal medical care. SB 23 in particular presented obstacles to providing quality medical care due to the legislative quickening of care. Physicians described two primary issues associated with performing abortions prior to approximately six weeks of pregnancy. The first was that it was difficult to determine whether they had removed all of the pregnancy tissue from the uterus because there is such a small amount at that stage.

Second, at such an early stage of gestation many pregnancies were considered “pregnancies of unknown location,” which means that the physician is unable to determine if it

was an intrauterine pregnancy or if the embryo had implanted outside of the uterus, otherwise known as an ectopic pregnancy. In the case of an ectopic pregnancy, a medical or in-clinic abortion would be ineffective: instead, a medication called methotrexate would be required to end the pregnancy and to avoid further complications. Because abortions were only legal prior to approximately six weeks of pregnancy, physicians were forced to perform them under less-than-optimal circumstances. The logics of care within clinics were shaped by the legislative uncertainty concerning abortion access. What is considered “good” or proper care becomes more about whether a patient can have a successful abortion and become “unpregnant” than with the nuances of how that care is received, i.e., patient preferences between medication and procedural abortion. In other words, “good care” here is what Puig de la Bellacasa would consider “as-well-as-possible care” (Puig de la Bellacasa 2017, 6). In this moment of crisis, care is equated with health care access.

Further, another example of how care was affected by SB 23’s temporal restriction involves the ban on abortion after approximately six weeks of pregnancy. Dr. Shepherd describes her difficulty with performing abortions at such an early period of gestation:

You would evacuate the uterus early enough prior to [the] establishment of a heartbeat with the hope that the pregnancy was in the uterus [and that] you were disrupting it. [I remember] those being some of the hardest procedures I have ever done because the uterus is just not primed like it is when you’re six or seven weeks pregnant. When you are doing these early terminations at four and five weeks— because everyone is coming in the minute they have a positive pregnancy test— it just felt like it was more technically challenging as well as more uncomfortable for the patients because the cervix doesn’t

have the prostaglandins and the hormones that cause it to be a little bit softer [and] more pliable for those procedures. That was hard because it was not following normal standard [procedure]... Normally, you would trend [a term for tracking the pregnancy hormone, human chorionic gonadotropin, through bloodwork] and ensure that you have an intrauterine pregnancy, but in order to get people what they needed we literally had to evacuate the uterus and then make sure their hormone levels fell to prove it wasn't an ectopic, rather than being able to wait. I think just not being able to practice [medicine] in the best way was the hardest.

Dr. Shepherd refers to needing to “get people what they needed,” which meant providing abortions even when the circumstances were not ideal. Due to SB 23, patients underwent procedures that were more uncomfortable than might have been necessary. They were also more likely to have an unsuccessful abortion because they needed to be done at such an early gestation. This effect on care was unexpected for the physicians with whom I spoke because abortions are generally performed after six weeks of pregnancy when physicians can confirm the pregnancy location is intrauterine (in the uterus). The inability to provide quality medical care demonstrates one of many hidden harms inherent to abortion bans.

Another unexpected outcome of SB 23 was that clinic staff felt they must counsel patients about the effectiveness of medication vs. in-clinic abortion. When SB 23 received a temporary restraining order, it was unclear in the coming days whether abortion would still be legal past six weeks of pregnancy. During my visit to Grand Plains Clinic, I watched as Dr. Webber flashed a comforting smile to the patient sitting next to her while explaining that medication abortion is effective, but not as effective as an in-clinic abortion using suction. She

told the patient who had furrowed brows and concerned eyes that she could return before the potential legal change for an ultrasound to determine if she needs a procedural abortion. When I asked why she emphasized the minute but very real possibility that a medication abortion may not be successful, she responded that the physicians were concerned that if the medication abortion did not end the pregnancy the patient would need to leave the state to obtain a legal abortion. Essentially, procedural abortion has a slightly higher rate of success to end a pregnancy (Ireland, Gatter, and Chen 2015). Even though the difference is almost negligible, some staff thought it might be safer to ensure the tissue had been removed in the clinic. Patients who attempt a medication abortion and later find that it has been unsuccessful would be unable to have an in-clinic abortion if the ban were to be in effect. Despite technically still having both medication and in-clinic abortion available, options were colored differently by the uncertain legislative future.

These constant fluctuations in legislation, and thus the ability to provide abortion care to patients, result in shifts in the logics of care within clinics. Temporal disruptions in care affect when physicians can provide care as well as *how* they can provide care with unexpected repercussions for clinic staff and patients. For example, in my conversations with several physicians and staff, they described their surprise at how performing abortions prior to six weeks of pregnancy shaped abortion care, such as the increased discomfort of procedural abortions. Fear of the unknown was a common sentiment among clinic staff who felt uncertain about the future of abortion care. The push and pull of laws with different temporal boundaries further complicate the administrative burdens they must navigate.

Care as a Temporal Experience for Patients

Patients have been profoundly affected by the fluctuation in access to abortion care in still other unanticipated ways. When SB 23 was in effect, staff said that the limited time to make a decision shaped the patient experience. The previous term limit was up to 21 weeks and 6 days of pregnancy, but when SB 23 went into effect, abortions were banned after approximately six weeks of pregnancy. Thus, patients went from having months or weeks to days or even hours to decide how they wanted to move forward with their pregnancy. When speaking with Alina, a nurse at Grand Plains Clinic, she spoke about how the patient experience changed after SB 23 was enacted:

Abortions [were] coerced by the state left and right... You can't have an abortion unless you're sure, but I've never seen indecision like I was seeing in that time... You literally found out you were pregnant this morning... People would be like "I'm gathering information. I'm trying to figure it out." I'm like "that's fine, but you don't really have time for that."

It's a tough balance to acknowledge that for people... I started being like... "they, [the staff], are acting like this is an emergency and the rest of the day everyone is going to act like this is an emergency but if it's not an emergency for you and you need time to figure it out it's totally fine. You do not have to come back tomorrow. If you decide that you want to think about this for a week and you develop cardiac activity you can call us and the navigator [staff member who assists patients who need to travel to a different clinic] will help you figure it out and you can leave the state." I can't look at your chart and

know that because you have four kids you can't leave the state or that because you needed financial assistance you can't leave the state. That's not for me to decide but it was difficult to keep reminding patients of that...

Obviously, it was not the effect that the state was trying to have, I guess. It was like do you want it to happen fast or do you want us to think about it for 24 hours? Which is it? you can't have it both ways. But they did! They can do whatever they want [sounds dismayed]. Patients were not feeling good and I wonder... Are we going to see that pouring out in the data... Are there people a year from now who are going to regret their abortion? Probably.

Thus, at that point in Ohio, the timeline between having a positive pregnancy test and being able to have an abortion in many instances shrank to a matter of days. As Alina astutely observes, in effect, just as some patients may feel remorse at not being able to have an abortion during the ban, other patients may feel that their decision to have an abortion was rushed due to the quickening of care. In Puig de la Bellacasa's words, the act of caring "can feel good; it can also feel awful" (2017, 1). Care during a crisis situation, while well-intentioned, can produce this rushed quickening of care and thus ambiguous responses from patients.

Alina also touches on an important point that not all patients have the luxury of waiting to make a decision and potentially needing to leave the state, which takes financial and other resources. As I described earlier in this chapter, needing an abortion tends to be an emergent situation and the thought of waiting weeks to receive care is a major deterrent. Further, Alina highlights how there is a temporal conflict between the 24-hour mandatory waiting period and

SB 23 banning abortions after approximately six weeks of pregnancy. The state is simultaneously slowing care by requiring a 24-hour mandatory waiting period while also quickening care by enforcing an abortion ban at approximately six weeks of pregnancy. These temporal clashes in the political organization of time shape the logics of care within clinics.

In addition to noting how patients feel pressured or rushed in their decision, several healthcare workers also described that they found that many patients search for “signs” in ordinary moments to indicate whether they should continue their pregnancy. The staff who referred to patients searching for signs said that this was related to the shortened length of time patients had to make a decision when SB 23 was in effect. Chloe, a paid non-medical abortion support person, told me about one woman’s story: “she said to me ‘is that a sign that I shouldn’t do this? That my daughter called me.’ I was like it can be a sign. It’s up to you how you interpret that... It could just be a coincidence.” When individuals feel that their fate is out of their control, they tend to look for signs to provide explanations (Lepselter 2016). Lepselter (2016) asserts that these symbolic moments also reveal power relations, including those that are along gender lines (19). In this case, the act of searching for signs might be construed as a way to make sense of an abortion ban that punishes pregnant women. I also contend that signs provide a sense of control in a situation where patients feel that they do not have control over their own reproductive future. If one can find a sign, then they can feel comforted that they have made the “right” decision in a situation where they are given few options and little time.

In cases where a patient was unsure of their decision, sometimes staff challenged the temporal restrictions put forth by SB 23 by implementing a slowing of care when needed. Even though most patients were described as being certain of their decision, there were cases when patients were unsure whether or not they wanted to have an abortion. In Ohio, a patient would

run out of time if they were approaching six weeks of pregnancy, but if they were able to travel across state lines to a protected state then they would have more time to make their decision. Clinic staff were quick to tell patients that they should take the time they needed even if that meant that they would need financial assistance to leave the state. However, even with this support there are other reasons that it may be difficult to travel, such as the costs of travel, the need for childcare, the challenge of taking time away from work, and risk of intimate partner violence. As I described previously, time is a valuable and unequally available resource that not all individuals are afforded. Even with clinic funds or mutual aid to pay for travel, hotel stays, and the abortion, patients still may not be able to arrange time away from home or work. However, within the confines of the law, clinics created their own policies to help patients leave the state if they decided they needed more time to make a decision about whether to have an abortion.

Perhaps most surprisingly, a couple of staff members described how many patients did not understand that these temporal barriers are created by the state and not the clinic. Indeed, Nyra states:

This idea that people don't really understand the legalities that go along with it was shocking... I can't tell you the amount of people that walk in here on a daily basis like "I'm getting my abortion today" and you've just got to tell them no and really explain to them. They are like "what are you talking about?" Even when it comes to explaining that to them, they just think it's us doing it as a clinic. "Why do y'all make people do this?" and it's like "no, no, no. I'm just in the middle of it. This is state law. There are people downtown in Columbus [the capital of Ohio] who work at this building that sit there with

suits and ties on and say this is what you can and cannot do. They are the people regulating this. I'm just here to make sure that you have an understanding and are aware of it.”

Because individual staff members in the clinics must work as agents of the state, some patients assume that these are clinic-level policies and are due to each clinic's social organization of time. As I established in Chapter 2, the promotion of ignorance around pregnancy development and legal requirements contribute to this misunderstanding. The transformation from law to policy makes it appear as though these rules originate in the clinic when, in fact, they are designed by lawmakers with an anti-abortion agenda who shift the burden of implementing policies to delay abortion access to the very people intent on providing care.

In response, some physicians educate their patients on the difference between state law and clinic policy. For example, Dr. Shepherd informs her patients that unnecessary medical procedures are due to state legislation:

I always say “I'm really sorry, you have to come back in. We have to do another ultrasound. If there's a heartbeat then there's another 24-hour waiting period. There's no medical reason behind this, but this is the state law and I have to work within the confines of the law. So, I mean that's basically the spiel. Some ask and some don't, but I think it's annoying when you're tacking on a second or third visit for a lot of people and they have to miss work and travel and it's a few hours out of the day. That's lost wages... [and] figuring out what excuse you're going to tell your boss when you can't go to work. I think it's hard for them and we feel bad making them do it. I want them to know it's not

something [that is] my intent or goal or my personal desire to make things harder for them.

Dr. Shepherd speaks in a serious tone as she explains that it is not her goal to make her patient's lives more difficult. Furthermore, this time burden is spread differently along the lines of race and class. Jade, an administrative staff member, informed me that she applied to work at the clinic after she lost her previous job because she missed three days of work in order to have an abortion. Low-wage or entry-level jobs where an individual may not have paid vacation time and less control over their schedule are more at risk for losing their job. Similar to Wendland's (2010) findings in Malawi where physicians would educate patients and their families about government corruption when their patient's did not have adequate resources, some clinic staff felt that their best option was to educate patients about the political circumstances of the provision of their care to help them identify where to direct their anger.

However, several physicians described that some patients do not question the burdensome practices around abortion care, or that they resign themselves to what is required by the state even when they are explicitly told that they are receiving unnecessary medical exams or inaccurate information. Dr. Webber recounts this phenomenon,

I try to disclose to the patient, "I'm doing this because this is state law. This is not medically necessary but I have to do it in order to have your abortion. We have to do it." [Dr. Webber sighs]. It's always surprising to me how unfazed people are when I say things like that. They're just like "oh, okay." [she laughs at this thought]. Why aren't you completely infuriated? Why aren't you like "what the fuck? How could you do that?!"

You know, I think women expect things to be hard. They expect that doing what they need to do for their lives is going to be hard. They don't expect bodily autonomy. It's not something that they've been taught is normal.

Without asking patients directly, it is difficult to know why they might appear unperturbed, but abortion stigma and gendered expectations around reproductive health treatment may offer explanations. In this way, Dr. Webber is resisting these policies by educating patients on why their time and reproductive autonomy are not valued by the state.

By focusing on the temporal aspects of policy and care, one can see the hidden harms and constraints imposed on patients. Due to different anti-abortion laws, patients are rushed to make healthcare decisions (e.g., gestational limits), while simultaneously being told they must take more time to think through their decision (e.g., mandatory waiting periods). Essentially, the political construction of time in abortion patient care conveys that the state intends to punish pregnant people. Yet according to some clinic staff, patients do not understand that these policies are determined by state legislation, not clinic-level policy. The everyday policy effects of such legislation are that patients may assume that abortion providers do not value their time. The harms of policy uncertainty and the political regulation of time with respect to abortion care become visible when paying attention to the mundane aspects of care.

Conclusion

The political construction of time in anti-abortion legislation and the hidden harms revealed in the localized logics of care are previously overlooked dimensions of reproductive governance. According to Shore and Wright, "a policy is a narrative in a continual process of

translation and contestation” (2011, 14). These stories told about anti-abortion policies reveal how some clinic staff and patients feel a lack of control over their futures. For clinic staff, this was shown in Nyra’s discussion of “the fear of the unknown” in relation to job security and the ability to serve patients. Anxieties around signing FHD forms and other aspects of localized policies were also an indication of a lack of control around one’s own time. On the other hand, there were instances where patients felt as though they did not have enough time under the “heartbeat” ban (SB 23) to decide whether to have an abortion and searched for symbolism in ordinary moments. Rapid shifts in legislation reveal the anxieties, tensions, and contestations that occur in the everyday experience of providing or seeking abortion.

Temporal aspects of policy— visible as the structural enforcement of health care restrictions —were evident in unintended and unexpected ways in the mundane aspects of care. Policies were translated in a variety of ways to provide “as-well-as-possible care” or what Mol et al. refer to as “good enough” care (13). When a patient wants or needs an abortion but is running out of time due to the gestational limit, there was a quickening of care to provide them with the abortion before it would become illegal. In contrast, when there was a mandatory waiting period there was a slowing of care to avoid criminalization. There were also moments of what I would describe as soft resistance when healthcare staff would notify a patient that they would provide resources to leave the state to buy them more time if they were unsure of their decision. This slowing of care, in particular, was a way to preserve patient self-determination in the face of anti-abortion legislation. Staff “tinker” (Mol, Moser, and Pols 2010) with the time they take to provide care under legal constraints to provide “good enough care.” These acts of tinkering are forms of soft resistance and constitute what Livingston (2012) would describe as “inherently political acts” (96). In crisis situations where abortion providers are scarce and access to abortion

is precarious, “good” care becomes more about the ability to obtain an abortion (even if it is not in the patient’s home state) than with how that abortion is experienced. Clinic staff care about the nuances of the care they provide, but crisis situations require a rapid response and, thus, undermine their ability to provide quality care.

As I have shown, time is another important dimension of reproductive governance. I have investigated the shifting tensions and moments of legal precarity as new legislation is passed and abortion clinics struggle to continue to provide care. In particular, I have focused on how healthcare workers navigate the shifting and fractured terrain of abortion care and how healthcare crises can reveal both unexpected harms and opportunities to contest reproductive governance. Investigations of policies in-flux reveal how uncertainty in access to care affects the provision of care. In this chapter, I advance literature on policy and care by arguing for the importance of investigating how policy fluctuations are translated into everyday care-in-practice. I pay special attention to how policy shifts produce hidden harms for patients and providers, and how staff innovate and improvise their care practices in return. Ultimately, this chapter demonstrates how the reconfiguring of reproductive time is an overlooked mechanism of reproductive governance used to shape and control bodies.

Conclusion

On November 7th, 2023 the majority of Ohio voters chose “yes” on Issue 1: the Right to Make Reproductive Decisions Including Abortion Initiative. This amendment to the Ohio state constitution protects the right to abortion, miscarriage, contraception, and fertility care. With this amendment, legislation like the “heartbeat” ban is no longer permitted; however, obstacles to abortion care such as the 24-hour mandatory waiting period continue to persist. And across the US, abortion access continues to be in a state of crisis with 17 states currently enacting complete or near-complete abortion bans since the *Dobbs* Supreme Court decision overturned *Roe v. Wade* on June 24th, 2022 (Guttmacher Institute 2024a). From a global perspective, this trend in the US stands in stark contrast to the 60 countries and territories that have liberalized their abortion laws over the past 30 years (Center for Reproductive Rights 2024). Still, within the US there is a fracturing of the reproductive health landscape across the country: for instance, states such as New York and Illinois have passed legislation securing access to abortion, whereas many others across the Midwest and South continue to enact increasingly restrictive abortion legislation. As the American reproductive landscape continues to change, it becomes ever more important to understand the inner-workings of reproductive governance in repressive regimes. For this reason, this dissertation has moved from the Statehouse to the intimate settings of clinics to explore how anti-abortion laws and budget regulations are passed; how they shape knowledge (and ignorance) production; and how they affect care in clinics. Ultimately, I argue for the conceptual value of attending to temporalities of structural violence, and specifically the pace at which political violence unfolds. In this concluding chapter, I outline three overlooked dimensions of reproductive governance and their conceptual intervention, provide an overview of my

conceptual contribution to structural violence scholarship, and look ahead to the future of the politics of abortion care in the US and future research directions.

Dimensions of Reproductive Governance

Reproductive governance builds upon Foucault’s notion of biopower—the ways in which regimes of authority manage the biological aspects of populations—to foreground how reproductive behaviors are shaped and controlled (Morgan and Roberts 2012). Regimes of authority can be restrictive or liberating in how they shape reproductive behaviors. In other words, they can constrain reproductive options or provide support for a range of reproductive outcomes. I have focused on the tactics of a restrictive regime that enacts what Morgan and Roberts (2012) call “legislative controls” to minimize reproductive health care access through the threat of criminalization of both healthcare provider and patient. In this case, anti-abortion legislation is used to control when and how pregnant people can obtain an abortion. In this dissertation, I hope to have provided new understandings of how states control people’s bodies. I argue that each chapter uncovers an overlooked dimension of reproductive governance: 1) administrative and regulatory strategies 2) the spread of ignorance, and 3) the political reconfiguring of reproductive time.

Administrative and regulatory strategies are apparent throughout the chapters, but especially so in Chapter 1 where I developed the concept of reproductive gerrymandering; a particular phenomenon wherein partisan redistricting suppresses the political power of voters who support reproductive healthcare access across political party lines. It gives the false impression that the majority of residents in states that predominately elect Republican representatives want government elimination of abortion and related services. Reproductive

gerrymandering and associated administrative processes are forms of reproductive governance that promote anti-abortion agendas through bureaucratic violence. This chapter demonstrates how bureaucratic procedures are weaponized to manipulate voting district map data and budgetary guidelines. In similar ways, bureaucratic processes are utilized in Chapters 2 and 3 to curtail abortion access by mandating the completion of paperwork associated with HB 59 and the need to document whether or not a “heartbeat” has been detected.

Further, the manipulation of budgetary processes is an example of “economic inducements” used to promote particular reproductive behaviors (Morgan and Roberts 2012, 243). As demonstrated in Chapter 1, the redirecting of state funding away from health centers with abortion services to CPCs that disseminate medical misinformation and promote moral judgment of abortion show how financial incentives are used to advance anti-abortion agendas. Hidden in the banalities of administrative meetings and documents hundreds of pages long, reproductive health care access is curtailed. These strategies are effective methods of control because they accomplish two things: 1) the manipulation of data can be used to gain or maintain control over governance and 2) the use of bureaucratic regulations make it difficult to pinpoint the individual(s) manipulating data and controlling economic incentives. Administrative and regulatory strategies of reproductive governance are particularly insidious because of their ability to conceal political motivations through data manipulation and economic inducements.

The deliberate spread of ignorance is the second dimension of reproductive governance that I reveal in this dissertation. Building upon administrative and regulatory strategies, in Chapter 2 I showed how SB 23 mandates “heartbeat” ban paperwork to enforce ignorance around when the heart is developed and does, in fact, begin to beat. I draw upon theories of agnotology—the study of ignorance—to argue that legislators who sponsor “heartbeat” bans

manipulate biomedical terms to imbue embryos with a particular social meaning at a very early stage of pregnancy. I explored how biomedical practices, in this case the use of ultrasound technology to detect a “heartbeat,” promotes the cultural production of ignorance around pregnancy and sends a particular message about the beginnings of life. This second dimension of reproductive governance promotes ignorance of biological and scientific understandings of pregnancy and produces terms that evoke particular images and emotions to serve political ends.

In addition to being a method of legislative control, “heartbeat” bans also operate as a type of “moral regime,” defined as “privileged standards of morality that are used to govern intimate behaviours, ethical judgements, and their public manifestations” (Morgan and Roberts 2012, 242). Morgan and Roberts (2012) build upon Foucault’s notion of “regimes of truth” and how systems in power produce knowledge to maintain certain “truths” (Foucault 1990). They also draw on Didier Fassin’s (2007) notion of the “politics of life” (Morgan and Roberts 2012, 242) and how moral discourses are harnessed for political means. The promotion of ignorance as it relates to reproductive governance, I argue, is a form of knowledge production imposed by state governments to spread misinformation and control how reproductive processes are viewed. This is demonstrated in the semantic message that characterizes the strategic use of the term “heartbeat” to incite a moral judgment on individuals who seek abortion, equating them with murderers. In this way, the semantic message becomes a mechanism for reproductive control by spreading a moral discourse, and these language choices permeate the walls of the clinics to become ingrained in clinical care—a public manifestation of moral judgment. The spread of ignorance shapes how reproductive processes are viewed.

Finally, the third dimension of reproductive governance I reveal is the political reconfiguring of reproductive time. In Chapter 3, I demonstrated how paying attention to the

push and pull of temporal markers shapes care in clinical settings. Legal mandates that shape how clinicians must spend their time providing abortion care and the constant state of uncertainty due to shifting legislation constrain the kind of care that providers can give, focusing them solely on helping patients who want an abortion to have one before time has run out. These temporal markers also produce new care regimes that are counter to established medical routines and standards. This highlights how policy uncertainty, which shapes how time is structured and valued, is a technique of reproductive governance. Time is yet another facet of reproductive governance that constrains reproductive options.

Reproductive governance mechanisms build upon one another and become embedded in everyday life. The first two chapters focus on strategies of reproductive governance, whereas the third chapter attends to the impacts. Chapter 1 demonstrates how anti-abortion legislation and associated budgetary guidelines are passed; Chapter 2 shows how that legislation becomes ingrained in clinics and eases the passage of subsequent bills; and Chapter 3 illustrates how different anti-abortion bills place temporal constraints on clinic staff and patients. In other words, through the manipulation of data, semantics, and time the state exerts control over pregnant people and their ability to decide if and when they plan to bring a pregnancy to term. These insidious tactics operate via deception and manipulation, seeping into the mundane aspects of clinical care.

By investigating the mechanisms of reproductive governance and the work that they do, one is able to reveal the hidden harms in the everyday provision of care. This became especially apparent in Chapter 3 with the temporal constraints on care, such as the need to provide in-clinic abortions prior to six weeks of pregnancy even though these procedures were likely more uncomfortable for patients. Further, despite relatively superficial discussions with clinic staff

concerning the race and class of patients, we know that those harms related to abortion access are experienced differentially along lines of social and economic difference with those most marginalized experiencing the most harm. Race and poverty are deeply entangled in the US (Cohen and Joffe 2020), and the demographic breakdown of abortion patients suggest that barriers to abortion access disproportionately affect poor persons of color (Jerman, Jones, and Onda 2016). Women with incomes lower than the federal poverty level account for roughly half of all abortions (Jones and Jerman 2017b). Thus, abortion access affects low-income pregnant persons at a disproportionate rate due to the high cost and declining number of providers in broad regions of the country. Consequently, those of a lower economic status are disproportionately affected by restrictive laws and abortion bans. In response to these reproductive governance tactics and the harm they cause clinic staff and patients, I offer four policy recommendations in Appendix A. These are important themes to ponder in future efforts to tackle the issues addressed in this dissertation. Finally, in the next section I outline the broader conceptual contribution of the dissertation.

Temporal Dimensions of Structural Violence

As a whole, this dissertation advances anthropological understandings of the temporal dimensions of structural violence. One temporal form of structural violence is encapsulated by Rob Nixon's (2013) concept of slow violence, which creeps along relatively unnoticed leaving destruction in its wake. Anthropologist Chloe Ahmann (2018) describes slow violence in terms of incrementality: "a pace that stays beneath thresholds of recognition, but that makes something lasting in the process. As a strategy, it can mean weakening an opponent through small, successive victories" (154-155). Ahmann builds upon Nixon's work to demonstrate how political

strategies can also be slow, but impactful over time. I advance these works by arguing for the conceptual value of attending to the pace of violence (fast, slow, stagnant) as a political strategy.

Time was a persistent theme throughout my fieldwork: how it was structured, manipulated, and navigated. I found that there were years of slow incremental violence building on one another with gerrymandering, the passage of increasingly restrictive abortion legislation, and the defunding of reproductive health programs. The manipulation of time becomes an essential strategy again in Chapter 2 with the distortion of gestational timelines and the spread of ignorance around when a heart, in fact, forms and begins to beat. Finally, in Chapter 3, I demonstrate how clinical temporalities and the logics of care are structured and shaped by uncertainty concerning abortion laws and policies. The constant fluctuation of policies demanded rapid or slow responses depending on the context. Importantly, the pace with which violence unfolds shapes the strategies and impacts associated with political violence.

Taken together, I contend that there are different temporalities of political violence with varying speeds. Within days, weeks, months, and years there is a pace with which violence trudges along, erupts in a sudden flash, or rests in relative stasis. I advance these works by arguing that structural violence operates in different temporalities: it is not simply slow or fast and there is no singular timeline; there is a pace or tempo that is fluid and synchronous. Importantly, I also demonstrate how manipulating temporalities is an effective tool of political violence to inflict more harm (e.g., mandatory waiting periods and gestational limits). By attending to these tempos, I argue that anthropologists can learn about the strategies and impacts of structural, and more specifically, political violence. In the next section, I look ahead to the future politics of abortion care and new research directions.

The Future Politics of Abortion Care and Future Research Directions

Just as abortion legislation is quickly shifting in states across the US, so are the politics of abortion care. *Roe v. Wade* (1973), as discussed in the introduction, established abortion as a right based on neoliberal notions of individual choice. The Supreme Court determined that the right to have an abortion fell under the Fourteenth Amendment's protection of the right to privacy, which had previously been used to argue for married couples' access to contraceptives in 1965 (*Griswold v. Connecticut*). As has been discussed by scholar of race and reproduction Dorothy Roberts, the constitutional right to privacy is a "'negative' right to be free from unjustified intrusion, rather than a 'positive' right to actually lead a free life...The Constitution, then, does not obligate the government to ensure the social conditions and resources necessary for individual liberty" (1997, 229). In other words, the Constitutional right to privacy protects the right to have an abortion but does not disallow impediments to accessing said right. Prior to the *Dobbs* decision, *Roe* did not provide all citizens with the ability to access abortion.

However, with the fall of *Roe* comes an opportunity to rebuild anew. As abortion provision becomes scarcer across much of the US and the ability to obtain an abortion becomes dependent on one's ability to travel to other states, it becomes ever more important to reimagine new forms of community support for abortion and the full spectrum of reproductive options. This study was limited in that I did not interview patients and gain their perspective of these policy shifts, which provides an opportunity for future research. However, I do have more data that I did not write about in this dissertation concerning activist networks. For example, I did not include this in these sections of my dissertation, but in my fieldwork I found that there has been a contemporary shift away from neoliberal individualist rights-based language to a reproductive justice framework focused on intersecting issues of social and economic justice. Reproductive

justice "centers unequal power relations, particularly as they are continually produced by the state...[including] the insistence on analyzing a range of policy and practice as part of an interconnected system" (Luna and Luker 2013, 329; see also Ross and Solinger 2017; Leonard 2017). In the future, I intend to examine the ways in which abortion activists and advocates are forming new ways of framing abortion rights and providing reproductive care in communities, including the use of reproductive justice ideals in abortion activism and the work done in mutual aid projects that resist restrictive abortion governance outside of clinic settings. These shifting terrains for reproductive policies and activist networks offer the opportunity to better understand mechanisms of state power used to control bodies. In this time of crisis, now that the previous protections under *Roe* have been abolished, there is an opportunity to reimagine a new reproductive landscape.

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Appendix A

State and Clinic Policy Recommendations

1) Redistricting Reform

In states where gerrymandering is prevalent, redistricting reform with an independent commission offers a way to counter gerrymandering. I note the importance of the commission being independent because there is already a redistricting committee in place in Ohio that is predominately Republican. In 2015, an overwhelming percentage (71%) of Ohioans voted for an amendment to the Ohio constitution stating that no district plan should favor a particular political party (*Article XI, Section 6 | Additional District Standards*, 2021). After this amendment was passed, a redistricting commission was created to include the governor, the auditor, the secretary of state, and four legislators. However, out of the seven members, five are Republican. The commission has been sued five times throughout 2021 and 2022 for drawing maps that reflected a partisan advantage for Republicans, and each time the Ohio State Supreme Court determined that the maps were gerrymandered. The redistricting committee moved forward with the gerrymandered maps and the Ohio Supreme Court failed to hold the committee members in contempt. Essentially, when the commission is unable to pass a constitutional map, it is adopted for four years instead of ten. Under the current system the committee is allowed to pass gerrymandered maps every four years without repercussion. Despite this attempt to foster an unbiased redistricting process, one political party still dominated the map-making process. In response, there is a campaign called “Citizens not Politicians” underway to amend the Ohio constitution and create an independent commission of 15 Ohio voters from across the state to draw the voting maps (Citizens Not Politicians

2024). The initiative will be voted on in the November 2024 election and, if passed, could help mitigate partisan control of the redistricting process.

2) Ballot Initiative

Another possible response to reproductive gerrymandering is to create ballot initiatives protecting abortion access. By allowing citizens to vote directly on whether they want abortion rights protected in their state, one is able to curtail the issue of partisan gerrymandering. Voter suppression and other issues still remain, but ballot initiatives alleviate some of the major issues with gerrymandering. As an example, in Ohio, Issue 1—Right to make Reproductive Decisions Including Abortion Initiative—was passed by popular vote. This initiative was successful despite a calculated misinformation campaign. Indeed, Ohio Secretary of State Frank LaRose admitted to collaborating with opponents of the amendment to manipulate the language used on the ballot and orchestrated an unprecedented August election in an attempt to change the definition of a “popular vote” to at least 60% majority (Cleveland.com 2023). Even in this difficult context, the majority of Ohio voters chose to protect abortion access. Over the next year, four states (Florida, Colorado, South Dakota, and Maryland) will have similar initiatives protecting the right to abortion on their ballots in the November 2024 election.

3) Semantic Shift

In Chapter 2, I showed how clinic staff tend to have difficulty navigating the use of the term “heartbeat” when it is scientifically inaccurate. For this reason, I recommend that clinics standardize the terminology they use to refer to the “heartbeat” to shift the language away from a term that misrepresents the actual biological processes. I have

chosen to use the term embryonic electrical impulses throughout this dissertation because I feel that it best describes the biological process occurring at approximately six weeks of pregnancy. However, perhaps a shortened version such as “embryo pulses” or “cellular pulses” might be better suited for patients with a range of understandings. I plan to discuss this idea with the clinics in my study. Another possible way to educate or change public perception could be for advocacy organizations to have billboards or social media advertisements to show that at about six weeks of pregnancy these are cells interacting.

4) Patient Advocacy

Abortion restrictions exacerbate physical and financial obstacles to abortion care, which in turn intensifies the social stigmatization of abortion. Patients tend to fear judgment for their decision from individuals and/or their community (Norris et al. 2011; Hanschmidt and et al 2016), which is only heightened by the fear of criminalization in the post-*Roe* landscape. Further, as demonstrated in this dissertation, abortion restrictions also intensify temporal obstacles to abortion care. At times, patients have difficulty navigating the push and pull of temporal markers in anti-abortion legislation, and may only have hours or days to decide if they will go through with an abortion. In response, abortion doulas in their role as reproductive health advocates can provide a possible solution to this ever-evolving set of patient needs. Abortion doulas are nonmedical volunteers who provide compassionate emotional, physical, and informational support to patients before, during, and after an abortion (Basmajian 2014; Mahoney and Michell 2017). Key techniques include hand-holding, comforting conversation, supportive silence, massage therapy, and breathing exercises (Basmajian 2014). Abortion doulas assist with patient

distraction, patient companionship, and function as a patient advocate. For example, if a patient is unsure of their decision to have an abortion, the doula can voice this concern to staff who can then assist the patient by providing resources to travel to another state if they need more time and will pass the gestational limit in their home state. For this reason, abortion doulas can provide emotional support as well as assess and translate patient needs to clinic staff. As abortion becomes increasingly difficult to access in much of the midwestern and southern US, abortion doulas can help mitigate the harms caused by anti-abortion legislation by advocating for patients. While staff can focus on providing abortion care to as many patients as possible, volunteer abortion doulas can focus on the nuances of that care to best serve the patient. For these reasons, I have shared a policy brief outlining the potential benefits of abortion doula programs with the groups that I worked with in Ohio.

Endnotes

¹ Throughout this text, all names of people, towns/cities, clinics, and organizations are pseudonyms.

² Some organizations identify as pro-choice and some identify as pro-abortion. Pro-abortion organizations and organizers view abortion as a community good and tend to operate under the tenets of a reproductive justice framework rather than a rights-based legal framework. In contrast, a rights-based framework assumes that having the legal right to abortion is sufficient, a reproductive justice framework centers the most marginalized and focuses their efforts on ensuring that individuals have the access needed to make reproductive decisions free from constraints, such as cost and other structural factors.

³ See also Lauren Berlant's (2007) essay on "slow death" and how obesity causes chronic health problems that lead to death primarily in lower-income communities.

⁴ Throughout this dissertation, I intentionally use gender neutral terminology, such as pregnant person instead of woman, to include individuals of all genders with a uterus who may obtain an abortion. At the same time, it is important to acknowledge that it is primarily women who are affected by anti-abortion legislation because the politics of abortion in the US are shaped by views of gender and sexuality. For this reason, at times I do refer to pregnant women when discussing gendered ideologies.

⁵ Throughout this dissertation, I use the term "anti-abortion" instead of "pro-life." The term pro-life insinuates that a pro-choice or pro-abortion stance promotes death. Similar to how I refer to the semantic massaging that occurs with the term "heartbeat," the term pro-life sends a political

message that pregnant people who have an abortion are murderers. For this reason, I am careful not to perpetuate this moral framing.

⁶ The Hyde Amendment also shaped how foreign aid was distributed and affected the politics of abortion internationally.

⁷ Ohio has a similar demographic makeup to the greater US in terms of age, sex, income per capita, and race/ethnicity with the exception that Ohio has a higher percentage of White identifying residents and a lower percentage of Hispanic or Latino identifying residents (U.S. Census Bureau 2023).

⁸ The goal of acquiring a Certificate of Confidentiality from the National Institutes of Health is that it lessens the possibility of a subpoena; thus far, this has not been tested thoroughly in court (see Khan 2019).

⁹ It is important to note that Ohio Issue 1 was passed by popular vote despite a calculated misinformation campaign, including Secretary of State Frank LaRose admitting to collaborating with opponents of the amendment to manipulate the language used on the ballot and the orchestration of an unprecedented August election attempting to change the definition of a “popular vote” to at least 60% majority (Cleveland.com 2023).

¹⁰ For examples of gerrymandered maps, see the Ohio Redistricting Commission (2024) website: <https://www.redistricting.ohio.gov/maps/view-maps> (accessed June 25th, 2024).

¹¹ I use the term “legal abortion” because individuals who are able to access medication abortion (misoprostol and mifepristone) can induce an illegal abortion without leaving their state.

¹² Abortion is legal in Ohio up to 22 weeks, which means that clinicians can provide abortions through 21 weeks and 6 days.